



**COVERED CALIFORNIA
QUALIFIED DENTAL PLAN ISSUER CONTRACT FOR 2017 - 2019**

between

**Covered California, the California Health Benefit Exchange
(the “Exchange”)**

and

_____ (**“Contractor”**)

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**COVERED CALIFORNIA
QUALIFIED DENTAL PLAN ISSUER CONTRACT**
between
**Covered California, California Health Benefit Exchange
(the “Exchange”)**
and
_____ (**“Contractor”**)

THIS QUALIFIED DENTAL 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 dental plan 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 dental plan issuers in order to make available to Enrollees of the Exchange dental care coverage choices that seek to provide the optimal combination of choice, value, access, quality and service to Qualified Individuals, Employers and Employees;

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 dental plan issuers to market, offer, and sell Qualified Dental Plans (QDPs) through the Exchange, (ii) are set forth in the QDP Issuer Application and (iii) are required under applicable laws, rules and regulations or otherwise necessary to meet the needs of QDP Enrollees in the Exchange, including those set forth at 10 CCR § 6400 et seq. 45 C.F.R. Part § 155 et seq.;

C. In connection with the evaluation of the responses to the Application received from dental plan issuers, the Exchange shall: (i) to evaluate the proposed QDP Issuer’s compliance with requirements imposed under the Application, and (ii) to give greater consideration to potential QDP Issuers that further the mission of the Exchange by promoting, among other items, the following: (1) affordability for the consumer and small employer – both in terms of premium and at point of care, (2) “value” competition based upon quality, service, and price, (3) competition based upon meaningful QDP 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 dental plan issuers;

D. Contractor is a dental plan issuer authorized to provide Specialized Health Care 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 license 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 QDP Issuer pursuant to the Exchange’s determination that Contractor’s proposed QDPs meet the requirements necessary to provide dental coverage as a QDP to Qualified Individuals and Employers who purchase dental coverage through the Exchange;

F. Contractor desires to participate in the Exchange as a QDP 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 QDP Issuer and operation of the QDPs 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) the coordination and cooperation between the Exchange and the Contractor on the promotion of better care and higher value 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 the 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 its mission by creating an innovative, competitive marketplace that empowers consumers to choose the dental 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 cost of health care services. By agreeing to these expectations as set forth in this Agreement, Contractor and the Exchange acknowledge a commitment to be active and engaged participants to promote change and to work collaboratively to define and implement additional initiatives to continuously improve quality and value.

1.2 Applicable Laws and Regulations

This Agreement is in accord with and pursuant to the California Affordable Care Act, California Government Code § 100500 et. seq., (Chapter 655, Statutes 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).

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

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 Parties

- (a) Independent Contractors. The parties acknowledge and agree that, as required by State and Federal law, in carrying out its responsibilities, the Exchange is not operating on behalf of Contractor or Contractor's QDPs or any authorized subcontractor of Contractor. In the performance of this Agreement, the Exchange and Contractor shall at all times be acting and performing as an independent contractor, and nothing in the Agreement shall be construed or deemed to create a relationship of employer and employee or partner or joint venture or principal and agent between the Exchange and Contractor. Neither Contractor nor Participating Providers, authorized subcontractors, or any agents, officers or employees of Contractor are agents, officers, employees, partners or associates of the Exchange.
- (b) Subcontractors. Contractor shall require any subcontractor or assignee to agree to be bound by all applicable provisions of this Agreement; provided however that nothing in this Section shall limit Contractor's ability to hold subcontractor liable for performance under the contract between Contractor and subcontractor. The obligation of Contractor to comply with responsibilities under this Agreement and applicable laws, rules and regulations shall remain and shall not be waived or released if Contractor subcontracts or otherwise delegates any Services required to be performed by Contractor under this Agreement or by laws, rules or regulations or any other obligations under this Agreement. Contractor shall be solely responsible for (i) exercising appropriate diligence in connection with its selection of its subcontractors, (ii) monitoring and auditing the services provided by such subcontractor to assure that the services provided by such subcontractors are provided in accordance with the terms set forth in this Agreement or imposed by Health Insurance Regulators or under other applicable laws, rules and regulations regarding arrangements by and between Contractor and subcontractors.

1.4 Duties of the Exchange

The Exchange is approved by the United States Department of Health Services ("DHHS") pursuant to 45 C.F.R. § 155.105 and shall perform its duties in accordance with the terms and conditions required of this Agreement pursuant to applicable laws, rules and regulations, including the California Affordable Care Act and the Federal Affordable Care Act. The duties of the Exchange shall include:

- (a) Certification of QDP Issuers (45 C.F.R. Part 155, Subpart K and 45 C.F.R. 155.1065);
- (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 and Internet website (45 C.F.R. § 155.205 and 45 U.S.C. § 18031(d));
- (d) Eligibility and enrollment in the Individual Exchange and Covered California for Small Business (45 C.F.R. Part 155, Subparts D, E, H, I);
- (e) Financial support for continued operations of the Exchange (45 C.F.R. § 155.160);
- (f) Navigator program standards designed to raise awareness of the Exchange by, among other items, 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 agents to enroll Qualified Individuals or employers in QDPs (45 C.F.R. § 155.220);

- (k) Allowance for the payment of premiums (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) The Exchange also has a duty, as part of its management of CalHEERS, to determine how information about the cost, quality and provider availability is presented to consumers to inform their selection of a Family Dental Plan and benefit design in the Exchange. The Exchange shall solicit comment from Contractor on the designs, but shall make design and presentation decisions at 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

All documents and information provided by Contractor to the Exchange or to the vendor for the Exchange shall be treated by the Exchange as confidential and exempt from public disclosure if they are deemed to be or qualify for treatment as confidential information under the Public Records Act, Government Code § 6250, et seq. and other applicable Federal and State laws, rules and regulations, including Government Code § 100508 (a). Documents and information that will be treated 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 QDPs are important to furthering the goal of the Exchange with respect to delivering better care and higher value. Contractor agrees that Contractor's QDPs identified at Attachment 1 ("Contractor's QDP List") shall be offered through the Exchange to provide access to Specialized Health Care Services to Enrollees in accordance with the terms and conditions required by this Agreement and as required for designation of each dental plan as a QDP.

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 Dental Plans identified in Attachment 1 are offered in 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; and
- (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.

1.6 Transition between the Exchange and Other Coverage

In order to further the Exchange's mission regarding continued access to dental 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") (regarding Medi-Cal) 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.

1.8 Changes in Requirements

The parties acknowledge that prospective changes to benefits and services may be made by the Exchange during a Contract Year to incorporate changes (1) required as a result of changes in State or Federal laws, rules or regulations; (2) imposed by regulators; or (3) as mutually agreed upon by the parties. The projected cost of any such benefit or service change will be included in the cost of oral 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 performance by Contractor with respect to fulfillment of its obligations set forth herein shall be evaluated by the Exchange 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 the 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, such notice 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 QDP Issuer, including those set forth at and 45 C.F.R. § 156.200 et seq. (Subpart C—Qualified Health Plan Minimum Certification Standards);
- (e) Significant changes in operations of Contractor that may reasonably be expected to significantly impair the Contractor's operation of QDPs and/or delivery of Specialized Health Care Services to Enrollees;
- (f) Changes in its Provider Network by notice consistent with Section 3.3; and
- (g) Change in Disclosures. Contractor shall notify the Exchange with respect to any material changes in its provider network as of and throughout the term of this Agreement with respect to prior disclosures made by Contractor in its Proposal. For purposes of this Agreement, a material change in the disclosures shall relate to an event or other information that may reasonably impact Contractor's ability to perform under this Agreement in comparison with the information previously disclosed by Contractor in the Proposal.

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 § 1557 (42 U.S.C. 18116) and its implementing regulations, 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 § 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.

(c) Contractor's notices to enrollees shall comply with the standards set forth in 45 C.F.R. part 92.

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 or indirect interest which 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 with respect to laws, rules and regulations that govern referrals required for the provision of certain Health Care 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 QDP Enrollees. Possible requests may include (but not be limited to), annual audited financial statements, annual profit and loss statements, and annual dental loss ratio.

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. 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 § 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 § 5200) of Part 5 of Division 9 of the Family Code.
- (d) Domestic Partners. Contractor shall fully comply with Public Contract Code § 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 § 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 from providers in the most recent 12-month period who provided services 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.

ARTICLE 2 – ELIGIBILITY AND ENROLLMENT

2.1 Eligibility and Enrollment Responsibilities

2.1.1 Exchange Responsibilities

- (a) The Exchange shall be responsible for the determination of eligibility and enrollment of individuals in the Exchange in accordance with Federal and State laws, rules and regulations. The Exchange will assume statutory obligations as required as part of initial enrollment that would otherwise be carried out by Contractor, such as assuring completion of Agent attestation, if applicable.
- (b) The enrollment of eligible individuals in the Exchange shall be made by 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 designated Contractor as the QDP. The Exchange shall transmit information required for Contractor to enroll the applicant, and Contractor shall enroll applicant within five (5) business days of receipt of verification of eligibility and selection of Contractor's QDP.

2.1.2 Contractor's Responsibilities

- (a) Contractor shall comply with all Federal and State eligibility and enrollment statutes 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 eligibility and enrollment determinations that shall be made for Enrollees by the Exchange, 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 appeal 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 QDP Issuer will work closely with the Exchange to implement the appeals decision as soon as reasonably possible.
- (c) 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.
- (d) Contractor shall accept changes to enrollment received from the Exchange other than during the Employer's Open Enrollment period for qualifying events as required under applicable laws, rules and regulations, including those set forth at 45 C.F.R. § 155.330.
- (e) Contractor shall send enrollment information to the Exchange on a daily basis and Contractor shall reconcile Enrollment information received from the Exchange with Contractor's enrollment data on a monthly basis.
- (f) 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.

- (g) 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 eligible Plan Year. Contractor shall provide this file within two (2) weeks of the receipt of the monthly reconciliation file.
- (h) 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 Employers or 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 Eligibility Periods

Contractor acknowledges and agrees that the Exchange is required (i) to allow Qualified Individuals to enroll in a QDP or change a QDP during annual Open Enrollment Periods, (ii) to allow certain Qualified Individuals to enroll in or change QDPs during Special Enrollment Periods as a result of specified triggering events per applicable Federal and State laws, rules and regulations.

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 QDP 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 following month for QDP 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/or 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 specific terms and conditions relating to commencement of coverage, including the cancellation or postponement of the effective date of coverage in the event of nonpayment or partial payment of an initial premium, shall be established by the Exchange 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 QDPs, 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; the Contractor shall not pursue collections of any said fees from the Exchange.

Premium charged to individuals includes the assessment of the participation fee, (see Section 5.1.3 Participation Fee). 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 for his/her premium to Contractor.

2.2.4 Terminations of Coverage

Contractor shall terminate an enrollee's coverage in a Contractor's QDP in accordance with the requirements established by the Exchange based on requirements set forth at 10 CCR § 6506 and other applicable State and Federal laws, rules and regulations. Contractor shall report information to the Exchange regarding delinquent full or partial payments of premium owing by Qualified Individuals in such format and intervals as is reasonably requested by the Exchange.

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 Agents in the Individual Market

- (a) Compensation. The provisions of this Section apply to Agents who sell Contractor's QDPs through 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 during both Open and Special Enrollment Periods. Contractor shall be solely responsible for compensating Agents who sell Contractor's QDP 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 QDPs through the Exchange to the Agent's sale of Contractor's 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. Contractor shall not change the Agent commission structure or rates during the plan year. Contractor will pay the same commission during Open and Special Enrollment for each plan year. Contractor shall pay Agents based on the total amount of monthly premium. 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 2.2.5(f) and 2.2.5 (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.

- (d) Agent Appointments. Contractor shall maintain a reasonable appointment process for appointing Agents who contract with Contractor to sell Contractor's QDPs 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 QDPs 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 QDPs 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 assure only Agents who have been duly certified by the Exchange and maintain that certification shall 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 Record 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 who enrolled a consumer. As such, an Agent delegation may consist of an agent, agency, or primary agent with an agency.

2.3 Covered California for Small Business Exchange

The Exchange has established Covered California for Small Business to assist Employers by facilitating enrollment of Employees into QDPs. The Exchange will assume statutory obligation as required as part of initial enrollment that would otherwise be carried out by Contractor, such as assuring completion of Agent attestation, if applicable. All specified Employees, and their Family Members, of Employers who are eligible in accordance with the Affordable Care Act, California Affordable Care Act, and Regulations may obtain coverage through Covered California for Small Business as permitted by State and Federal laws, rules and regulations. Contractor shall process Covered California for Small Business enrollments from small businesses determined by the Exchange to be eligible for coverage in the Covered California for Small Business in accordance with the terms set forth in this Agreement and State and Federal laws, rules and regulations.

2.3.1 Covered California for Small Business Enrollment Periods

Contractor agrees to allow Employers and Employees to purchase coverage in Covered California for Small Business at any point during the year (“rolling enrollment period”) and as a result of specified triggering events, during Special Enrollment Periods. Contractor shall accept new Employers and Employees in Covered California for Small Business and eligible dependents who enroll during these periods.

2.3.2 Covered California for Small Business Coverage Effective Dates

- (a) Upon verification of eligibility and selection of Contractor’s QDP, the Exchange shall (i) process enrollment of Employees into Contractor’s QDPs, (ii) establish effective dates of Employee coverage, and (iii) transmit enrollment information for Employees to Contractor and Contractor shall notify Employee of the effective date of coverage.
- (b) Contractor shall coordinate and cooperate with Exchange to the extent necessary during the Exchange’s enrollment process that shall commence following the Exchange’s acceptance of the single Employer and single Employee application forms. Contractor shall provide Services as may be required to support the Exchange during the enrollment process conducted by the Exchange in accordance with the Exchange’s responsibilities under State and Federal laws, rules and regulations. Such Services shall include support of the Exchange’s performance of the following activities that must occur before the effective date of coverage: (i) determination of Employer eligibility, (ii) selection of Contractor’s QDPs by Employers and Employees, and (iii) verification of Employee’s eligibility
- (c) Covered California for Small Business coverage shall commence on the first (1st) day of a month or such other date as may be established by the Exchange under its enrollment timeline and processes in accordance with State and Federal laws, rules and regulations. The specific terms and conditions relating to commencement of coverage, including cancellation or postponement of the effective date of coverage in the event of nonpayment or partial payment of an initial premium will be determined in accordance with applicable laws, rules and regulations.

2.3.3 Premiums for Covered California for Small Business

Covered California for Small Business will be responsible for collection of premiums, including delinquent payments. Premium charged in Covered California for Small Business includes the assessment of the participation fee, as well as a percentage for Agent and General Agent compensation. Agent compensation shall be set at a rate as set forth in Attachment 3. Covered California for Small Business shall collect a percentage of the premium in order to compensate Agents and General Agents. Contractor acknowledges that Covered California for Small Business may have excess funds as a result of collecting a percentage of Enrollee premiums for Agent and General Agent compensation. In no event shall Covered California for Small Business be required to remit excess funds to Contractor. Any excess funds shall belong to Covered California for Small Business.

Contractor shall review and reconcile information received from the Exchange on a monthly basis relating to the administration of premium payments, including information required under 45 C.F.R. § 155.705 and other applicable laws, rules and regulations necessary to the administration of premiums. Such reconciliation process will include the Contractor’s review of information relating to the receipt of premium amounts due to the Exchange from each Employer and Employee in Covered California for Small Business. Contractor shall provide the Exchange notice of any reconciling enrollment information with premium payment information, which shall be evaluated by the Exchange in consultation with Contractor.

Contractor shall not be entitled to collect from Enrollees or receive from Employers any amounts or receive funds from the Employers above the premium amounts except with respect to cost-sharing amounts or to the extent that such payment (i) is expressly authorized under the QDPs, 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; the Contractor shall not pursue collections of any said fees or unpaid premiums from the Exchange.

2.3.4 Covered California for Small Business Terminations of Coverage

Contractor acknowledges and agrees that the Exchange shall be responsible for the aggregation and administration of premiums for Covered California for Small Business. The Exchange shall be responsible for: (1) the submission of bills to each Employer on a monthly basis in a form that identifies Employer and Employee contributions and the total amount due, (2) collecting the amounts due from each Employer, and (3) making payments to Contractor for Enrollees in Contractor's QDPs on a monthly basis or such other intervals as mutually agreed upon by the Exchange and Contractor. In no event shall the Exchange be liable to Contractor with respect to any interest or other charges relating to premium funds received by the Exchange that are not yet disbursed by the Exchange to QDP Issuers.

The specific terms and conditions relating to terminations, including Contractor's right to terminate an Employer in connection with the receipt of non-payment or partial payments from Employers, shall be established by the Exchange in accordance with applicable laws, rules and regulations.

Except as otherwise required under applicable laws, rules or regulations, an Employee's enrollment through Employer may be terminated in connection with the termination of Employer's coverage and/or with respect to the events described in Section 2.2.4. With respect to an Employee, his or her eligibility shall cease at such time as he or she is no longer a qualified Employee to whom Employer has offered coverage. The Exchange will notify Contractor within five (5) business days of any Employer or Employee termination.

2.3.5 Covered California for Small Business Minimum Participation Rates

Contractor shall comply with minimum participation and contribution rates for Employers participating in Covered California for Small Business in accordance with 10 CCR § 6522. Participation rates shall be established by the Exchange in consultation with dental plan issuers and may be modified by the Exchange no more frequently than annually based on consideration of various factors, including prevailing market standards and changes in applicable laws, rules and regulations.

2.3.6 Agents in the Covered California for Small Business Exchange

- (a) The provisions of this Section apply to Agents who sell Contractor's QDPs through Covered California for Small Business.
- (b) Agent Compensation. The Exchange's intent is to pay market level broker and General Agent compensation.

In order to facilitate the Exchange's ability to administer enrollment in Covered California for Small Business based on efforts that are consistent for non-Exchange products and to achieve consistency in compensation arrangement for products sold inside and outside the Exchange: (i) the Exchange shall enter into arrangements with Agents to sell Contractor's QDPs through Covered California for Small Business, (ii) the Exchange will be responsible for payment of Agents, (iii) the Exchange will provide Enrollee specific and Agent-specific information to Contractor regarding compensation paid.

- (c) General Agents. The commission rate payable to a General Agent by the Exchange shall be established by the Exchange based on its evaluation of market data, including pricing information submitted in connection with its rate bids and pursuant to other policies that are established by the Covered California for Small Business Exchange from time to time. The Exchange will contract with multiple General Agents to represent Covered California for Small Business.
- (d) Incentive Compensation Program. In order to enhance consistency in sales efforts for products offered inside and outside of the Exchange, Contractor shall consider information provided by the Exchange regarding sales commissions in order to credit the Agent's sale of QDPs through

Covered California for Small Business to the Agent's sale of Contractor's policies outside the Exchange for purposes of determining Agent's aggregate sales that shall be used by Contractor to determine incentive or other compensation payable by Contractor to Agent. 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.

- (e) Agent Appointments. Agents enrolling Employers in Covered California for Small Business do not need to be appointed by each individual dental plan that participates in Covered California for Small Business. As long as the Agent is licensed by the California Department of Insurance and certified by Covered California, the Agent may enroll Employers in Covered California for Small Business. The Exchange's appointment standards are intended to encourage all qualified Agents who sell for Covered California for Small Business to maintain or receive issuer appointments; provided, however that not all qualified Agents are required to receive an issuer appointment in order to sell QDPs through the Exchange. Contractor shall not take any action that may restrict Agents certified by the Exchange from becoming appointed by all dental plan issuers that elect to market products through an Agent.
- (f) Agent Conduct. The Exchange shall implement policies, procedures, training, monitoring, and other processes to ensure that Agents who sell Contractor's QDPs through Covered California for Small Business will fairly and objectively represent all dental plan issuers and all products offered on the Exchange that market through Agents in order to present dental plan options in an unbiased manner and that minimizes steerage.
- (g) Training. Agents shall receive training and certification in order to promote the offer of the broad array of potential products available to potential Enrollees.

2.4 Certified Plan-Based Enroller Program

Contractor shall meet all eligibility requirements of the Plan-Based Enroller (PBE) Program in Title 10, California Code of Regulations, Chapter 12, § 6700 et seq. to be eligible to participate in the PBE Program. If selected as a Certified Plan-Based Enrollment Entity by the Exchange, Contractor agrees to adhere to all rules and regulations of the program, as specified in 10 CCR 6700 et seq.

2.5 Enrollment and Marketing Coordination and Cooperation

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

The Exchange will take such action as it deems is 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) 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 QDPs available in the Exchange in addition to Contractor's QDPs;
- (b) A standard interface through which Contractor may electronically accept from the Exchange the initial binder payment (via ACH or EFT) to effectuate coverage and accept subsequent premium payment in Covered California for Small Business;
- (c) Complete documentation and reasonable testing timelines for interfaces with the Exchange's eligibility and enrollment system;
- (d) Eligibility and enrollment training for Contractor's staff and for licensed agents and brokers;
- (e) Joint marketing activities of the Exchange, Contractor and other dental plan issuers designed to drive awareness and enrollment in the Exchange;

- (f) The Exchange will treat as confidential, all Contractor marketing plans and materials consistent with Section 1.4.1;
- (g) The Exchange's annual marketing plans, including Open Enrollment Period (OEP) and Special Enrollment Period (SEP) retention and renewal efforts; and
- (h) Customer service support that will include extended customer service hours during Open Enrollment Periods. Dental Plan Issuers in Covered California for Small Business are not required to provide Customer Service support on weekends.

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

- (1) Educate its Agents on Contractor's QDPs offered in the Exchange, work with the Exchange to efficiently educate its Agents and brokers about the Exchange's individual and small group marketplaces; and inform Agents that a prospective Enrollee's oral health status is irrelevant to advice provided with respect to Qualified Dental Plan selection, other than informing individuals about their estimated out-of-pocket costs;
- (2) 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;
- (3) Cooperate with the Exchange to develop and implement an Enrollee retention plan;
- (4) 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 Special Enrollment should be submitted to the Exchange at least thirty (30) days prior to January 1. Marketing plans for Retention and Renewal efforts should be submitted to the Exchange within thirty (30) days after Open Enrollment begins;
- (5) Submit to the Exchange annual actualized spend amounts for: (1) OEP within thirty (30) days after OEP closes; (2) SEP for the year, thirty (30) days after the 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
- (6) 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.

2.6 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 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 outlined in the Covered California Brand Style Guide. The Exchange shall make the updated Brand Style Guide available to Contractor online and notify Contractor of changes.
- (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 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 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 which may include electronic cards or a no-card eligibility verification system. 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 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 Contract 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 web site through December 31 of the then-current benefit year. The same requirements apply to Dental Plan Issuers' Certificate of Coverage when applicable.
- (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 health 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 – QDP 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 QDPs offered under this Agreement. For purposes of this Agreement, each dental plan 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 specialized health care service plan (“SHCSPP”) 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 in 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
<u>Verification that issuer holds a state health care service plan license or insurance certificate of authority.</u>		
• 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	
<u>Affirmation of no material¹ statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable:</u>		
• 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	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	

¹Covered 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 and Consumer Protection Standards

Contractor shall comply with requirements that apply to QDPs 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 dental plan it offers in the Exchange qualifies as a QDP.

- (a) Contractor and the Exchange recognize that several of the market reforms in the Affordable Care Act do not apply to QDPs. For Contractor's QDPs sold inside the Exchange, the Contractor agrees to comply with the following provisions:
- (i) Prohibition of preexisting conditions or other discrimination based on health status pursuant to 42 U.S.C. § 300gg-3, California Health and Safety Code § 1357.51, and California Insurance Code § 10198.7;
 - (ii) Fair health insurance premiums pursuant to 42 U.S.C. § 300gg, California Health and Safety Code § 1357.512(a), and California Insurance Code § 10753.14;
 - (iii) Guaranteed availability of coverage pursuant to 42 U.S.C. § 300gg-1, California Health and Safety Code § 1399.849(g), and California Insurance Code § 10965.3(g);
 - (iv) Guaranteed renewability of coverage pursuant to 42 U.S.C. § 300gg-2, California Health and Safety Code § 1389.7(a), and California Insurance Code § 10119.2(a);
 - (v) Nondiscrimination in health care pursuant to 42 U.S.C. § 300gg-4, 42 U.S.C. § 300gg-5, California Health and Safety Code § 1357.503(f), and California Insurance Code § 10753.05(h);
 - (vi) Except for non-pediatric dental essential health benefits in the Family Dental Plan, elimination of waiting periods pursuant to 42 U.S.C. § 300gg-7, California Health and Safety Code § 1357.51(c), and California Insurance Code § 10198.7(c);
 - (vii) Except for non-pediatric dental essential health benefits, elimination of annual and dollar limits pursuant to 42 U.S.C. § 300gg-11, 10 CCR 6426, California Health and Safety Code § 1367.001, and California Insurance Code § 10112.1;
 - (viii) Network adequacy requirements pursuant to Section 3.3 of this Agreement; and
 - (ix) Timely access to care.

3.1.3 Plan Naming Conventions

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

3.1.4 Operational Requirements and Liquidated Damages

The timely and accurate submission of Contractor's QDP 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 QDPs 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.

3.2 Benefit Standards

3.2.1 Benefit Design

Each QDP offered by Contractor under the terms of this Agreement shall provide the Children's Dental Plan and Family Dental Plan in accordance with the Benefit Plan Design requirements at 10 CCR 6460 and as identified in Attachment 2, and as required under this Agreement, and as applicable, any other laws, rules and regulations, including California Health and Safety Code § 1367.005, California Insurance Code § 10112.27., California Government Code § 100503(e), 45 C.F.R. § 155.1065, 45 C.F.R § 156.150, 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 QDPs identified in Attachment 1 provide the benefits and services at the cost-sharing and actuarial cost levels described in the Standard Benefit Plan Designs, as summarized in Attachment 2 ("Benefit Plan Designs"), and as may be amended from time to time as required under applicable laws, rules and regulations or as otherwise authorized under this Agreement.

3.2.3 Family Deductible and Out-of-Pocket Maximum Accumulation

Contractor shall institute policies and procedures to prevent the re-setting of an enrolled family's accumulation toward their family out-of-pocket maximum, and family deductible if applicable, in the event of a mid-year change in enrolled family composition. Contractor shall not re-set a family's out-of-pocket accumulation, or family deductible accumulation if applicable, for family members for whom there is no break in coverage in a plan year, regardless of change in Subscriber. All out-of-pocket costs paid by enrolled family members enrolled in the plan year shall be counted in the accumulation to the family's out-of-pocket maximum for that plan year.

3.2.4 Offerings outside of the Exchange

- (a) Contractor acknowledges and agrees that QDPs bundled with Qualified Health Plans and substantially similar plans offered by Contractor outside the Exchange must be offered at the same rate whether offered inside the Exchange or whether the plan is offered outside the Exchange directly from the issuer or through an Agent as required under State and Federal law.
- (b) For purposes of this subdivision, “product” does not include contracts entered into pursuant to Part 6.2 (commencing with § 12693) of Division 2 of the Insurance Code between the Department of Health Care Services (DHCS) and health care service plans for enrolled Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with § 14000) of, or Chapter 8 (commencing with § 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.

3.2.5 Coordination of Benefits

Contractor’s Qualified Dental Plans shall include a Coordination of Benefits (COB) provision in its Evidence of Coverage or Policy Form that (1) is consistent with Health and Safety Code § 1374.19 and Insurance Code § 10120.2 and (2) provides that the Qualified Dental Plan is the secondary dental benefit plan or policy under that COB provision to any Qualified Health Plan that provides the Pediatric Dental Essential Health Benefit. This provision shall apply to Contractor’s QDPs offered both inside and outside of the Individual and Covered California for Small Business Exchanges, 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.

3.3 Network Requirements

3.3.1 Service Area

- (a) Service Area Listing. During each year of this Agreement, in conjunction with the establishment of Monthly Rates payable to Contractor under Article 5 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 QDPs. Any such changes shall be effective as of January 1 of each 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 dental plan issuers regarding the development of Service Area listing based on the 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 Specialized Health Care 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 ensure continued compliance with eligibility requirements related to: (i) participation by Employers in Covered California for Small Business, including those requirements related to the Employer’s principal place of business or primary worksite in the Service Area or (ii) participation of Qualified Individuals in the Individual Exchange, including requirements related to residency in Contractor’s service area.

Contractor shall notify the Exchange if it becomes aware that an Employer or individual Enrollee enrolled in a QDP of Contractor no longer meets the requirements for eligibility, based on place of business, primary worksite or 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. Contractor and its subcontractors will have no duty to investigate representations made by Employers regarding eligibility; provided, however, that Contractor shall notify the Exchange in the event that it becomes aware that such representation may not be accurate.

3.3.2 Network Stability

- (a) Network standards. Contractor's QDPs shall comply with the network adequacy standards established by the applicable Health Insurance Regulator responsible for oversight of Contractor, including those requirements applicable to specialized health care service plans as set forth at Health and Safety Code § 1367.03 and 28 CCR § 1300.67.2.2 (if Contractor is a licensed health care service plan) or Insurance Code § 10133.5 and 10 CCR § 2240-2240.5 (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. The information provided to the Exchange shall reasonably take into consideration the ethnic and language diversity of providers available to serve Enrollees of the Exchange. Contractor shall cooperate with the Exchange to implement network changes as necessary to address reasonable 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 Specialized Health Care 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) Contractor shall implement reasonable 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.
- (d) 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 Dental Essential Community Providers

Contractor shall maintain a network that includes participation of dental providers with a history of serving uninsured and low income populations that are available through Contractor to provide reasonable and

timely access to Specialized Health Care Services to low-income populations in each geographic region where Contractor's QDPs provide services to Enrollees.

- (a) For purposes of this Section, "participation of dental Essential Community Providers including dental providers with a history of serving uninsured and low income populations" shall be determined by the Exchange 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 contracting arrangements with Federally Qualified Health Centers who provide dental services in each geographic rating region in which Contractor's QDPs provides Specialized Health Care Services to Enrollees, (ii) the inclusion of a sufficient number of providers that participate or have participated with the Medi-Cal and/or Healthy Families program, and (iii) other factors as mutually agreed upon by the Exchange and the Contractor regarding Contractor's ability to serve the low income population.
- (b) "Low-income populations" shall be defined as families living at or below 200% of Federal poverty level.
- (c) Contractor shall notify the Exchange with respect to any material changes as of and throughout the term of this Agreement to its contracting arrangements with Federally Qualified Health Centers that provide dental services and other information relating to contracting with dental Essential Community Providers including providers who serve the low-income and uninsured populations.

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 Specialized Health Care Services to any individual enrolled in Contractor's QDP in the Individual Exchange who is determined by the Exchange to be an eligible American Indian or Alaskan Native as defined in § 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 provide monthly special enrollment periods for American Indians or Alaskan Natives enrolled through the Exchange.
- (b) Contractor shall comply with other applicable laws, rules and regulations relating to the provision of Health Care Services to American Indians, including the Indian Health Care Improvement Act §§ 206 (25 U.S.C. 1621e) and 408 (25 U.S.C. 1647a).

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 Specialized Health Care 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 dental 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.

Contractor shall require the following provisions 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. Except as expressly set forth herein, capitalized terms set forth herein shall have the same meaning as set forth in the Agreement between Contractor and the Exchange; provided that Contractor may use different terminology as necessary to be consistent with the terms used in the Provider Agreement or subcontracting

arrangements entered into by Participating Providers so long as such different terminology does not change the meaning set forth herein and the Agreement.

- (c) Provision of Covered Services. Contractor shall require each Participating Provider to ensure that each subcontracting arrangement entered into by each Participating Provider complies with the applicable terms and conditions set forth in the 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 (Section 1.7);
 - 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 3.3.2);
 - 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 2.6);
 - xiii. Disclosure of information required by the Exchange, including if applicable, 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);
 - 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, if applicable (Article 7);
 - xx. Security and privacy requirements, including compliance with HIPAA (Article 9); and
 - xxi. Maintenance of books and records (Article 10).

In addition to the foregoing, Contractor shall include in each Provider Agreement a requirement that Participating Providers comply with other applicable laws, rules and regulations.

The descriptions set forth shall not be deemed to limit the obligations set forth in the Agreement, as amended from time to time.

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 appropriate Health Insurance 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 Specialized Health Care 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 QDPs either (i) provide coverage for out-of-network services and/or (ii) impose additional fees for such services, Contractor shall disclose to the Enrollee, at the enrollee's request, the amount or percentage 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 their 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 QDP networks in a format prescribed by the Exchange on a monthly basis to support the Exchange's planned centralized provider directory containing every QDP'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, QDP Issuers shall continue to provide Participating Provider information to the Exchange on a monthly basis.

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 QDPs as agreed upon with the Exchange. Contractor may vary premiums by geographic area as permitted by applicable laws, rules and regulations including 45 C.F.R. § 156.255(b).

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 and are set for the applicable 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 Covered California for Small Business Exchange Rates

Covered California for Small Business rates for 2017-2019 will be established through an annual negotiation process between the Contractor and the Exchange and are set for the applicable year. Contractor shall also submit rate 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. The Exchange will permit an update of rates to be offered on the Covered California for Small Business Exchange no more frequently than on an annual basis. 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.

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 Providers 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 the 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 1.2 – 1.4 in Group 1 of Attachment 14. The Contractor shall provide this information to the Exchange upon request.

3.6.2 Enrollee Appeals and Grievances

Internal Grievances and Appeals. Contractor shall maintain an internal review process to resolve 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 QDP. 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 QDPs.

3.6.3 Applications and Notices

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 web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and § 504 of the Rehabilitation Act, or (2) with limited English language proficiency.

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 § 1367.04 and Insurance Code § 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 extended 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 (6:00) o'clock p.m. (Pacific Standard Time), if call volume warrants, 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 call center hours during non-Open-Enrollment periods. Dental Plan Issuers in Covered California for Small Business are not required to provide customer service support on weekends.
- (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 their call center with highly trained individuals to provide detailed benefit information, answer Enrollee questions about QDP 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 compliance with related Performance Standards as outlined in Attachment 14.

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

3.6.5 Customer Service Transfers

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 Contractor 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.

- (a) Examples of issues or complaints include, but are not limited to, premium billing or claims issues; benefit coverage questions (before and after enrollment); grievance; network or provider details; and Contractor-specific questions.
- (b) Contractor shall refer Enrollees and applicants with questions regarding premium tax credit and Exchange eligibility determinations to the Exchange's website or Service Center, as appropriate.
- (c) 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 45 C.F.R. Part 92, and provide culturally competent customer service to all Exchange Enrollees in accordance with the applicable provisions of 45 C.F.R. §155.205, which refers to consumer assistance tolls and the provision of culturally and linguistically appropriate information and related products.
- (b) Contractor shall comply with HIPAA 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 yearly.

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 to the Exchange and the Enrollee 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 § 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 QDPs offered on the Exchange. This summary information will be used by the Exchange customer service staff when referencing Contractor or Qualified Dental Plan 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 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) 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 Enrollees in individual QDPs within ten (10) business days of receiving complete and accurate enrollment information from the Exchange and the binder payment and within ten (10) business days of receipt of complete and accurate enrollment information for Covered California for Small Business QDP Enrollees. 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, or communication approved by the Exchange issued to Enrollee regarding use of approved no-card eligibility verification system;
- (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, and 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) Other materials required by the Exchange.

- (b) Contractor shall maintain access to enrollment packet materials; 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 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.

3.6.12 Access to Dental Services Pending ID Card Receipt

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

3.6.13 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.

3.6.14 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 Federal and State 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 oral health costs and research condition information.

3.6.15 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, first call resolution, response to written correspondence, and number/accuracy/timeliness of ID card distribution;
- (b) Use of Plan website;
- (c) Quality assurance activities;
- (d) Enrollment reports; and
- (e) Premiums collected.

3.6.16 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.

3.6.17 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 QDP 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 oral 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 Specialized Health Care 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/or (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.

Consistent with The Exchange's mission to promote better care, better health and lower cost as part of a Quality Improvement Strategy, Contractor agrees to:

- (a) Implement a quality assurance program in accordance with Title 28, CCR, § 1300.70, for evaluating the appropriateness and quality of the covered services provide to members;
- (b) Maintain a system of accountability for quality improvement in accordance with all applicable statutes and regulations, monitoring, evaluating and taking effective action to address any needed improvements, as identified by the Exchange, in the quality of care delivered to members; and
- (c) Work with Exchange to craft a quality improvement program that is dental-specific and tailored to the Exchange population.

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 Health Insurance 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 disclosing applicable information relating to claims payment policies and practices, periodic financial disclosures, enrollment, disenrollment, claims denials, rating practices, cost-sharing, payments with regard to any out-of-network coverage, and Enrollee rights. Contractor may include pre-treatment estimates as one method of satisfying this obligation. 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 Dental Utilization Reporting

Contractor shall submit to the Exchange dental utilization data to include the measure numerator, denominator and rate for the required measure set. The Exchange reserves the right to use the Contractor-reported measures scores to construct Contractor summary quality ratings that the Exchange may use for such purposes as the Exchange's plan oversight management.

4.6 Data Submission Requirements

Contractor shall submit a complete data set, inclusive of all member and provider identified data, claims, and encounter data, on a quarterly basis to the Exchange or the Exchange's designated recipient to be used by the Exchange as it determines to be necessary. Such submissions will conform to all applicable Federal and State personal health information and related privacy laws, rules and regulations, and shall comply with the terms and conditions set forth in the Agreement by and between Contractor and the Exchange. Contractor will bear the full cost of data collection, extraction and submission; provided, however, that except as expressly set forth in this Attachment or the Agreement, Contractor will not be required to pay for any expenses related to the analysis of that data in order to comply with the terms of this Agreement. When data is submitted to a vendor for the Exchange, that vendor will be a Business Associate of the Contractor and shall protect the information provided to the extent required under applicable laws, rules and regulations.

Working with Contractors, the Exchange will develop data file formats that will be required of Contractor to support oversight requirements, including actuarial review, clinical quality improvement, network management and fraud and waste reduction, delivery system reform goals, consumer information and research. Additional data and expanded file formats may be requested in the future in support of the Exchange contributing data to statewide collaborative efforts to advance development of an all payer claims database.

Specific data submission areas may include:

- Plan and Product
- Member
- Member History
- Providers (all providers with paid claims, including non-contracted)
- Professional Claims

If Contractor does not maintain such information and/or is unable to produce such information in the file format requested by the Exchange, Contractor shall coordinate with the Exchange with a plan to address data gaps or format preferences prior to the Contractor's submission of such information. For any non-paid claims for capitated services, the Contractor shall provide full and complete encounter data.

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 in 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 QDPs, (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 QDPs 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 Sections 2.2.4 and 2.3.4. 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 QDP due to non-payment of premiums, loss of eligibility, fraud or misrepresentation, change in Enrollees selection of QDP, decertification of Contractor’s QDP and/or as otherwise authorized under Sections 2.2.4 and 2.3.4, Contractor must include applicable Regulator-approved appeals language, and any Exchange-required appeals language, in its notice of termination of coverage to the Enrollee.

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 QDPs 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, and across Contractor's entire book of business in the single risk pool (both inside and outside the Exchange) for the small employer 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 QDPs for such month. The Participation Fee will be assessed by the Exchange and payable monthly by Contractor based on gross premium attributable to Enrollees in Contractor's QDPs 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 years 2014 to 2016, the Participation Fee shall be calculated pursuant to the QDP 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 QDP 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.

5.2 Covered California for Small Business Exchange

5.2.1 Rates and Payments

- (a) Schedule of Rates. The rates for the Covered California for Small Business plan year 2016 are set forth in Attachment 10 ("Monthly Rates – Covered California for Small Business"). The parties acknowledge and agree that the premium rates for Covered California for Small Business are actuarially determined to assure 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 QDPs, (ii) administrative expenses and reasonable reserves by Contractor to meet the requirements outlined in this Agreement and in accordance with applicable laws, rules and regulations, and (iii) the Contractor's payment of the Participation Fee to the Exchange. The Participation Fee payable with respect to Enrollees in Covered California for Small Business includes a fee specified by the Exchange as necessary to support payment of Agent and General Agent compensation. Contractor acknowledges and agrees that any Participation Fees due to

the Exchange from Contractor shall be withheld by the Exchange before passing through any premium payments received by the Exchange from Employers and Employees to Contractor in accordance with paragraph (d) of this Section 5.2.1.

- (b) Updates. The Monthly Rates shall be established in accordance with the procedures set forth at Section 3.5 and in Attachment 11 (“Rate Updates – Covered California for Small Business”). The Exchange may authorize an update of rates no more frequently than on a quarterly basis in the Covered California for Small Business, in accordance with requirements and update schedules to be determined by the Exchange.
- (c) Rate Determinations. Rates will be determined for the Exchange in accordance with applicable laws, rules and regulations. Rates for plan years for Employers and all covered Employees will be determined by ZIP Code of the Employer’s primary business address. Rates for an Employer and all covered Employees will be determined and frozen at initial enrollment, or upon renewal, for twelve (12) months, until the next group renewal. Rates for all Employees including new Employees or Employees with qualifying events during the Employer Plan Year will be determined by the prevailing rates at group enrollment.
- (d) Collection and Remittance. The Exchange agrees to perform collection and aggregation of monthly premiums with respect to Contractor’s QDPs in the small business exchange and will remit said premiums, net of (i) Participation Fees payable to the Exchange and (ii) the fee associated with Agent compensation paid by the Exchange pursuant to Section 2.3.6.
- (e) The Exchange’s collection of premiums and remittance of net amounts to Contractor’s QDPs as described in this Section shall be made on a monthly basis.
- (f) Grace Period. Contractor acknowledges and agrees that applicable laws, rules and regulations, including the Knox-Keene Act and Insurance Code, set a grace period with respect to the delinquent payment of premiums for the small group market.

5.2.2 Covered California for Small Business 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 QDPs and (ii) Contractor is responsible for the timely payment of any Participation Fees to the Exchange. The Exchange shall collect Participation Fee and Agent and General Agent compensation from premiums remitted by Employers and Employees.
- (b) The Participation Fee payable to the Exchange during each month of this Agreement shall be equal to 5.2 percent of the gross premium attributable to each Enrollee in Contractor’s QDPs for such month plus additional fees as necessary to pay Agent commissions. The Participation Fee will be assessed by the Exchange and payable monthly by Contractor based on premium attributable to enrollees in Contractor’s QDPs sold through the Covered California for Small Business 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 years 2014 to 2016, the Participation Fee shall be calculated pursuant to the QDP Issuer Agreement that was in place during the applicable plan year or years.
- (c) With respect to Covered California for Small Business, Contractor acknowledges that (i) the Exchange is responsible for collecting premiums from Employers and Employees, and (ii) the Exchange will remit applicable Employer and Employee premiums collected by the Exchange to Contractor, net of (1) Participation Fees computed in accordance with the Participation Methodology - determined in accordance with the terms set forth at Section 2.3.6. Covered California for Small Business shall transfer funds to Contractor on a monthly basis or such other intervals as mutually agreed upon by the Exchange and Contractor and shall establish a process to resolve any disagreements on premium amounts due in a timely manner and prior to transfer of funds to Contractor as required under this Section.

- (d) 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.
- (e) 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 and follow up audits or examinations may be performed by the Exchange more frequently than annually to monitor Contractor's implementation of such corrective actions.
- (f) 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 MEASURES

6.1 Standards

Contractor shall comply with the performance standards set forth in this Agreement and Attachment 14 (“Performance Standards”). Contractor shall measure and report Individual Exchange and Covered California for Small Business lines of business separately. 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 will review results of the Contractor’s Performance Standards. The parties will meet and confer on the results of the Contractor’s Performance Standards. The Exchange, in its sole discretion, may use some or all of the Performance Standards set forth in Attachment 14 as part of its Recertification and Decertification process in subsequent years.

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.

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, with 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 QDP 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 Health Care 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 7.1.1, 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 QDPs are displayed in CalHEERS or plan preview;
- 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 period 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 the 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 will 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 re-certification of its QDPs 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 QDPs 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 Specialized Health Care 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 set forth in this Section. In the event that Contractor continues to offer coverage in the individual or small group market, Contractor shall comply with the same requirements found in Health and Safety Code § 1365(a)(6) and Insurance Code §§ 10713(e) and 10273.6(e).

Contractor shall take any further action reasonably required by the Exchange to provide Specialized Health Care 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, Employers and Employees in Covered California for Small Business and other stakeholders regarding the transition of Enrollees to another QDP.

- (c) Individual Exchange. The following provision 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;
 - (iii) 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 QDP during the Special Enrollment Period.
- (d) Covered California for Small Business. The following provisions shall apply to the Covered California for Small Business Exchange:

- (i) In the event that Contractor continues to offer small group coverage in the State following the Notice of Non-Recertification Election, Contractor shall comply with applicable laws, rules and regulations relating to the discontinuation of a benefit package, including those set forth at § 10713 of the Insurance Code.

The termination of the Agreement shall occur upon the termination of coverage which shall be determined as follows:

- (1) Contractor shall provide coverage to Employers and Employees until the expiration of the Employer's first Plan Year that commences after the Non-Recertification Election.
 - (2) Contractor shall notify Employers and Employees that the Contractor's QDP will not be available for renewal at least ninety (90) days prior to policy expiration. Non-renewal notification must be in a format approved by the Exchange.
- (ii) Contractor shall comply with other requirements of the Exchange relating to the continuation and transition of coverage following Contractor's Non-Recertification Election, including without limitation, those relating to protocols and timing for the removal of Contractor from the listing of QDPs to be selected by Employers and Employees, the commencement of coverage for new Employers and Employees, and termination and transition of coverage.

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 QDP based on the Exchange's evaluation of Contractor's QDP during the recertification process that shall be conducted by Exchange pursuant to Section 7.3.

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 QDPs shall be deemed decertified and shall cease to operate as QDPs 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 QDPs upon expiration of the term of this Agreement. Contractor may appeal the decertification of its QDP 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 QDPs 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 7.2.2 in the event that Contractor makes a Non-Recertification Election.
- (e) Contractor shall cooperate fully to effect an orderly transfer of Specialized Health Care Services to another QDP during (i) any notice period set forth at Sections 7.2.3, 1.10(g) or 7.3.2, and (ii) if requested by the Exchange to facilitate the transition of care or otherwise required under Section 7.5, following the termination of this Agreement. Such cooperation shall include the following:
 - (i) Upon termination, Contractor, if offering a DHMO, shall complete the processing of all claims for benefit payments under the QDP for Specialized Health Care Services other than Capitated Services, and if offering a DPPO, shall complete the processing of all dental claims for benefit payments under Contractor's QDP for Specialized Health Care Services rendered on or before the termination date.
 - (ii) Contractor will provide communications developed or otherwise approved by the Exchange, to communicate new QDP information to Enrollees and Employers 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 QDP 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 Specialized Health Care 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 and regulations, and consistent with industry standards to facilitate transfer of Specialized Health Care 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 QDP, (ii) the transfer of Enrollee coverages to another QDP 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 QDP in good faith with respect to taking such actions that are reasonably determined to be the best interest of the QDP, Enrollees, and Employers.
- (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 Specialized Health Care Services received by Enrollees during the period of the Agreement. Contractor is responsible for submitting any outstanding financial or other reports required for Specialized Health Care 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 QDP, and/or (ii) take any such further action as is required to effect an orderly transition of Enrollees to another QDP 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 QDP Contractor shall cooperate fully with the Exchange in order to effect an orderly transition of Enrollees to another QDP as directed by the Exchange. This cooperation shall include (i) attending post- termination meetings, (ii) providing or arranging for the provision of Specialized Health Care 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 dental plan, the terms of coverage under Contractor's QDP shall not be carried over to the replacement QDP but rather the transferred Enrollees shall be entitled only to the extent of coverage offered through the replacement QDP as of the effective date of transfer to the new QDP.

7.7 Termination Due to Contractor Merger

- a) If the Exchange receives notice from Contractor pursuant to Section 1.10(b), the Exchange reserves the right to stop offering a Contractor's QDPs following thirty (30) days written notice.

ARTICLE 8 INSURANCE AND INDEMNIFICATION

8.1 Contractor Insurance

8.1.1 Required Insurance

- (a) Without limiting the Exchange's right to obtain indemnification or other form 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/or as otherwise required by law, including without limitation, coverage required to be provided and documented pursuant to § 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 Specialized Health Care 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 Subcontractors

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

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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 prompt 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

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 () 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 dental 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 be given the meaning shown:

(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 dental record documentation system adequate to fully disclose and document the medical and dental condition of each Enrollee and the extent of dental 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 dental 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 dental 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. All such records are the property of the Exchange and must be returned to the Exchange or its authorized representatives upon demand.
- (c) Contractor shall maintain historical claims data and other records and data relating to the utilization of Specialized Health Care Services by Enrollees on-line for two (2) years from date that the Agreement is terminated with respect to Specialized Health Care 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 Social Services, Department of Health Care Services, 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 confidential 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 audit/review findings within 90 days. In the instance Contractor cannot complete the corrective action of a finding within 90 days, it will submit a status report to the Exchange stating why it cannot correct the finding within the specified time frame and proposes another date for correction. In all instance, 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 term 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 are 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, 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 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.
- (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 personam 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 Specialized Health Care Services to Enrollees.

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 – 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 amendments, 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.

Application -The QDP Issuer 2017-2019 Renewal Application.

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. For the purposes of this contract, CalHEERS includes any other eligibility and enrollment system used by the Exchange, including the system operated by Pinnacle HCMS.

Children's Dental Plan - A plan certified by the Exchange that provides only the pediatric dental benefits required in Health and Safety Code 1367.005(a)(5) and Insurance Code 10122.27(a)(5).

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 Dental Plans to small employers and their Employees.

Case Management – Contractor's medical utilization and oversight systems that attempt to optimize available benefit coverage and resources for Enrollees with complex and exceptional needs due to chronic or catastrophic illness or injury.

CCR – California Code of Regulations

CDI – California Department of Insurance

Confidentiality of Medical Information Act (CMIA) – The Confidentiality of Medical Information Act (California Civil Code § 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 dental plan issuer contracting with the Exchange under the Agreement to operate a QDP and perform in accordance with the terms set forth in the 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 QDPs 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 Specialized Health Care Services referred to in this Agreement refers to those services which are covered benefits under the applicable QDP and described in the Evidence of Coverage (EOC).

DHCS – California Department of Health Care Services

DHHS – United States Department of Health and Human Services

DMHC – California Department of Managed Health Care

Dental Health Maintenance Organization (DHMO) – A type of dental plan product that delivers dental services by requiring assignment to a primary dental care provider who is paid a capitated fee for providing all required dental services to the enrollee unless specialty care is needed. DMHOs require referral to specialty dental providers. These products do not include coverage of services provided by dental care providers outside the dental plan.

Dental Plan Issuer – Has the same meaning as that term is defined in 10 CCR 6446(b)(3).

Dental Preferred Provider Organization (DPPO) – A type of dental plan product that delivers dental services to members through a network of contracted dental care providers and includes limited coverage of out-of-network services.

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

Eligibility Information – The information that establishes an Enrollee's eligibility including but not limited to: name, age, and Social Security Number.

Eligibility File – The compilation of all Eligibility Information 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 § 1312(f)(2) of the Act.

Encounter – Any dental service or bundle of related dental services provided to one Enrollee by one Health Care Professional within one time period. Any dental services provided must be recorded in the Enrollee’s health record.

Encounter Data – Encounter information Contractor can use to demonstrate the provision of dental services to Enrollees.

Enrollee – Enrollee means each and every individual or an Employee and each of their Family Members enrolled in a QDP offered through the Exchange for the purpose of receiving health benefits. An Enrollee may be referred to as a member of a QDP who is entitled to receive covered services.

Evidence of Coverage (EOC) and Disclosure Form – The booklet(s) which describe(s) the benefits, exclusions, limitations, conditions, and the benefit levels of the applicable Plan(s).

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

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 Health Care Services.

Family Dental Plan – A plan certified by the Exchange that provides the pediatric dental benefits required in Health and Safety Code 1367.005(a)(5) and Insurance Code 10122.27(a)(5), and also includes coverage for certain benefits for adult Enrollees.

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

General Agent – A licensed insurance brokerage firm, qualified and operating under the laws of the state of California, with a network of affiliated Agents in the state of California, that is contracted with the Exchange.

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, dental 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 Health Care 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 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.

Individual Exchange – The Exchange through which Qualified Individuals may purchase QDPs.

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 § 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 §§ 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.

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.

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 Provider – An individual Health Care Professional, hospital, clinic, facility, entity, dentist, dental assistant, dental hygienist or any other person or organization that provides Health Care or Dental 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 § 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

Plan(s) – The QDPs the Exchange has entered into a contract with a dental plan issuer to provide hereinafter referred to as the Plan(s) or QDPs.

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 (1) Enrollee after any advance premium tax credits are applied, if any, (2) Employer, or (3) Employee, to the CCSB or 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 Provider (PCP) – The following types of health care providers or organizations are considered Primary Care Providers and provide medical care, either through team members or as individual health care providers, which includes coordination of care as needed and as used in this Agreement: a California licensed doctor of medicine or osteopathy who is a general or family practitioner, internist, obstetrician-gynecologist, pediatrician, Health Center or a Patient-Centered Medical Home (PCMH) and who has a contract with Contractor and has assumed the primary responsibility for providing initial and primary medical care to Enrollees and coordinating care for an enrollee, including facilitating access to specialists and hospital care and maintaining the continuity of Enrollee’s medical care.

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 § 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 Health Care Services.

Provider Claim(s) – Any bill, invoice, or statement from a specific Provider for Health Care 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 Dental Plan or QDP – QDP means either a Children’s Dental Plan or a Family Dental Plan.

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 Board. (California Code of Regulations, Title 10, Chapter 12, § 6400, et seq.)

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 Health Care 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 QDP through the Exchange outside of the initial and annual Open Enrollment Periods.

Specialized Health Care Service Plan or SHCSP – Any person who undertakes to arrange for the provision of health care services to subscribers or Enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or Enrollees as defined in Health and Safety Code § 1345 (f)

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



**COVERED CALIFORNIA
QUALIFIED DENTAL PLAN ISSUER CONTRACT FOR 2017-2019
between**

**Covered California, the California Health Benefit Exchange
and
_____ (“Contractor”)**

List of Attachments to Qualified Dental Plan Issuer Model Contract

- Attachment 1 Contractor’s QDP List by Region
- Attachment 2 Benefit Plan Designs
- Attachment 3 Small Group Distribution Costs for CCSB
- Attachment 4 Service Area Listing
- Attachment 5 Dental Carrier Evaluation
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Attachment 1 – Contractor’s QDP List for Region

Attachment 2 – Benefit Plan Designs

2017 Dental Standard Benefit Plan Designs

April 7, 2016

Final Board-approved

Actuarial Value updated May 6, 2016



2017 Dental Standard Benefit Plan Designs

Date: April 7, 2016

Summary of Benefits and Coverage

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

Children's Dental Plan and Family Dental Plan designs apply to Individual Marketplace and Covered California for Small Business.

	Children's Dental Plan		
	Coinsurance Plan		Copay Plan
	Pediatric Dental EHB		Pediatric Dental EHB
	Up to Age 19		Up to Age 19
Actuarial Value	86.8%	86.8%	83.2%
	In-Network	Out-of-Network	In-Network
Individual Deductible	\$65	\$65	None
Family Deductible (Two or more children)	\$130	\$130	Not Applicable
Individual Out of Pocket Maximum	\$350	None	\$350
Family Out of Pocket Maximum (Two or More Children)	\$700	None	\$700
Office Copay	\$0	\$0	\$0
Waiting Period <small>(Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))</small>	None	None	None
Annual Benefit Limit <small>(the maximum amount the dental plan will pay in the benefit year)</small>	None	None	None

Procedure Category	Service Type	Member Cost Share	Member Cost Share	Member Cost Share
Diagnostic & Preventive	Oral Exam	No charge	10%	No charge
	Preventive - Cleaning	No charge	10%	No charge
	Preventive - X-ray	No charge	10%	No charge
	Sealants per Tooth	No charge	10%	No charge
	Topical Fluoride Application	No charge	10%	No charge
	Space Maintainers - Fixed	No charge	10%	No charge
Basic Services	Restorative Procedures	20% Deductible Applies	30% Deductible Applies	See 2017 Dental Copay Schedule
	Periodontal Maintenance Services			
	Adult Periodontics (other than maintenance) (Group Dental Plans only)			
Adult Endodontics (Group Dental Plans only)				
Major Services	Periodontics (other than maintenance)	50% Deductible Applies	50% Deductible Applies	See 2017 Dental Copay Schedule
	Endodontics			
	Crowns and Casts			
	Prosthodontics			
	Oral Surgery			
Orthodontia	Medically Necessary Orthodontia	50% Deductible Applies	50% Deductible Applies	\$350



2017 Dental Standard Benefit Plan Designs

Date: April 7, 2016

Summary of Benefits and Coverage

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

Children's Dental Plan and Family Dental Plan designs apply to Individual Marketplace and Covered California for Small Business.

		Family Dental Plan			
		Coinsurance Plan			
		Pediatric Dental EHB		Adult Dental	
		Up to Age 19		Age 19 and Older	
Actuarial Value		86.8%	86.8%	Not Calculated	Not Calculated
		In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible		\$65	\$65	\$50	\$50
Family Deductible (Two or more children)		\$130	\$130	Not Applicable	Not Applicable
Individual Out of Pocket Maximum		\$350	None	Not Applicable	Not Applicable
Family Out of Pocket Maximum (Two or More Children)		\$700	None	Not Applicable	Not Applicable
Office Copay		\$0	\$0	\$0	\$0
Waiting Period <small>(Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))</small>		None	None	6 months for Major Services, Waived with Proof of Prior Coverage	6 months for Major Services, Waived with Proof of Prior Coverage
Annual Benefit Limit <small>(the maximum amount the dental plan will pay in the benefit year)</small>		None	None	\$1,500	
Procedure Category	Service Type	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share
Diagnostic & Preventive	Oral Exam	No charge	10%	No charge	10%
	Preventive - Cleaning	No charge	10%	No charge	10%
	Preventive - X-ray	No charge	10%	No charge	10%
	Sealants per Tooth	No charge	10%	Not Covered	Not Covered
	Topical Fluoride Application	No charge	10%	Not Covered	Not Covered
	Space Maintainers - Fixed	No charge	10%	Not Covered	Not Covered
Basic Services	Restorative Procedures	20% Deductible Applies	30% Deductible Applies	20% Deductible Applies	30% Deductible Applies
	Periodontal Maintenance Services				
	Adult Periodontics (other than maintenance) (Group Dental Plans only)				
	Adult Endodontics (Group Dental Plans only)				
Major Services	Periodontics (other than maintenance)	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies
	Endodontics				
	Crowns and Casts				
	Prosthodontics				
	Oral Surgery				
Orthodontia	Medically Necessary Orthodontia	50% Deductible Applies	50% Deductible Applies	Not Covered	Not Covered



2017 Dental Standard Benefit Plan Designs

Date: April 7, 2016

Summary of Benefits and Coverage

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

Children's Dental Plan and Family Dental Plan designs apply to Individual Marketplace and Covered California for Small Business.

		Family Dental Plan	
		Copay Plan	
		Pediatric Dental EHB	Adult Dental
		Up to Age 19	Age 19 and Older
Actuarial Value		83.2%	Not Calculated
		In-Network	In-Network
Individual Deductible		None	None
Family Deductible (Two or more children)		Not applicable	Not Applicable
Individual Out of Pocket Maximum		\$350	Not Applicable
Family Out of Pocket Maximum (Two or More Children)		\$700	Not Applicable
Office Copay		\$0	\$0
Waiting Period <small>(Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))</small>		None	None
Annual Benefit Limit <small>(the maximum amount the dental plan will pay in the benefit year)</small>		None	None
Procedure Category	Service Type	Member Cost Share	Member Cost Share
Diagnostic & Preventive	Oral Exam	No charge	No charge
	Preventive - Cleaning	No charge	No charge
	Preventive - X-ray	No charge	No charge
	Sealants per Tooth	No charge	Not Covered
	Topical Fluoride Application	No charge	Not Covered
	Space Maintainers - Fixed	No charge	Not Covered
Basic Services	Restorative Procedures	See 2017 Dental Copay Schedule	See 2017 Dental Copay Schedule
	Periodontal Maintenance Services		
	Adult Periodontics (other than maintenance) (Group Dental Plans only)		
	Adult Endodontics (Group Dental Plans only)		
Major Services	Periodontics (other than maintenance)	See 2017 Dental Copay Schedule	See 2017 Dental Copay Schedule
	Endodontics		
	Crowns and Casts		
	Prosthodontics		
	Oral Surgery		
Orthodontia	Medically Necessary Orthodontia	\$350	Not Covered



2017 Dental Standard Benefit Plan Designs

Date: April 7, 2016

Summary of Benefits and Coverage

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

Children's Dental Plan and Family Dental Plan designs apply to Individual Marketplace and Covered California for Small Business.

Covered California for Small Business					
Group Dental Plan					
Coinsurance Plan					
Pediatric Dental EHB			Adult Dental		
Up to Age 19			Age 19 and Older		
Actuarial Value	86.8%	86.8%	Not Calculated	Not Calculated	
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Individual Deductible	\$65	\$65	\$50	\$50	
Family Deductible (Two or more children)	\$130	\$130	Not Applicable	Not Applicable	
Individual Out of Pocket Maximum	\$350	None	Not Applicable	Not Applicable	
Family Out of Pocket Maximum (Two or More Children)	\$700	None	Not Applicable	Not Applicable	
Office Copay	\$0	\$0	\$0	\$0	
Waiting Period <small>(Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))</small>	None	None	None	None	
Annual Benefit Limit <small>(the maximum amount the dental plan will pay in the benefit year)</small>	None	None	\$1,500		
Procedure Category	Service Type	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share
Diagnostic & Preventive	Oral Exam	No charge	10%	No charge	10%
	Preventive - Cleaning	No charge	10%	No charge	10%
	Preventive - X-ray	No charge	10%	No charge	10%
	Sealants per Tooth	No charge	10%	Not Covered	Not Covered
	Topical Fluoride Application	No charge	10%	Not Covered	Not Covered
	Space Maintainers - Fixed	No charge	10%	Not Covered	Not Covered
Basic Services	Restorative Procedures	20% Deductible Applies	30% Deductible Applies	20% Deductible Applies	30% Deductible Applies
	Periodontal Maintenance Services				
	Adult Periodontics (other than maintenance) (Group Dental Plans only)				
	Adult Endodontics (Group Dental Plans only)				
Major Services	Periodontics (other than maintenance)	50% Deductible Applies	50% Deductible Applies	See Basic Services	See Basic Services
	Endodontics			See Basic Services	See Basic Services
	Crowns and Casts			50% Deductible Applies	50% Deductible Applies
	Prosthodontics				
	Oral Surgery				
Orthodontia	Medically Necessary Orthodontia	50% Deductible Applies	50% Deductible Applies	Not Covered	Not Covered

Endnotes to 2017 Dental Standard Benefit Plan Designs

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan, Family Dental Plan or Group Dental Plan)

- 1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
- 2) Deductible is waived for Diagnostic and Preventive Services.
- 3) Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
- 4) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
- 5) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
- 6) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
- 7) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.
- 8) 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.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan and Group Dental Plan)

- 9) Each adult is responsible for an individual deductible.
- 10) Deductible is waived for Diagnostic and Preventive Services.
- 11) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.
- 12) Tooth whitening, adult orthodontia and implants are not covered services.

Attachment 3 – Small Group Distribution Costs for CCSB

Attachment 3

Small Group Distribution Costs for CCSB QDP Premiums

To meet the requirements of the ACA and this contract set forth in Section 5.2, this Attachment outlines a rating process that accounts for the differences in distribution costs between QDP-issued small group business sold inside the Exchange and business sold directly by Contractors outside of the Exchange. Distribution costs include but are not limited to Agent and General Agent compensation as these and other costs may apply. This rating process provides a mechanism to spread these distribution cost differences to produce a single premium rate for QDPs sold inside and outside the CCSB exchange. Subject to the Statement of Risk as discussed below, this process further enables the Exchange to collect sufficient funds to compensate Agents and General Agents.

CCSB Exchange Distribution Cost Percentage for 2017 Rates: 8.0%

Annually Covered California will finalize the CCSB Exchange distribution cost percentage as noted above, and Contractor should use the below formula to determine their expected average distribution cost across on CCSB and off CCSB Exchange, and submit their final CCSB Exchange rates based on this percentage.

Composite distribution percentage for use by Contractor in rate setting =

$$\begin{aligned} & \text{(Distribution Cost Percentage for CCSB Exchange) * (Assumed \% of QDP premium to be sold on CCSB} \\ & \qquad \qquad \qquad \text{Exchange)} \\ & \qquad \qquad \qquad + \\ & \text{(Contractor distribution compensation as \% of premium for non-CCSB) * (Assumed \% of QDP premium to} \\ & \qquad \qquad \qquad \text{be sold off CCSB Exchange)} \end{aligned}$$

Statement of Risk

The Contractor, not the Exchange, is at risk for the assumptions used in the Contractor bid regarding what percentage of business will be on and off the CCSB Exchange. In addition the Contractor assumes the risk for any miscalculation of the Contractor distribution costs which may include but are not limited to Agent and General Agent compensation.

- Each Contractor is responsible for its own assumption about the percentage of QDP business sold through the CCSB Exchange. If the percentage assumption proves to be insufficient to cover the Contractor's costs, then this will be a loss to the Contractor.

The Exchange is solely responsible for estimating its own distribution costs and covering any miscalculations.

- The Exchange is responsible for the assumption about the distribution percentage it will charge against QDP premiums collected via the CCSB Exchange. If the distribution cost percentage is insufficient to cover the Exchange's distribution costs, then this will be a loss to the Exchange. If the distribution cost percentage sufficiently covers the distribution costs and results in excess funds, then this will be a gain to the Exchange. The Contractor is not at risk for the Exchange's assumption about the Exchange's compensation levels.

Attachment 4 – Service Area Listing

Attachment 5 – Dental Carrier Evaluation

Dental 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 dental 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 conducive 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 and Delivery System Standards

Attachment 7. Quality, Network Management and Delivery System Standards

Quality, Network Management and Delivery System Standards

Preamble

PROMOTING HIGHER QUALITY AND BETTER VALUE

The mission of Covered California (the “Exchange”) is to increase the number of insured Californians, improve health care quality and access to care, promote better health, lower costs, and reduce health disparities through 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 cost of health care services. The Exchange and Contractor recognize that promoting better quality and value will be contingent upon smooth implementation and large enrollment in the Exchange.

Qualified Dental Plan issuers (“QDP issuers” or “Contractor”) are central partners for the Exchange in achieving its mission. By entering into an agreement with the Exchange (“Agreement”), Contractor agrees to work in partnership with the Exchange to develop and implement policies and practices that will promote the Triple Aim, impacting not just the Enrollees of the Exchange but the Contractor’s California membership. QDP Issuers have the opportunity to take a leading role in helping the Exchange 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 the Exchange can promote improvements in the entire care delivery system. The Exchange will seek to promote care that reduces excessive costs, minimizes unpredictable quality and reduces inefficiencies of the current system. For there to be a meaningful impact on overall oral healthcare cost and quality, solutions and successes need to be sustainable, scalable and expand beyond local markets or specific groups of individuals. The Exchange expects its QDP partners to engage in a culture of continuous quality and value improvement, which will benefit all Enrollees.

These Quality, Network Management and Delivery System Standards outline the ways that the Exchange and the Contractor will focus on the promotion of better care and higher value for the Plan Enrollees and for other California health care consumers. This focus will require both the Exchange and the 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 the Exchange, Contractor affirms its commitment to be an active and engaged partner with the Exchange and to work collaboratively to define and implement additional initiatives and programs to continuously improve quality and value.

Article 1. Improving Care, Promoting Better Health and Lowering Costs

1.01 Coordination and Cooperation. Contractor and the Exchange agree that the Quality, Network Management and Delivery System Standards 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 oral health care and reduce administrative burdens will require active partnership between both the Exchange and the Contractor, but also with Providers, consumers and other important stakeholders.

(a) The Exchange shall facilitate ongoing discussions with the Contractor and other stakeholders through the Exchange's Plan Management and Delivery System Reform Advisory Group, Dental Technical Workgroup, 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:

- (i) Enrollees and other consumers;
- (ii) Providers in terms of burden, changes in payment and rewarding the triple aim of improving care, promoting better health and lowering costs; and
- (iii) Contractors in terms of the burden of reporting, participating in quality or delivery system efforts.

(b) The Contractor agrees to participate in Exchange advisory and planning processes, including but not limited to participating in the Plan Management and Delivery System Reform Advisory Group, and Dental Technical Workgroup.

1.02 Participation in Collaborative Quality Initiatives. The Exchange and Contractor will collaboratively identify and evaluate the most effective programs for improving care for enrollees and the Exchange and Contractor may consider participation by Contractor as a requirement for future certification.

1.03 Reducing Health Disparities and Assuring Health Equity. Covered California and the Contractor recognize that promoting better health requires a focus on addressing health disparities and health equity. Because of this, Contractor agrees to work with the Exchange to identify strategies that will address health disparities in meaningful and measurable ways. This shall include:

(a) Participating in Exchange workgroups and forums to share strategies and tactics that are particularly effective;

(b) Working with the Exchange to determine how data can best be collected and used to support improving oral health equity including the extent to which data might be better collected by the Exchange or the Contractor and how to assure that the collection and sharing of data is sensitive to Enrollees' preferences. In working with the Exchange, Contractor agrees to report how it plans to collect and use data on demographic characteristics, including but not limited to:

- (i) Race
- (ii) Ethnicity
- (iii) Gender
- (iv) Primary language
- (v) Disability status

Article 2. Provision and Use of Data and Information for Quality of Care

2.01 Dental Utilization Reporting. Contractor shall submit to the Exchange dental utilization data to include the measure numerator, denominator and rate for the required measure set. The Exchange reserves the right to use the Contractor-reported measures scores to construct Contractor summary quality ratings that the Exchange may use for such purposes as the Exchange's plan oversight management.

2.02 Data Submission Requirements to the Exchange. Contractor shall submit a complete data set, inclusive of all member and provider identified data, claims, and encounter data, on a quarterly basis to the Exchange or the Exchange's designated recipient to be used by the Exchange as it determines to be necessary. Such submissions will conform to all applicable Federal and State personal health information and related privacy laws, rules and regulations, and shall comply with the terms and conditions set forth in the Agreement by and between Contractor and the Exchange. Contractor will bear the full cost of data collection, extraction and submission; provided, however, that except as expressly set forth in this Attachment or the Agreement, Contractor will not be required to pay for any expenses related to the analysis of that data in order to comply with the terms of this Agreement. When data is submitted to a vendor for the Exchange, that vendor will be a Business Associate as defined by HIPAA of the Contractor and shall protect the information provided to the extent required under applicable laws, rules and regulations.

Working with Contractors, the Exchange will develop data file formats that will be required of Contractor to support oversight requirements, including actuarial review, clinical quality improvement, network management and fraud and waste reduction, delivery system reform goals, consumer information and research. Additional data and expanded file formats may be requested in the future in support of the Exchange contributing data to statewide collaborative efforts to advance development of an all payer claims database.

Specific data submission areas may include:

- Plan and Product
- Member
- Member History
- Providers (all providers with paid claims, including non-contracted)
- Professional Claims

If Contractor is unable to produce such information in the file format requested by the Exchange, Contractor shall coordinate with the Exchange with a plan to address data gaps or format preferences prior to the Contractor's submission of such information. For any non-paid claims for capitated services, the Contractor shall provide full and complete encounter data.

2.03 Determining Enrollee Health Status and Use of Risk Assessments. Contractor shall demonstrate the capacity and systems to collect, maintain and use individual information about Exchange Plan Enrollees' oral health status and behaviors in order to promote better oral health and to better manage Enrollees' oral health conditions. Contractor shall demonstrate the use of Risk Assessment to identify members in need of dental treatment services including but not limited to preventive and diagnostic services.

To the extent the Contractor uses or relies upon Risk Assessments to determine oral health status, Contractor shall offer, upon initial enrollment and on a regular basis thereafter, a Risk Assessment to all Plan Enrollees, including those Plan Enrollees that have previously completed such an assessment. If a Risk Assessment tool is used, Contractor should select a tool that adequately evaluates Plan Enrollees current oral health status and provides a mechanism to conduct ongoing monitoring for future intervention(s).

2.04 Reporting to and Collaborating with the Exchange Regarding Health Status. Contractor shall provide to the Exchange, in a format that shall be mutually agreed upon, information on how it collects and reports, at both individual and aggregate levels, changes in Exchange Plan Enrollees' oral health status. Reporting may include a comparative analysis of oral health status improvements across geographic regions and demographics.

Contractor shall report to the Exchange its process to monitor and track Plan Enrollees' oral health status, which may include its process for identifying individuals who show a decline in oral health status, and referral of such Plan Enrollees to Contractor care management and chronic condition program(s) as defined in Section 4.03, for the necessary intervention. Contractor shall annually report to the Exchange the number of Plan Enrollees who are identified through their selected mechanism and the results of their referral to receive additional services.

Contractor agrees to work with the Exchange to standardize: (1) indicators of Plan Enrollee risk factors; (2) oral health status measurement; and (3) oral health assessment questions across all Contractors, with the goal of having standard measures used across the Exchange's Contractors in a period of time mutually agreed upon by Contractor and the Exchange.

Article 3. Preventive Health and Wellness

3.01 Health and Wellness Services. Contractor is required to actively outreach and monitor the extent to which Exchange Plan Enrollees obtain preventive health and wellness services within the Enrollee's first year of enrollment. Contractor shall submit information annually to the Exchange related to Plan Enrollees' access to preventive health and wellness services. Specifically, Contractor shall assess and discuss the participation by Plan Enrollees in necessary diagnostic and preventive services appropriate for each enrollee.

Contractor shall annually submit to the Exchange documentation of a health and wellness communication process to Exchange Enrollees and Participating Providers.

3.02 Community Health and Wellness Promotion. The Exchange and Contractor recognize that promoting better health for Plan 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 shall report annually in a mutually agreed upon form the initiatives, programs and/or projects that it supports that promote wellness and better community health that specifically reach beyond the Contractors' Enrollees. Such programs may include, but are not limited to, partnerships with local or state public health departments and voluntary health organizations which operate preventive and other health programs.

Contractor shall develop and provide reports on how it is participating in community health and wellness promotion. Report information should be coordinated with existing national measures, whenever possible.

Article 4. Access, Coordination, and At-Risk Enrollee Support

The Exchange and Contractor recognize that access to care, coordination of care and early identification of high risk enrollees are central to the improvement of Enrollee health. Traditionally, Primary Care Providers (PCP) have provided an entry point to the system (access), coordination of care and early identification of at risk patients, and the Exchange strongly encourages the full use of PCPs by Contractors. Contractor and the Exchange shall identify further ways to increase access and coordination of care and agree to work collaboratively to achieve these objectives.

4.01 Encouraging Consumers' Access to Appropriate Care. Contractor is encouraged to assist Exchange Enrollees in selecting a primary care dentist or Federally Qualified Health Center that provides dental care within sixty (60) days of enrollment. In the event the Enrollee does not select a primary care dentist within the allotted timeframe, Contractor may auto-assign the enrollee to a primary care dentist and the assignment shall be communicated to the Plan Enrollee. The Contractor will also make reasonable effort to notify the primary care dentist of the Enrollee assignment. In the event of an auto-assignment, Contractor shall use commercially reasonable efforts to make the primary care dentist assignment consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, if known, and should consider geographic accessibility and existing family member assignment or prior provider assignment.

4.02 Promoting Development and Use of Care Models Contractor shall report annually, in a format to be mutually agreed upon between Contractor and Exchange, on: (1) the number and percentage of Exchange Plan Enrollees who have selected or been assigned to a primary care dentist, as described in Section 4.01. In the event that the reporting requirements identified herein include Protected Health Information, Contractor shall provide the Exchange only with de-identified Protected Health Information as defined in 45 C.F.R. Section 164.514.

Contractor shall not be required to provide the Exchange any data, information or reports that would violate peer review protections under applicable laws, rules and regulations.

4.03 Identification and Services for At-Risk Enrollees. Contractor agrees to identify and proactively manage the Plan Enrollees with existing and newly diagnosed need for dental treatment beyond diagnostic and preventive dental services and Plan Enrollees with chronic conditions and who are most likely to benefit from well-coordinated care ("At-Risk Enrollees"). As described in Section 2.04, Contractor shall determine the health status of its new enrollees including identification of those with chronic conditions or other significant dental needs within the first one hundred twenty (120) days of enrollment, provided the Exchange has provided timely notification of enrollment. The Exchange will work with Contractor to develop a documented process, care management plan and strategy for targeting these specific Enrollees. Such documentation may include the following:

- (a) Methods to identify and target At-Risk Enrollees;
- (b) Description of Contractor's predictive analytic capabilities to assist in identifying At Risk Plan Enrollees who would benefit from early, proactive intervention;
- (c) Communication plan for known At-Risk Enrollees to receive information prior to provider visit;
- (d) Process to update At-Risk Enrollee dental history in the Contractor maintained Plan Enrollee health profile;

(e) Mechanisms to evaluate access within 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;

(f) Care and network strategies that focus on supporting a proactive approach to at-risk Plan Enrollee intervention and care management. Contractor agrees to provide the Exchange with a documented plan and include “tools” and strategies to supplement and/or expand care management and provider network capabilities, including an expansion and/or reconfiguration of specialties or health care professionals to meet clinical needs of At Risk Enrollees.

Article 5. Patient-Centered Information and Communication

5.01 Provider Cost and Quality. Contractor shall provide the Exchange with its plan, measures and process to provide Plan Enrollees with current cost and quality information for network providers. Contractor shall report how it is or intends to make provider specific cost and quality information available by region, and the processes by which it updates the information. Information delivered through Contractor's Provider performance programs should be meaningful to Plan Enrollees and reflect a diverse array of Provider clinical attributes and activities, including, but not be limited to: provider background; quality performance; patient experience; volume; efficiency; price of services; and should be integrated and accessible through one forum providing Plan enrollees with a comprehensive view.

5.02 Enrollee Cost Transparency. The Exchange and Contractor acknowledge and agree that information relating to the cost of procedures and services is important to enrollees, the Exchange, the Contractor and providers. The Exchange also understands that Contractor negotiates Agreements with providers, including dental practice groups and other clinical providers, which may result in varied provider reimbursement levels for identical services and or procedures. In the event that Contractor's provider contracts result in different provider reimbursement levels that have an impact on Plan Enrollee costs within a specific region, as defined by paid claims for Current Dental Terminology (CDT) services, Contractor agrees to provide the Exchange with its plan, measures and process to assist Plan Enrollees in identifying total cost and out-of-pocket cost information for the highest frequency and highest cost service(s) and or procedure(s). When available, this pricing information shall be prominently displayed and made available to both Plan Enrollees and contracted Contractor providers if provided. This information shall be updated on at least an annual basis unless there is a contractual change that would change enrollee out-of-pocket costs by more than 10%. In that case, information must be updated within thirty (30) days of the effective date of the new contract.

5.03 Enrollee Benefit Information. Contractor shall provide Plan Enrollees with current information regarding annual out-of-pocket costs, status of deductible, status of benefit limit if applicable, and total oral health care services received to date.

Article 6. Promoting Higher Value Care

Reserved for future use

Quality, Network Management and Delivery System Standards

Glossary of Key Terms

Active Purchaser - Health care purchasers, typically employers or employer coalitions, that proactively define and manage performance expectations through their health plan contracts or direct contracting arrangements with providers. These expectations include a range of service models including (but not limited to) benefit design and incentives, health and wellness, service delivery for enrollees, transaction processing, delivery system performance and reform, health information technology adoption and use, quality of care for enrollees, and other innovation models. Further, these expectations may also include active development, financial support, and contractual expectations for collaborative participation in accordance with applicable laws, rules and regulations, among multiple payers and/or providers that collectively serve a specific geographic area and/or multiple purchasers.

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.

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 health care services. Generally these models require improved care coordination, provider and payer information sharing and programs that identify and manage populations of individuals through care delivery and payment models.

Dental Primary Care - Professional guidelines for addressing pediatric oral health needs are predicated on early and periodic clinical examinations to assess for evidence of pathologic changes or developmental abnormalities, diagnoses to determine treatment needs, and follow-up care for any conditions requiring treatment. These recurring periodic oral assessments ("dental checkups") are generally coupled with routine preventive services and increasingly seek to incorporate assessments of risk factors that elevate the likelihood of destructive changes if allowed to persist. This pattern of periodic assessments, preventive services, and necessary follow-up care also generally applies for adults, who collectively are more susceptible to the development of periodontal disease, oro-pharyngeal cancers, and other soft tissue abnormalities.

Dental Home - Oral health care is best delivered in a "dental home" where competent oral health care practitioners provide continuous and comprehensive services. Ideally a dental home should be established at a young age. An adequate dental home should be expected to provide patients with: An accurate examination and risk assessment for dental diseases, an individualized preventive dental health program based upon the examination and risk assessment, information about proper diet and nutrition practices, a continuing care provider that accomplishes restorative and surgical dental care when necessary in a manner consistent with the patient's psychological needs, referrals to dental specialists when care cannot be directly provided within the dental home, and coordination of care with the patient's primary care medical provider as applicable. Additionally, for pediatric patients and their caregivers, an adequate dental home should provide advice for injury prevention and a plan for dealing with dental emergencies, information about proper care of the child's teeth and supporting structures, pit and fissure

sealants, a place for the child and parent to establish a positive attitude about dental health, and anticipatory guidance about growth and developmental issues.

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 enrollees 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.

The information set forth in this Attachment shall not limit the Exchange's right to obtain information in accordance with the terms set forth in the Agreement and/or applicable laws, rules and regulations.

Attachment 8 – Monthly Rates – Individual Exchange

Attachment 9 – Rate Updates – Individual Exchange

Attachment 10 – Monthly Rates – Covered California for Small Business

Attachment 11 – Rate Updates – Covered California for Small Business

Attachment 12 – Reserved for future use

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:
Enrollment Reconciliation Comparison extract	2.1.2	Monthly	As required in 2.1.2	SFTP
Marketing Plan – Open Enrollment	2.5	Annually	30 days prior to open enrollment	QHPMarketingMaterials@covered.ca.gov
Marketing Plan – Special Enrollment	2.5	Annually	30 days prior to January 1 st	QHPMarketingMaterials@covered.ca.gov
Marketing Plans of Retention and Renewal	2.5	Annually	30 days after open enrollment begins	QHPMarketingMaterials@covered.ca.gov
Marketing Actualized Spend Amounts	2.5	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 14				
Customer Service and Operational Performance Standards	Attachment 14 Groups 1 & 2	Monthly	The 10 th of the following month	QHP@covered.ca.gov
Dental Quality Alliance (DQA) Pediatric Measure Set	Attachment 14 Group 3	Annually	For calendar year 2017, due on April 30, 2018	QHP@covered.ca.gov
Covered California Performance Measurement Standards and Reporting Requirements Utilization Measures for Adult Dental	Attachment 14 Group 4	Annually	For calendar year 2017, due on April 30, 2018	QHP@covered.ca.gov

Reporting Requirements in Attachment 14 (continued)				
Reducing Health Disparities and Assuring Health Equity - Attachment 7, 1.03(b)	Attachment 14 Group 5, 5.1	Annually	For calendar year 2017, due on February 28, 2018	QHP@covered.ca.gov
Risk Assessment - Attachment 7, 2.03	Attachment 14 Group 5, 5.2	Annually	For calendar year 2017, due on February 28, 2018	QHP@covered.ca.gov
Reporting to and Collaborating with the Exchange Regarding Health Status - Attachment 7, 2.04	Attachment 14 Group 5, 5.3	Annually	For calendar year 2017, due on February 28, 2018	QHP@covered.ca.gov
Health and Wellness Services - Attachment 7, 3.01	Attachment 14 Group 5, 5.4	Annually	For calendar year 2017, due on February 28, 2018	QHP@covered.ca.gov
Community Health and Wellness Promotion - Attachment 7, 3.02	Attachment 14, Group 5, 5.5	Annually	For calendar year 2017, due on February 28, 2018	QHP@covered.ca.gov
Promoting Development and Use of Care Models - Attachment 7, 4.02	Attachment 14 Group 5, 5.6	Annually	For calendar year 2017, due on February 28, 2018	QHP@covered.ca.gov
Identification and Services for At-Risk Enrollees - Attachment 7, 4.03	Attachment 14 Group 5, 5.7	Annually	For calendar year 2017, due on February 28, 2018	QHP@covered.ca.gov
Provider Cost and Quality – Attachment 7 5.01	Attachment 14 Group 5, 5.8	Annually	For calendar year 2017, due on February 28, 2018	QHP@covered.ca.gov
Enrollee Benefit Information – Attachment 7, 5.03	Attachment 14, Group 5, 5.9	Annually	For calendar year 2017, due on February 28, 2018	QHP@covered.ca.gov

Financial Management Division – Required Reports				
<p>Payment Reconciliation – Schedule of Notifications</p> <p>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.</p>		<p>Contractor will provide if requested</p>		<p>Contractor will provide to the person requesting this data.</p>
<p>Billing Detail – Discrepancy Report</p> <p>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.</p>		<p>Monthly</p>	<p>Report due in the month following the payment due date. Use FMD Issuer Billing Discrepancy Report Template.</p>	<p>Accounting SCRtickets@covered.ca.gov</p> <p>Please include "PMPM Billing Detail Discrepancy Report - for <billing month-year>" in the subject line of the email.</p>

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 6.2 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 five percent (5%) 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, and three percent (3%) of the total Participation Fee that is payable to the Exchange in accordance with the terms set forth in Section 5.1.6 for Covered California for Small Business. 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. Credits from one category may be used to offset penalties in that category, or applied to offset penalties assessed in another category.

The Exchange will calculate penalties and credits at the end of each calendar year, based on Contractor's final year-end data. The Exchange will calculate penalties and credits for Group 1 and 2 and provide Contractor with a Contractor Performance Standard Evaluation Report by February 28th of the following calendar year. An invoice for any penalties assessed will be mailed to the Contractor within 30 calendar days of Contractor's receipt of the Contractor Performance Standard Evaluation Report. In no event shall the total credits to Contractor exceed the total amount of the performance penalty owed to the Exchange by Contractor.

If Contractor does not agree with the 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.

Any amounts collected as performance penalties under this Attachment must be used to support Exchange operations.

Performance Standards Reporting - Group 1 - Customer Service and Group 2 – Operational, Performance Standards 1.1 – 1.15 and 2.1 – 2.5

Monthly Performance Report: Beginning January 1, 2017, Contractor shall monitor and track its performance each month against the Performance Standards set forth in Group 1 and 2. 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 Exchange business only and shall report Contractor's Exchange Enrollees in the Individual Exchange separate from Contractor's Exchange Enrollees in Covered California for Small Business.

Performance Standards Reporting – Group 3 – Dental Quality Alliance (DQA) Pediatric Measure Set, Group 4 – Utilization Measures for Adult Dental, Group 5 - Quality and Delivery System Reform

Annual Performance Report: An annual report will be required for the performance measurement data in Group 3, 4 and 5. The performance period is the 2017 contract term. Annual report for Group 3 and 4 is due on April 30, 2018 and the Narrative Report for Group 5 is due on February 28, 2018. Contractor shall report Exchange business only and shall report Individual Exchange separate from Contractor's Exchange Enrollees in Covered California for Small Business.

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 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.

- 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. Performance Standards Tables - The Performance Standards are set forth in the below tables, Covered California Performance Standards and Reporting Requirements for Contractor:

Group 1: Customer Service Performance Standards 24% of Total Performance Penalty At Risk or Credit				
Performance Standard		Individual	Small Business	Performance Requirements
1.1	Inbound Call Volume - Covered California Calls Only	<u>X</u>	<u>X</u>	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	<u>X</u>	<u>X</u>	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	<u>X</u>	<u>X</u>	Reporting Required Only. No penalty or credit. Do not include calls abandoned in 10 seconds or less.
1.4	Abandonment Rate (%) 4% of total performance penalty for this Group.	<u>X</u>	<u>X</u>	Divide number of abandoned calls by the number of calls offered to a phone representative. <u>Expectation:</u> No more than 3% of incoming calls abandoned in a calendar month. <u>Performance Level:</u> >3% abandoned: 4% performance penalty. 2-3% abandoned: no penalty. <2% abandoned: 4% performance credit.
1.5	Average Speed of Answer 4% of total performance penalty for this Group.	<u>X</u>	<u>X</u>	<u>Expectation:</u> 80% of calls answered in 30 seconds or less. <u>Performance Level:</u> <80%: 4% performance penalty. 80%-90%: no penalty. >90%: 4% performance credit.

Group 1: Customer Service Performance Standards 24% of Total Performance Penalty At Risk or Credit				
Performance Standard		Individual	Small Business	Performance Requirements
1.6	Average Handle Time	<u>X</u>	<u>X</u>	Reporting Required Only. <u>No penalty or credit.</u> This includes talk time, hold time, and after call wrap up time.
1.7	Number of Binder Payment Notices Generated	<u>X</u>		Reporting Required Only. <u>No penalty or credit.</u>
1.8	Binder Payment Processing Time	<u>X</u>		Reporting Required Only. <u>No penalty or credit.</u>
1.9	Number of Binder Payments Processed	<u>X</u>		Reporting Required Only. <u>No penalty or credit.</u>
1.10	ID Card Processing Time If carrier uses a no-card eligibility verification system: the time frame from receipt of binder payment or complete and accurate enrollment information through the date consumer receives carrier communication regarding use of no-card eligibility verification system. 4% of total performance penalty for this Group.	<u>X</u>	<u>X</u>	For the Individual Exchange: Expectation: 99% of ID cards issued within 10 business days of receiving complete and accurate enrollment information and binder payment for a specific consumer. For Small Business: Expectation: 99% of ID cards issued within 10 business days of receipt of complete and accurate enrollment information for a specific consumer. Performance Level: <99%: 4% performance penalty.
1.11	Number of ID Cards Processed If carrier uses a no-card eligibility verification system: the time elapsed from receipt of binder payment or complete and accurate enrollment information through the date consumer receives carrier communication regarding use of no-card eligibility verification system.	<u>X</u>	<u>X</u>	Reporting Required Only, <u>no penalty or credit.</u>

Group 1: Customer Service Performance Standards 24% of Total Performance Penalty At Risk or Credit				
Performance Standard		Individual	Small Business	Performance Requirements
1.12	Initial Call Resolution 4% of total performance penalty for this Group.	<u>X</u>	<u>X</u>	<p><u>Expectation:</u> 85% of Covered California enrollee issues will be resolved within one (1) business day of receipt of the issue.</p> <p><u>Performance Level:</u> <85%: 4% performance penalty. 85-95%: no penalty. >95%: 4% performance credit.</p>
1.13	Grievance Resolution 4% of total performance penalty for this Group.	<u>X</u>	<u>X</u>	<p><u>Expectation:</u> 95% of Covered California enrollee grievances resolved within 30 calendar days of initial receipt.</p> <p><u>Performance Level:</u> <95% resolved within 30 calendar days of initial receipt: 4% 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: 4% performance credit.</p>
1.14	Covered California member Email or Written Inquiries	<u>X</u>	<u>X</u>	<p><u>Reporting Required Only. No penalty or credit.</u> Volume will be used in calculation of performance standard 1.15.</p> <p>Total number of Covered California member email or written inquiries received.</p>
1.15	Covered California member Email or Written Inquiries Answered and Completed 4% of total performance penalty for this Group.	<u>X</u>	<u>X</u>	<p><u>Expectation:</u> 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.</p> <p><u>Performance Level:</u> <90%: 4% performance penalty. 90-95%: no penalty. >95%: in 15 days 4% performance credit.</p>

Group 2: Operational Performance Standards 10% of Total Performance Penalty at Risk				
Performance Standard		Individual	Small Business	Performance Standards
2.1	834 Processing Pilot Period: January 1, 2017 – March 31, 2017	<u>X</u>		<u>Expectation:</u> 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. <u>Performance Level</u> <95% below expectation
2.2	834 Generation Pilot Period: January 1, 2017 – March 31, 2017	<u>X</u>		<u>Expectation:</u> 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. <u>Performance Level</u> <95% below expectation
2.3	Reconciliation Process	<u>X</u>		<u>Expectation:</u> 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. <u>Performance Level:</u> <90%: below expectation

Group 2: Operational Performance Standards 10% of Total Performance Penalty at Risk				
Performance Standard		Individual	Small Business	Performance Standards
2.4	<p>Data Submission specific to contract Section 3.4.4</p> <p>5% of total performance penalty for this Group.</p>	<u>X</u>	<u>X</u>	<p><u>Expectation:</u> Full and regular submission of data according to the standards outlined.</p> <p><u>Performance Level:</u> Incomplete, irregular, late or non-useable data submission: 5% 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</p>
2.5	<p>Agent of Record Exception Reports</p> <p>5% of total performance penalty for this Group.</p> <p>Pilot Period: January 1, 2017 – March 31, 2017</p>	<u>X</u>		<p><u>Expectation:</u> The Exchange shall receive the required Agent of Record exception reports referenced in Section 2.2.5(f) and (g) within 7 business days of the due date.</p> <p><u>Performance Level:</u> 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 out of 12 submissions: no penalty.</p>

Group 3: 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 age 19.	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 age 19.	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 3: 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.	$(\text{NUM}/\text{DEN}) \times 100,000$	< 15%

Group 3: 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%

**Group 4: Covered California Performance Standards and Reporting Requirements
Utilization Measures for Adult Dental**

Utilization Measures	Performance Standards Covered California will work with contractors as appropriate to adjust measure sets where a contractor does not have all of the specific Utilization measures.				
<p>Annual Dental Visit (ADV)</p> <p>Measure includes all members ages 19 years and older as of December 31, 2016 (denominator) who had at least one dental visit in 2016 (numerator). Measure include members enrolled for at least 11 of the 12 months in 2016.</p>	<table border="1" data-bbox="683 527 1122 632"> <thead> <tr> <th>Age Group</th> <th>Expectation</th> </tr> </thead> <tbody> <tr> <td>19+</td> <td>75%</td> </tr> </tbody> </table>	Age Group	Expectation	19+	75%
Age Group	Expectation				
19+	75%				
<p>Preventive Dental Services (PDS).</p> <p>Measure includes members enrolled for at least 11 of the 12 months in 2016 (denominator) who received any preventive dental service (D1000-D1999) in 2016 (numerator).</p>	<table border="1" data-bbox="683 800 1122 905"> <thead> <tr> <th>Age Group</th> <th>Expectation</th> </tr> </thead> <tbody> <tr> <td>19+</td> <td>75%</td> </tr> </tbody> </table>	Age Group	Expectation	19+	75%
Age Group	Expectation				
19+	75%				
<p>Use of Dental Treatment Services (UDTS).</p> <p>Measure includes members enrolled for at least 11 of the 12 months of 2016 (denominator) who received any dental treatment other than diagnostic or preventive services (D2000-D9999) in 2016 (numerator).</p>	<table border="1" data-bbox="683 1041 1122 1146"> <thead> <tr> <th>Age Group</th> <th>Expectation</th> </tr> </thead> <tbody> <tr> <td>19+</td> <td>75%</td> </tr> </tbody> </table>	Age Group	Expectation	19+	75%
Age Group	Expectation				
19+	75%				

Group 5: Covered California Performance Standards for Contractor: Quality and Delivery System Reform

The following questions support the narrative reporting requirement for Performance Measurement Standards. In performing its services under this agreement, Contractor shall use commercially reasonable efforts to meet or exceed the Performance Measurement Standards. Group 5 expectations apply equally to individual and small group lines of business and should be reported separately. The completed questions are to be submitted to Covered California by February 28, 2018 in electronic format to be determined by Covered California.

5.1 Attachment 7, 1.03(b) Reducing Health Disparities and Assuring Health Equity

5.1.1 Identify the sources of data used to gather members' race/ethnicity, primary language, and disability status. The response "enrollment form" pertains only to information reported directly by members or passed on by CalHEERS.

Data Element	Data Collection Method (Select all that apply)	Percent of Covered California membership for whom data is captured
Race/ethnicity	<ul style="list-style-type: none"> <input type="radio"/> Enrollment form <input type="radio"/> Oral health risk assessment <input type="radio"/> Information requested upon website registration <input type="radio"/> Inquiry upon call to customer service <input type="radio"/> Indirect method such as surname or zip code analysis <input type="radio"/> Other (please explain) <input type="radio"/> Data not collected 	
Primary language	<ul style="list-style-type: none"> <input type="radio"/> Enrollment form <input type="radio"/> Oral health risk assessment <input type="radio"/> Information requested upon website registration <input type="radio"/> Inquiry upon call to customer service <input type="radio"/> Indirect method such as surname or zip code analysis <input type="radio"/> Other (Please explain) <input type="radio"/> Data not collected 	
Disability	<ul style="list-style-type: none"> <input type="radio"/> Enrollment form <input type="radio"/> Oral health risk assessment <input type="radio"/> Information requested upon website registration <input type="radio"/> Inquiry upon call to customer service <input type="radio"/> Indirect method such as surname or zip code analysis <input type="radio"/> Other (Please explain) <input type="radio"/> Data not collected 	

5.1.2 If the dental plan answered “data not collected” in the data elements (5.1.1) above, please discuss how the plan is making progress on collecting data elements to support improving health equity.

5.1.3 Indicate how race/ethnicity, primary language, and disability status data are used to address quality improvement and health equity. Select all that apply.

- Assess adequacy of language assistance to meet members’ needs
- Calculate dental quality performance measures by race/ethnicity, language, or disability status
- Calculate member experience measures by race/ethnicity, language, or disability status
- Identify areas for quality improvement
- Identify areas for health education/promotion
- Share provider race/ethnicity/language data with member to enable selection of concordant dentists
- Share with dental network to assist them in providing language assistance and culturally competent care
- Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care
- Analyze disenrollment patterns
- Develop outreach programs that are culturally sensitive (please explain)
- Other (please explain)
- Race/ethnicity data not used for quality improvement or health equity
- Language data not used for quality improvement or health equity
- Disability data not used for quality improvement or health equity

5.1.4 If the Contractor answered “data not collected” in the data elements (5.1.1) above, please discuss how the plan is making progress on using data elements to support improving health equity.

5.2 Attachment 7, 2.03 Risk Assessment

5.2.1 Indicate features of the oral health risk assessment to determine enrollee oral health status. Select all that apply.

- Oral health risk assessment offered online or in print
- Oral health risk assessment offered through telephone interview with a live person
- Oral health risk assessment offered in multiple languages
- Upon completion of oral health risk assessment, risk-factor education is provided to member based on member-specific risk, e.g. if member reports tobacco use, education is provided on gum disease risk
- Personalized oral health risk assessment report is generated with risk modification actions
- Member is directed to interactive intervention module for behavior change upon risk assessment completion
- Email on self-care generated based on enrollee responses
- Email or phone call reminders to schedule preventive or diagnostic visits generated based on enrollee responses
- Oral health risk assessment not offered

5.2.2 Does the Contractor collect information on enrollee oral health status using any of the following sources of data? Select all that apply.

- Oral health risk assessment
- Claims data

- Other (please explain)
- Data on oral health status not collected

5.2.3 Discuss any planned activities to build capacity or systems to determine enrollee oral health status.

5.3 Attachment 7, 2.04 Reporting to and Collaborating with the Exchange Regarding Health Status

5.3.1 Does the Contractor use any of the following sources of data to track changes in oral health status among Plan Enrollees? Select all that apply.

- Oral health risk assessment
- Claims data
- Other (please explain)
- Data on oral health status not used

5.3.2 Discuss any planned activities to build capacity or systems to track changes in enrollee oral health status.

5.4. Attachment 7, 3.01 Health and Wellness Services

5.4.1 Which of the following activities are used by the Contractor to encourage use of diagnostic and preventive services?

- Mailed printed materials about preventive services with \$0 cost-share to members (oral exam, cleaning, X-rays)
- Emails sent to membership about preventive services with \$0 cost-share to members (oral exam, cleaning, X-rays)
- Automated outbound telephone reminders about preventive services with \$0 cost-share to members (oral exam, cleaning, X-rays)
- Other (please explain)
- No current activities used to encourage use of preventive services

5.4.2 Discuss any planned activities to encourage use of diagnostic and preventive services.

5.4.3 If Contractor indicated that any of the activities in 5.4.1 are used to encourage use of diagnostic and preventive services, please upload as an attachment screenshots and/or materials demonstrating these activities.

5.4.4 Which of the following activities are used by the Contractor to communicate oral health and wellness (i.e. self-care for maintaining good oral health)?

- Mailed printed materials about oral health self-care
- Emails sent to membership about oral health self-care
- Other (please explain)
- No current activities used to encourage oral health self-care

5.4.5 Discuss any planned activities to communicate oral health and wellness information to Enrollees.

5.4.6 If Contractor indicated that any of the activities in 5.4.4 are used to communicate oral health and wellness, please upload as an attachment screenshots and/or materials demonstrating these activities.

5.5 Attachment 7, 3.02 Community Health and Wellness Promotion

5.5.1 Please indicate the type of initiatives, programs, and projects the Contractor supports and describe how such activities specifically promote community health and/or address health disparities. Select all that apply and provide a narrative report in the “details” describing the activity.

Type of Activity	Details
Internal facing, member-related efforts to promote oral health (e.g. oral health education programs)	
External facing, high-level community facing activities (e.g. health fairs, attendance at community coalitions, participation in health collaboratives)	
Engaged with non-profit health systems or local health agencies to conduct community risk assessments to identify high priority needs and health disparities related to oral health	
Community oral health effort built on evidence-based program and policy interventions, and planned evaluation included in the initiative	
Funded community health programs based on needs assessment or other activity	
Plan is currently planning a community health promotion activity	
Plan does not conduct any community health initiatives	

5.6 Attachment 7, 4.02 Promoting Development and Use of Care Models

5.6.1 If applicable to the QDP Issuer’s delivery system, please report the number of Covered California enrollees who have been assigned a primary care dentist.

Number of Covered California enrollees who have been assigned a primary care dentist	
Number of Covered California enrollees	

5.6.2 If assignment to a primary care dentist is not required, describe how Contractor encourages member’s use of dental home.

5.6.3 If assignment to a primary care dentist is not required, describe how Contractor encourages contracted providers to retain patients for continued care.

5.7 Attachment 7, 4.03 Identification and Services for At-Risk Enrollees

5.7.1 How does the Contractor currently identify at-risk enrollees, which may include members with existing or newly diagnosed needs for dental treatment or members with co-morbid conditions?

- o Claims data
- o Website registration prompts self-report of existing/newly diagnosed need for dental treatment and/or co-morbid conditions

- Oral health risk assessment
- Other (please explain)
- Plan does not currently identify at-risk enrollees

5.7.2 Discuss any planned activities to identify at-risk enrollees.

5.7.3 Please report the number of Covered California enrollees who have been identified as “at-risk.”

Number of Covered California enrollees who have been identified as “at-risk”	
Number of Covered California enrollees	

5.8 Attachment 7, 5.01 Provider Cost and Quality

5.8.1 Indicate how the Contractor provides members with cost information for network providers. Select all that apply.

- Web site includes a cost calculator tool for dental services (e.g. crowns, casts, endodontics, periodontics, etc.)
- Web site provides information on average regional charges for dental services (e.g. crowns, casts, endodontics, periodontics, etc.)
- Cost information on provider-specific contracted rates available upon request through Web site or customer service line
- Members directed to network providers to request cost information
- Other (please explain)
- Cost information not provided to membership

5.8.2 If the plan does not currently provide members with cost information, please report how the Contractor intends to make provider-specific cost information available to members.

5.8.3 To what extent does the Contractor encourage use of high quality network dental providers?

- Auto-assign members to high-performing dental providers
- Identify high-performing providers through the provider directory or other web site location
- Customer service referral to dental provider
- Other (please explain)
- Contractor does not encourage use of high-performing dental providers

5.8.4 If the Contractor encourages use of high-performing dental providers, what criteria does the Contractor use to identify high-performing providers?

- Dental quality measures
- Health improvement initiatives
- Preventive services rendered
- Patient satisfaction
- Low occurrence of complaints and grievances
- Other (please explain)
- Contractor does not encourage use of high-performing dental providers

5.8.5 If the plan does not currently identify or encourages use of high-performing dental providers, please report how the Contractor intends to identify high-performing dental providers.

5.9 Attachment 7, 5.03 Enrollee Benefit Information

5.9.1 Indicate how the plan provides plan enrollees with current information regarding annual out-of-pocket costs, status of deductible, status of benefit limit if applicable, and total oral health care services received to date. Select all that apply.

- Status of deductible, out-of-pocket costs, and oral health services received to date provided through member login to the dental plan website
- Status of deductible, out-of-pocket costs, and oral health services received to date provided by mailed document upon request
- Status of deductible, out-of-pocket costs, and oral health services available upon member request to customer service
- Other (please explain)
- Status of deductible, out-of-pocket costs, and oral health services received to date not provided