COVERED CALIFORNIA
QUALIFIED DENTAL PLAN CONTRACT FOR 2015
between

Covered California, the California Health Benefit Exchange
and
_____ ("Contractor")

List of Attachments to Qualified Dental Plan Model Contract

FINAL VERSION MARCH 5, 2015

Attachment 1. Contractor's QDP by Region List [to be attached specifically for each Issuer]

Attachment 2. Benefit Plan Designs [to be attached specifically for each issuer]

Attachment 3. Definition of Good Standing

Definition of Good Standing	Regulatory Agency	Relevant to EHB	Relevant to Non-EHB
Verification that issuer holds a state health care service plan license or insurance certificate of authority.			
• Approved for what lines of business (e.g. commercial, small group, individual)	DMHC	X	X
• Approved to operate in what geographic service areas	DMHC	X	X
• Most recent financial exam and medical survey report	DMHC	X	X
• Most recent market conduct exam	CDI	X	X
Affirmation of no material[1] statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable:			
• Financial solvency and reserves	DMHC and CDI	X	X
• Administrative and organizational capacity	DMHC	X	X
• Benefit Design			
• State mandates (to cover and to offer)	DMHC and CDI	X	
• Essential health benefits Pediatric Dental only (as of 2014)	DMHC and CDI	X	
• Basic health care services	CDI	X	
• Copayments, deductibles, out-of-pocket maximums	DMHC and CDI	X	
• Actuarial value confirmation (per Federal rules)	DMHC and CDI	X	
• Network adequacy and accessibility standards	DMHC and CDI	X	
• Provider contracts	DMHC and CDI	X	
• Claims payment policies and practices	DMHC and CDI	X	X
• Provider complaints	DMHC and CDI	X	X
• Utilization review policies and practices	DMHC and CDI	X	X
• Quality assurance/management policies and practices	DMHC	X	
• Enrollee/Member grievances/complaints and appeals policies and practices	DMHC and CDI	X	X
• Marketing and advertising	DMHC and CDI	X	
• Guaranteed issue individual and small group	DMHC and CDI	X	X

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

Attachment 4. Service Area Listing [to be attached specifically for each Issuer]

Attachment 5. Provider Agreement - Standard Terms

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.

1. 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:

- Coordination with the Exchange and other programs and stakeholders (Section 1.06);
- Relationship of the parties as independent contractors (Section 1.08(a)) and Contractor's exclusive responsibility for obligations under the Agreement (Section 1.08(b));
- Participating Provider directory requirements (Section 3.05(b));
- Implementation of processes to enhance stability and minimize disruption to provider network (Section 3.05(c) and (d));
- Notice, network requirements and other obligations relating to costs of out-of-network and other benefits (Section 3.13);
- Credentialing, including, maintenance of licensure and insurance (Section 3.14);
- Customer service standards (Section 3.16);
- Utilization review and appeal processes (Section 3.15);
- Maintenance of a corporate compliance program (Section 3.17);
- Enrollment and eligibility determinations and collection practices (Sections 3.18 to 3.24);
- Appeals and grievances (Section 3.25);
- Enrollee and marketing materials (Section 3.26);
- Disclosure of information required by the Exchange, including if applicable, financial and clinical (Section 3.30; Quality, Network Management and Delivery System Standards (Article 4) and other data, books and records (Article 10);
- Nondiscrimination (Section 3.31);
- Conflict of interest and integrity (Section 3.32);
- Other laws (Section 3.33);
- Quality, Network Management and Delivery System Standards to the extent applicable to Participating Providers (Article 4);
- Performance Measures, to the extent applicable to Participating Providers (Article 6);
- Continuity of care, coordination and cooperation upon termination of Agreement and transition of Enrollees, if applicable (Article 7);
- Security and privacy requirements, including compliance with HIPAA (Article 9); and

- Maintenance of books and records (Article 10).

2. 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.

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

Attachment 6. Customer Service Standards

Customer Service Standards

1. Customer Service Call Center.

(a) During Open Enrollment Period, call center hours shall be Monday through Friday eight o'clock (8:00) a.m. to eight o'clock (8:00) p.m. and Saturday eight o'clock (8:00) a.m. to six (6:00) o'clock p.m. (Pacific Standard Time) except on holidays observed by the Exchange. During non-Open Enrollment periods, the Contractor shall maintain call center hours Monday through Friday eight o'clock (8:00) a.m. to six o'clock (6:00) p.m. and Saturday eight o'clock (8:00) a.m. to five o'clock (5:00) p.m. (Pacific Standard Time), however, Contractor may adjust Saturday hours as required by customer demand. Contractor shall inform the Exchange of its standard call center hours during non-Open-Enrollment periods. Dental Plan Issuers in SHOP are not required to provide Customer Service support on weekends.

(b) The Call Center will be staffed at such levels as reasonably necessary to handle call volume and achieve compliance with Performance Measurement 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 the QDP, and 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) Oral interpreter services shall be 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, in a format and frequency to be determined by the Exchange, but no more frequently than monthly, on the volume of calls received by the call center and Contractor's ability to meet the Performance Measurement Standards.

(e) As required under Section 3.16, the Contractor shall meet all State requirements for language assistance services for all of its commercial lines of business. The Exchange and Contractor agree to assess the adequacy of the language services during 2015, both phone and written material, and consider the adoption of additional standards in 2016.

2. Customer Service Transfers.

(a) During Contractor's regularly scheduled customer service hours, Contractor shall have the capability to accept and handle calls transferred from the Exchange to respond to callers requesting additional information from Contractor. Contractor shall maintain such staffing resources necessary to comply with Performance Measurement Standards and to assure that the Exchange can transfer the call to a live representative of Contractor prior to handing off the call. Contractor shall also maintain live call transfer resources to facilitate a live transfer (from the Exchange to Contractor) of customers who call the Exchange with issues or complaints that need to be addressed by Contractor.

(b) During Contractor's regularly scheduled customer service hours, Exchange shall have the capability to accept and handle calls transferred from the Contractor to respond to callers requesting additional information from the Exchange. The Exchange shall maintain such staffing resources necessary to assure that Contractor can transfer the call to a live representative of the Exchange prior to

handing off the call. The Exchange shall also maintain a live all transfer resource to facilitate a live transfer (from Contactor to the Exchange) of customers who call Contractor with issues or complaints that need to be addressed by the Exchange.

(c) 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.

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

(e) 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. Customer Care.

(a) Contractor shall comply with the applicable requirements of the Americans with Disabilities Act and provide culturally competent customer service to all the Exchange enrollees in accordance with the applicable provisions of 45 C.F.R. §155.205 and §155.210, which refer to consumer assistance 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.

4. 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) 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.

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

5. Issuer-Specific Information.

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

(b) 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. The Exchange will develop a form to collect uniform information from Contractor.

6. Enrollee Materials.

(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 Health Care Regulators, be provided to the Exchange as directed by the Exchange, and shall include information brochures, a summary of the Plan that accurately reflects the coverage available under the Plan (a Summary of Benefits and Coverage) and related communication materials. Contractor shall, upon request by the Exchange, provide copies of Enrollee communications and give the Exchange the opportunity to comment and suggest changes in such material.

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

(i) Welcome letters

(ii) Enrollee ID card

(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.

(c) New Enrollee Enrollment Packets.

(i) 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 SHOP 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 Measurement Standards set forth in this Agreement. The enrollment packet shall include, at the minimum, the following:

(a) Welcome letter;

(b) 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

1. 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,.

(c) Other materials required by the Exchange.

(ii) 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.

(d) 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. The listing shall comply with the requirements required under applicable laws, rules and regulations, including those set forth at 45 C.F.R. Section 156.230 relating to identification of Providers who are not accepting new Enrollees.

(e) 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.

(f) 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.

(i) 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 upon implementation of Plan and in Spanish within ninety (90) days after the Effective Date and any other languages required under applicable laws, rules or regulations. The secure website shall contain information about the Plan, including, but not limited to, the following:

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

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

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

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

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

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

7. Standard Reports. Contractor shall submit standard reports as described below, pursuant to timelines, periodicity, rules, procedures, demographics and other policies mutually established by the Exchange and Contractor, which may be amended by mutual agreement from time to time. Standard reports shall include, but are not limited to:

(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.

8. Performance Measurement Standards for Subcontractors. Contractor shall, as applicable, ensure that all Subcontractors comply with all Agreement requirements and Performance Measurement Standards, including, but not limited to, those related to customer service. Subcontractor's failure to comply with Agreement requirements and all applicable Performance Measurement Standards shall result in specific remedies referenced in Attachment 14 applying to Subcontractor.

9. Contractor Staff Training about the Exchange

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

10. 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.

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. QDPs 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 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.

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 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 by the fourth quarter of 2015. 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.

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.

3.03 Health and Wellness Enrollee Support Process. Contractor shall annually submit to the Exchange the following:

(a) Documentation of health and wellness communication process to Exchange Enrollees and Participating Provider;

(b) Documentation of process to ensure network adequacy required by State or Federal laws, rules and regulations - given the focus on prevention and wellness and the impact it may have on network capacity; and

(c) Documentation of a process to incorporate Enrollee's health and wellness information into Contractor's data and information specific to each individual Enrollee. This Enrollee's data is Contractor's most complete information on each Enrollee and is distinct from the Enrollee's medical record maintained by the providers.

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 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. 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. All information provided to the Exchange in this section shall be treated by the Exchange as confidential information.

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 regulation.

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, Contactor 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 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 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

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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.

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 [to be attached specifically for each Issuer]

Attachment 9. Rate Updates - Individual Exchange [to be attached specifically for each Issuer]

Attachment 10. Monthly Rates- SHOP [to be attached specifically for each SHOP Issuer]

Attachment 11. Rate Updates - SHOP [to be attached specifically for each Issuer]

Attachment 12.

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Attachment 13

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Attachment 14. Performance Measurement Standards

In the event that the reporting requirements identified herein include Personal Health Information, Contractor shall provide the Exchange only with de-identified Personal 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 and regulations.

During the term of this Agreement, Contractor shall meet or exceed the Performance Measurement Standards identified in this Attachment. The parties will meet and confer on the results of the Contractor's Performance Measurement Standards. The Exchange, in its sole discretion, may use some or all of the Performance Measurement Standards set forth in Attachment 14 as part of its Recertification and Decertification process in subsequent years.

1. Call Center Operations

(a) 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 at Section 3.16 to provide support to Exchange Enrollees and in a manner designed to assure compliance with these Performance Measurement Standards.

(b) Reporting: Contractor shall provide the following minimum reports to the Exchange at the specified time and frequency at no additional charge to the Exchange:

- Performance Measurement Standards reporting: Customer Service, Operational and Quality, Network Management and Delivery System Reform; monthly, quarterly and annually.

- Monthly accumulative monitoring scoring.

2. Performance Measurement Standards Reporting Requirements Group 1 – Customer Service, Group 2 – Operational, Group 3 – Utilization Measures and Group 4 - Quality and Delivery System Performance Measurement Standards.

(a) **Monthly Performance Report:** Beginning January 1, 2015, Contractor shall monitor and track its performance each month against the Performance Measurement Standards set forth below. Contractor shall provide detailed supporting information 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 SHOP.

(b) **Measurement Rules:** Except as otherwise specified below in the Performance Measurement Standards table, the reporting period for each Performance Standard shall be one calendar month; all references to time of day shall be to Pacific Standard Time; all references to hours will be actual hours during a calendar day; and all references to days, months, and quarters shall be to calendar days, calendar months, and calendar quarters, respectively.

(c) **Performance Measurement Standards:**

(i) General - The Performance Measurement Table sets forth the categories of Performance Measurement Standards and their associated measurements. In performing its services under this Agreement, Contractor shall use commercially reasonable efforts to meet or exceed the Performance Measurement Standards.

(ii) Root Cause Analysis/Corrective Action - If Contractor fails to meet any Performance Measurement 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 Measurement 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.

(iii) Performance Measurement Standard Exceptions; Contractor shall not be responsible for any failure to meet a Performance Measurement Standard if and to the extent that the failure is excused pursuant to Section 12.07 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 Measurement 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 second month following the failure to meet such Performance Measurement Standard: (a) the identity of the Performance Measurement 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.

(iv) Agreed Adjustments/Service Level Relief - In addition, the Parties may agree on Performance Measurement Standard relief or adjustments to Performance Measurement Standards from time to time, including, the inclusion of new and/or temporary Performance Measurement Standards.

(v) Performance Measurement Defaults - If the Exchange elects to assess sanctions for failure to meet Performance Measurement Standards, it will so notify Contractor in writing following the Exchange's receipt of the Monthly Performance Report setting forth the performance level attained by Contractor for the calendar quarter to which the sanctions relate. If Contractor does not believe it is appropriate for the Exchange to assess sanctions for a particular calendar quarter or calendar year (as applicable), it shall so notify the Exchange in writing within thirty (30) days after receipt of the Exchange's notice of assessment and, in such event, the Exchange will meet with Contractor to consider, in good faith, Contractor's explanation of why it does not believe the assessment of sanctions to be appropriate; provided, however, that it is understood and agreed that the Exchange, acting in good faith, will make the final determination of whether or not to assess the sanctions.

(vi) Performance Measurement Tables - The Performance Measurement Standards are set forth in the below table, Covered California Performance Standards and Reporting Requirements for Contractor:

Group 1: Covered California Performance Measurement Standards and Reporting Requirements Customer Service				
Performance Standard		**Individual**	**SHOP**	**Performance Requirements**
1.1	**Inbound Call Volume** Total number of calls received by the ACD.	X	X	Reporting Required Only. Volume will be used in calculation of performance standards 1.3 and 1.4
1.2	**Abandoned Call Volume** Number of calls offered to the service center by the ACD, but terminated by the person originating the call outside the Service Level.	X	X	Reporting Required Only. Volume will be used in calculation of performance standards 1.3 and 1.4
1.3	**Telephone Abandonment Rate** Percentage of calls abandoned, calculated by dividing the Abandon Call Volume by the Inbound Call Volume.	X	X	Expectation: No more than 3% of incoming calls in a calendar month. Performance Level: >3% abandoned: below expectation. 2-3% abandoned: meets expectation. <2% abandoned: exceeds expectation.
1.4	**Call Answer Timeliness** The percentage of calls answered within a defined period of time (i.e., 80% of calls answered within 30 seconds)	X	X	Expectation: 80% of calls answered 30 seconds or less. Performance Level: <80%- below expectation. 80%-90%: meets expectation. >90%: exceeds expectation
1.5	**Average Handling Time** The average number of minutes of talk time, hold time, and wrap time necessary to complete the interaction	X	X	Report only, no performance level.
1.6	**Number of Binder Payment Notices Generated** For the Individual Exchange, number of binder payment notices generated and mailed to the consumer.	X		Report only, no performance level.
1.7	**Binder Payment Processing Time** For the Individual Exchange, the time elapsed from the date the binder payment invoice was mailed for a specific consumer(s) through the date the carrier received the	X		Report only, no performance level.

	binder payment from the consumer.			
1.8	**Number of Binder Payments Processed** For the Individual Exchange, number of binder payments paid-in-full and processed	X		Report only, no performance level.
1.9	**ID Cards Processing Time** For the Individual Exchange: The time elapsed from receipt of complete and accurate enrollment information and binder payment for a specific consumer through the date carrier mails the ID card to that consumer. For SHOP: Time elapsed from the receipt of complete and accurate enrollment information for a specific consumer through the date a carrier mails the ID card to that consumer. 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.	X	X	For the Individual Exchange: Expectation: 99% ID cards issued within 10 business days of receiving complete and accurate enrollment information and binder payment for a specific consumer For SHOP: Expectation: 99% ID cards issued within 10 business days of receipt of complete and accurate enrollment information for a specific consumer. <99% below expectation.
1.10	**Number of ID Cards Processed** Number of initial ID cards processed and issued to the consumer. 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.	X	X	Report only, no performance level.
1.11	**Initial Call Resolution** Number of calls where the Enrollee's issue is resolved within one business day of receipt of the issue.	X	X	Expectation: 85% of enrollee issues will be resolved within one (1) business day of receipt of the issue. Performance Level: <85%: below expectation 85-95%: meets expectation >95%:

				exceeds expectation
1.12	**Grievance Resolution** Percentage of enrollee grievances resolved within 30 calendar days of initial receipt.	X	X	Expectation: 95% of enrollee grievances resolved within 30 calendar days of initial receipt. Performance Level: <95% resolved within 30 calendar days of initial receipt: below expectation 95% or greater resolved within 30 calendar days of initial receipt: meets expectation 95% or greater resolved within 15 calendar days of initial receipt: exceeds expectation
1.13	**Member Email or Written Inquiries** Total number of member email or written inquiries received.	X	X	Reporting required only. Volume will be used in calculation of performance measurement 1.14.
1.14	**Member Email or Written Inquiries Answered** Percentage of member email or written inquiries answered within 15 business days of the inquiry. Does not include appeals or grievances.	X	X	Expectation: 90% of member email or written inquiries answered within 15 business days of the inquiry.

Group 2: Covered California Performance Measurement Standards and Reporting Requirements Operational Performance Standards				
Performance Standard		**Individual**	**SHOP**	**Performance Standards**
2.1	**Payment Reconciliation** Contractors participating in the individual exchange shall report full or partial premiums to the Contractor. The schedule shall include a record of all notifications, including phone calls and letters, if applicable, to participants of delinquent accounts.	X		Report suspended for 2015.
2.2	**Enrollment and payment transactions**	X		Expectation: The Exchange will receive the 999 file within two to three business days of receipt of the 834 file 85% of the time. Performance Level <85% below expectation
2.3	**Reconciliation of Pended Status Enrollee(s)**	X		Expectation: The Exchange will receive the effectuation 834 file within 60 days from effective date of member 90% of the time. Performance Level <90% below expectation
2.4	**Reconciliation Process**	X		Expectation: For non-payment the Exchange will receive an 834 cancellation file within 60 days of the member's intended effective date 90% of the time.
2.5	**Billing Detail – Discrepancy Report** Contractors participating in the Individual Exchange shall use the billing discrepancy template to communicate disputed or contested PM/PM (per member, per month) billed amounts to the Exchange. Contractors shall use PM/PM billing detail, as provided by the Exchange, to reconcile and identify discrepancies with their roster of	X		Report suspended for 2015.

	covered lives. Discrepancies are defined as member duplication, individual cancelled, individual terminated, calculation error, individual missing or other.			
2.6	**Data Submission specific to contract Section 3.05(c) and Attachment 7, Section 2.02**			Expectation: Full and regular submission of data according to the standards outlined. Performance Level: Incomplete, irregular, late or non-useable data submission: below expectation Full and regular submission according to the formats specified and useable by Covered California within 30 days of each quarter end: meets expectation

Group 3: Covered California Performance Measurement Standards and Reporting Requirements Utilization Measures

Utilization Measures	**Performance Measurement 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.**
Annual Preventive/Diagnostic Visit Measure includes all members ages 2 years of age and older as of December 31, 2015 (denominator) who had at least one preventive or diagnostic dental visit in 2015 (numerator) with no more than one gap in enrollment of up to 45 days during 2015.	Age Group / Expectation / Performance 2-3 / 75% / 4-6 / 75% / 7-10 / 75% / 11-14 / 75% / 15-18 / 75% / 19+ / 60% /
Annual Dental Visit (ADV) Measure includes all members ages 2 years and older as of December 31, 2015 (denominator) who had at least one dental visit in 2015 (numerator) with no more than one gap in enrollment of up to 45 days during 2015.	Age Group / Expectation / Performance 2-3 / 75% / 4-6 / 75% / 7-10 / 75% / 11-14 / 75% / 15-18 / 75% / 19+ / 60% /
Examinations/Oral Health Evaluations (OHE) Measure includes members enrolled for at least 11 of the 12 months of 2015 (denominator) who received comprehensive or periodic oral health evaluation (D1020 or D1050) in 2015 (numerator); members under the age of three not receiving service D1020 or D1050 are also included if they received an oral health evaluation and counseling with the primary care giver (D0145) in 2015.	Age Group / Expectation / Performance 2-3 / 75% / 4-6 / 75% / 7-10 / 75% / 11-14 / 75% / 15-18 / 75% /
Preventive Dental Services (PDS). Measure includes members enrolled for at least 11 of the 12 months in 2015 (denominator) who received any preventive dental service (D1000-D1999) in 2015 (numerator).	Age Group / Expectation / Performance 2-3 / 75% / 4-6 / 75% / 7-10 / 75% / 11-14 / 75% / 15-18 / 75% / 19+ / 60% /

Group 3 (continued): Covered California Performance Measurement Standards and Reporting Requirements
Utilization Measures

Utilization Measures	**Covered California Performance Requirements Covered California will work with contractors as appropriate to adjust measure sets where a contractor does not have all of the specific Utilization measures.**
Continuity of Care (COC) Measure includes members who continuously enrolled in the same plan for 2 years with no gap in coverage who received a comprehensive or periodic oral health evaluation (D1020, D1050) or a prophylaxis (D1110, D1120) in 2014 (denominator) and who received a comprehensive or periodic oral health evaluation (D0120, D1050) or a prophylaxis in 2015 (numerator).	 Age Group: 2-3 — Expectation: n/a — Performance: Age Group: 4-6 — Expectation: 75% — Performance: Age Group: 7-10 — Expectation: 75% — Performance: Age Group: 11-14 — Expectation: 75% — Performance: Age Group: 15-18 — Expectation: 75% — Performance:
Filling to Preventive Services Ratio (FPSR). Measure includes members enrolled for at least 11 of the 12 months of 2014 who received one or more fillings (D2000-D2999) in 2015 (denominator) and who also received a topical fluoride (D1203, D1204, or D1206) a sealant application (D1351, D1352) or education to prevent caries (D1310 and D1330) in 2015 (numerator).	 Age Group: 2-3 — Report in 2015: — Set Performance Standards in 2016: Age Group: 4-6 — Report in 2015: — Set Performance Standards in 2016: Age Group: 7-10 — Report in 2015: — Set Performance Standards in 2016: Age Group: 11-14 — Report in 2015: — Set Performance Standards in 2016: Age Group: 15-18 — Report in 2015: — Set Performance Standards in 2016:
Use of Dental Treatment Services (UDTS). Measure includes members enrolled for at least 11 of the 12 months of 2015 (denominator) who received any dental treatment other than diagnostic or preventive services (D2000-D9999) in 2015 (numerator).	*Report only, monitor trends over time* Age Group: 2-3 Age Group: 4-6 Age Group: 7-10 Age Group: 11-14 Age Group: 15-18
Overall Utilization of Dental Services (OUDS). Measure includes members enrolled for at least 11 of the 12 months of 2015 (denominator) who received any dental service (D0100-D9999), including preventive services, during 2015 (numerator).	 Age Group: 2-3 — Expectation: 75% — Performance: Age Group: 4-6 — Expectation: 75% — Performance: Age Group: 7-10 — Expectation: 75% — Performance: Age Group: 11-14 — Expectation: 75% — Performance: Age Group: 15-18 — Expectation: 75% — Performance: Age Group: 19+ — Expectation: 60% — Performance:

Group 3 (continued): Covered California Performance Measurement Standards and Reporting Requirements Utilization Measures	
Utilization Measures	**Covered California Performance Requirements Covered California will work with contractors as appropriate to adjust measure sets where a contractor does not have all of the specific Utilization measures.**
Percentage of pediatric members enrolled for at least 11 of the 12 months in 2015 who reached their Out-of-Pocket Maximum of $350 by the end of the calendar year.	Expectation: report only Quarter 1 2016
Percentage of members enrolled for at least 11 of the 12 months in 2015 who satisfied the deductible by the end of the calendar year.	Expectation: report only Quarter 1 2016

Group 4: Covered California Performance Standards for Contractor Quality and Delivery System Reform				
		Individual	**SHOP**	**Expectation**
4.1	**Attachment 7, 1.03(b) Reducing Health Disparities and Assuring Health Equity**	**X**	**X**	Narrative report describing progress made by Contractor to collect and use, or how Contractor currently collects and uses the data elements described in Attachment 7, 1.03(b). Submit to QHP@covered.ca.gov December 1, 2015.
4.2	**Attachment 7, 2.03 Risk Assessment**	**X**	**X**	Narrative report describing current or planned capacity and systems to determine Plan Enrollee oral health status. Submit to QHP@covered.ca.gov February 29, 2016.
4.3	**Attachment 7, 2.04 Reporting to and Collaborating with the Exchange Regarding Health Status**	**X**	**X**	Narrative report describing progress made by Contractor to collect or use of current practices to collect data on changes in Plan Enrollees' oral health status. Submit to QHP@covered.ca.gov February 29 , 2016
4.4	**Attachment 7, 3.01 Health and Wellness Services**	**X**	**X**	Narrative report describing outreach methods employed by Contractor to encourage participation in diagnostic and preventive services. Submit to QHP@covered.ca.gov February 29 , 2016
4.5	**Attachment 7, 3.02 Community Health and Wellness Promotion**	**X**	**X**	Narrative report describing initiatives, programs and projects Contractor supports and how such programs specifically promote community health and/or address health disparities. Submit to QHP@covered.ca.gov February 29 , 2016
4.6	**Attachment 7, 3.03 Community Health and Wellness Enrollee Support Process**	**X**	**X**	Narrative report describing: (1) health and wellness communication process to Enrollee and Participating Provider (2) process to ensure network adequacy given the focus on health and wellness; (3) process to incorporate Enrollee's health and wellness information into Contractor's data specific to individual Enrollee, as distinct from medical

				record Submit to QHP@covered.ca.gov February 29 , 2016
4.7	**Attachment 7, 4.02 Promoting Development and Use of Care Models**	**X**	**X**	If applicable to QDP's delivery system, report Enrollees who have been assigned a primary care dentist. Suggested formula: # of Members who have been assigned a primary care dentist (numerator)/ # of Members Enrolled (denominator) Submit to QHP@covered.ca.gov February 29 , 2016
4.8	**Attachment 7, 4.03 Identification and Services for At-Risk Enrollees**	**X**	**X**	Narrative report describing Contractor's current or planned approach to identification of At-Risk Enrollees. If currently measured, report Covered California Enrollees who have been identified as "At Risk". Suggested formula: # of Members identified (numerator) / # of Members Enrolled (denominator) Submit to QHP@covered.ca.gov February 29, 2016