COVERED CALIFORNIA
STAND-ALONE DENTAL PLAN CONTRACT FOR 2014
between

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

List of Attachments to Stand-Alone Dental Plan Model Contract

FINAL REDLINE VERSION ISSUED AUGUST 19, 2013

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

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

Attachment 3. Good Standing

Definition of Good Standing	Agency
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
• Approved to operate in what geographic service areas	DMHC
• Most recent financial exam and medical survey report	DMHC
• Most recent market conduct exam	CDI
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
• Administrative and organizational capacity	DMHC
• Benefit Design	
• State mandates (to cover and to offer)	DMHC and CDI
• Essential health benefits[2] Pediatric Dental only (as of 2014)	DMHC and CDI
• Copayments, deductibles, out-of-pocket maximums	DMHC and CDI
• Actuarial value confirmation (per Federal rules)	DMHC and CDI
• Network adequacy and accessibility standards	DMHC and CDI
• Provider contracts	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
• Enrollee/Member grievances/complaints and appeals policies and practices	DMHC and CDI
• Marketing and advertising	DMHC and CDI

[1] Material violations are those that represent a relevant and significant departure from normal business standards that a health plan issuer is expected to adhere to.

[2] Certain listed items, such as essential health benefits and actuarial value, are not required until 2014.

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. To the extent that such terms are not included in the Contractor's current agreements, Contractor shall take such action as is reasonably necessary to assure that such provisions are included in the contract by July 1, 2014. 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 Saturday eight o'clock (8:00) a.m. to eight o'clock (8:00) p.m. (Pacific Standard Time). During non-Open Enrollment periods, call center hours shall be Monday through Friday eight o'clock (8:00) a.m. to six o'clock (6:00) p.m. (Pacific Standard Time) and Contractors shall inform the Exchange of additional call center hours their service centers are open. Dental Plan Issuers in SHOP are not required to provide Customer Service support on weekends.

(b) The 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 the Call Center with highly trained individuals to provide detailed benefit information, answer Enrollee questions about the SADP, 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, for 2014 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 2014, both phone and written material, and consider the adoption of additional standards in 2015.

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); complaints; network or provider details; and Issuer-specific questions or issues.

(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 other laws, rules and regulations respecting privacy and security, as well as establish protocols for handling the Exchange customers who have documented domestic violence or other security concerns. Contractor shall monitor compliance and file these protocols with the Exchange 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 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 SADPs offered on the Exchange. This summary information will be used by the Exchange customer service staff when referencing Contractor or Stand-Alone Dental Plan information. The Exchange will develop a form to collect uniform information from Contractor.

6. Enrollee Materials.

(a) Contractor or its QHP bundled partner 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 within ten (10) business days of receiving enrollment verification from the Exchange. 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;

(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) Enrollee Identification Card. No later than 10 business days after receiving enrollment information from the Exchange, Contractor shall be responsible for distribution of an identification card to each Enrollee in a form that is approved by the Exchange, unless contractor uses an approved no-card eligibility verification system.

(f) 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.

(g) 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.

Stand-Alone Dental Plan issuers ("SADP 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. SADPs 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 SADP 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 2014. 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 Plan Enrollees' oral health status and behaviors to promote better oral health and to better manage Enrollees' oral health conditions. Contractor shall demonstrate the use of Risk Assessment to identify pediatric 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 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 Plan Enrollees obtain preventive health and wellness services within the first year of enrollment. Contractor shall develop and provide a report annually regarding how it is maximizing Plan Enrollees access to preventive health and wellness services. As part of that report, Contractor shall assess and discuss the participation by Plan Enrollees innecessary 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. Upon Contractor Plan certification, Contractor shall submit to the Exchange the following information:

(a) Health and wellness communication process to Enrollee and Participating Provider, or other caregiver;

(b) Process to ensure network adequacy required by State or Federal laws, rules and regulation 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 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 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 sections 2.04, Contactor shall determine the health status of its new enrollees that includes identification of chronic conditions and 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, which will 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 focuses 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 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.

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.

Appendix 1 to Attachment 7: Required Reports

Contractor shall provide such reports, data, documentation and other information reasonably requested by the Exchange and as reasonably necessary to document and evaluate Contractor's provision of Services in accordance with the terms and conditions set forth in the Agreement and under applicable laws, rules and regulations, including without limitation, the following items:

- Collaborative marketing and enrollment efforts, including, Contractor's marketing plan and documentation relating to testing of interfaces with Exchange's eligibility and enrollment system (Section 1.05(b);
- Evaluation of Contractor’s performance (Section 1.10);
- Compliance with requirements for status as a Certified SADP (Section 3.01(a));
- Licensure and good standing (Section 3.02);
- Benefit plan design (Section 3.03);
- Sales and marketing practices for products through the Exchange and outside the Exchange (Section 3.04);
- Network adequacy standards (Section 3.05);
- Service Area (Section 3.05(b));
- Participating Provider Directory (Section 3.05(c));
- Participating Provider recruitment and retention (Section 3.05(d));
- Changes in Participating Provider network (Section 3.05(),(e)(f));
- Changes in contracting with Federally Qualified Health Centers that provide dental services and providers who serve the low-income and uninsured populations (Section 3.06);
- Applications and notices (Section 3.07);
- Rate information provided to Health Insurance Regulators and in such form as required by Exchange (Section 3.08, 3.09)
- Transparency in coverage (Section 3.10);
- Compliance with special rules governing American Indians or Alaskan Natives (Section 3.11);
- Participating Provider Agreements (Section 3.12);
- Out-of-network, other benefit costs and network requirements (Section 3.13);
- Credentialing (Section 3.14)

- Utilization review and appeals (Section 3.15);
- Customer service standards (Section 3.16) (see further listing below);
- Compliance programs (Section 3.17);
- Enrollment and eligibility reconciliations (Section 3.18 to 3.20);
- Minimum Participation Rates (section 3.21);
- Premium information and reconciliation (Section 3.22);
- Collection practices (Section 3.24);
- Appeals and grievances (Section 3.25);
- Enrollee and marketing materials (Section 3.26);
- Agent compensation, appointment and conduct (Section 3.27 and 3.28);
- Notice of changes (Section 3.29);
- Other financial information, including, audited financial statements, annual profit and loss statement and other financial information (Section 3.30);
- Nondiscrimination (Section 3.31);
- Conflict of interest (Section 3.32);
- Compliance with other laws (Section 3.33);
- Contractor's representations and warranties (Section 3.34);
- Quality, Network Management and Delivery System Standards (Article 4). See further discussion below.
- Rate updates, premium collection and remittance (Section 5.01, 5.02)
- Participation fee, including, allocation of fee across entire risk pool (5.03(a)), payment information (Section 5.03(b) and information necessary to conduct evaluations (Section 5.03(c));
- Performance measures (Article 6);
- Recertification process (Section 7.02);
- Breach of agreement (Section 7.04);
- Insolvency (Section 7.06);

- Duties upon non-recertification (Section 7.07);
- Further assurance regarding transition and continuity of care (Section 7.08, 7.09);
- Insurance (Article 8);
- Privacy and security standards (Article 9);
- Books, records and data, including, clinical records (Section 10.01), financial records (including electronic commerce standards) (Section 10.02); storage and back up (Sections 10.03 and 10.04), examination and audit (Section 10.05 and 10.06), and tax reporting (Section 10.08);
- Intellectual Property (Article 11);
- Quality, Network Management and Delivery System Standards (Attachment 7) (all following references are to sections in Quality, Network Management and Delivery System Standards unless otherwise indicated):
- Dental Utilization reporting (Attachment 7, Section 2.01)
- Participation in quality initiatives (Attachment 7, Section 1.02)
- Data sets (Attachment 7, Section 2.02)
- Enrollee reports (e.g., claims, utilization) (Attachment 7, Section 2.02)
- Prevention, Health and Wellness (Attachment 7, Article 3)
- Access, Coordination, and At-Risk Enrollee Support (Article 4)
- Patient Centered Care (Article 5)
- Customer Service Standards, (Attachment 6), including:
  - Customer call volumes
  - Telephone responsiveness
  - Responsiveness to written correspondence
  - Number, accuracy, and timeliness of ID card distribution
  - Nurse advice line volume, talk time, and topics discussed
  - Use of Contractor’s website

Appendix 2 to Attachment 7: Reporting, Notification and Participation Requirements Specific to Attachment 7- Quality, Network Management and Delivery System Reform

Reporting and Data Submission	Participation
	1.01
1.02	1.02
2.01	
2.02	
2.04	
2.03	
3.01	
3.02	
3.03	
4.02	
4.03	
5.01	
5.02	

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.

Reserved for future use.

Attachment 13

Reserved for future use.

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) Baseline Period: During the first six (6) months Contractor begins to take operational calls under this Agreement ("Baseline Period"), the parties will collaborate to evaluate and refine Performance Measurement Standards based upon the call volumes and arrival patterns established during the Baseline Period. Contractor shall take reasonable efforts to staff sufficiently during the Baseline Period to meet or exceed the Performance Measurement Standards listed below.

(b) 800 Number: 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 Exchange Enrollees and in a manner designed to assure compliance with these Performance Measurement Standards.

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

- Switch reporting: monthly, quarterly and annually.
- Phone statistics, Performance Measurement Standards reporting and operations reporting: monthly, quarterly and annually.
- Accumulative monitoring scoring: weekly and monthly.

2. Performance Measurement Standards Reporting

(a) **Monthly Performance Report:** Beginning the first full calendar month after the expiration of the Baseline Period, Contractor shall monitor and track its performance each month against the Performance Measurement Standards set forth below. Contractor shall provide detailed supporting information (as mutually agreed by the parties) for each Monthly Performance Report to the Exchange in electronic format.

(b) **Measurement Rules:** Except as otherwise specified below in the Performance Measurement Standards table, the measurement period for each Performance Guarantee 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 Guarantee Exceptions; Contractor shall not be responsible for any failure to meet a Performance Guarantee 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 Guarantee 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 Guarantee Tables - The Performance Measurement Standards are set forth in the Charts 1, 2 and 3. Covered California Performance Standards below:

Chart 1: Covered California Performance Standards for Contractor Customer Service	
Customer Service Measures	**Covered California Performance Requirements**
Call Answer Timeliness	Expectation: 80% of calls answered 30 seconds. Performance Level: <80%- below expectation . 80%-90%: meets expectation. >90%: exceeds expectation
Processing ID Cards	Expectation: 99% sent within 10 business days of receiving complete and accurate enrollment information from the Exchange and premium[3].. Performance Level: <50%: below expectation . 50-98%: meets expectation 99%: exceeds expectations.
Telephone Abandonment Rate for Covered California	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
Initial Call Resolution	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
Grievance Resolution	Expectation: 95% of enrollee grievances resolved within 30 calendar days. Performance Level: <95% resolved within 30 calendar days: below expectation 95% or greater resolved within 30 calendar days: meets expectation 95% or greater resolved within 15 calendar days: exceeds expectation

[3] Companies that operate with electronic ID cards or no-card eligibility verification systems are not subject to this performance standard.

Chart 2: Covered California Performance Standards for Contractor Operational Standards	
Operational Standards	**Covered California Performance Requirements**
Enrollment and payment transactions **6 month pilot period: 10/1/13-3/31/14** **Measurement period: 4/1/14-12/31/14**	Expectation: The Exchange will receive the 999 file within one business day of receipt of the 834/820 file 85% of the time and within 3 bus days of receipt of the 834/820 file 99% of the time within any given month. Expectation and Performance Level and methodology to be determined after the pilot period (based on pilot period).
Effectuation of enrollment upon receipt of payment **6 month pilot period: 10/1/13-3/31/14** **Measurement period: 4/1/14-12/31/14**	Expectation: The exchange will receive the 834 file within one business day of receipt of the member's initial payment file 85% of the time and within 3 bus days of receipt of the member's initial payment 99% of the time within any given month. Expectation and Performance Level and methodology to be determined after the pilot period (based on pilot period).
Member payment **6 month pilot period: 10/1/13-3/31/14** **Measurement period: 4/1/14-12/31/14**	Expectation: The Exchange[4] will receive the 820 file within one business day of receipt of the member's payment file 95% of the time and within 3 business days of receipt of the member's payment 99% of the time within any given month. Expectation and Performance Level and methodology to be determined after the pilot period (based on pilot period).
Enrollment change upon non-receipt of member payment, 30 day notice and termination **6 month pilot period: 10/1/13-3/31/14** **Measurement period: 4/1/14-12/31/14**	Expectation: The Exchange will receive the 834 file within one business day of receipt of change of the members' status 95% of the time and within 3 business days of receipt of change of the members' status 99% of the time within any given month. Expectation and Performance Level and methodology to be determined after the pilot period (based on pilot period).
Member Email or Written Inquiries	Expectation: Correspondence 90% response to email or written inquiries within 15 working days of inquiry. Does not include written grievances or appeals. 10% of total performance requirement expected. Performance Level: <70%: below expectation 70-90%: below expectation 90% or greater: meets expectation Greater than 90% in 2 days: exceeds expectation

[4] Does not apply in the SHOP Exchange.

Chart 2 continued: Operational Standards	**Covered California Performance Requirements for Contractor**
Member Call Volume	Track Only- No performance requirement or penalty assessment
Data Submission specific to 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
Reporting	Expectation: Submission of all required reports to Covered California within contractually specified times (varies by report or type of report). Performance Level: one or more reports submitted more than 4 months after required submission date: below expectation One or more reports submitted after 30 days of required submission date: below expectation All required reports submitted within 5 business days of required submission: meets expectation

Chart 3: Covered California Performance Standards for Contractor
Quality and Delivery System Standards

<table>
<tr><th>Utilization Measures</th><th colspan="3">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.</th></tr>
<tr><td rowspan="6">Annual Preventive/Diagnostic Visit

Measure includes all members ages 1 through 18 years of age as of December 31, 2014 (denominator) who had at least one preventive or diagnostic dental visit in 2014 (numerator) with no more than one gap in enrollment of up to 45 days during 2014.</td><td>Age Group</td><td>Expectation</td><td>Performance</td></tr>
<tr><td>2-3</td><td>75%</td><td></td></tr>
<tr><td>4-6</td><td>75%</td><td></td></tr>
<tr><td>7-10</td><td>75%</td><td></td></tr>
<tr><td>11-14</td><td>75%</td><td></td></tr>
<tr><td>15-18</td><td>75%</td><td></td></tr>
<tr><td rowspan="6">Annual Dental Visit (ADV)

Measure includes all members ages 2 through 18 years as of December 31, 2014 (denominator) who had at least one dental visit in 2014 (numerator) with no more than one gap in enrollment of up to 45 days during 2014.</td><td>Age Group</td><td>Expectation</td><td>Performance</td></tr>
<tr><td>2-3</td><td>75%</td><td></td></tr>
<tr><td>4-6</td><td>75%</td><td></td></tr>
<tr><td>7-10</td><td>75%</td><td></td></tr>
<tr><td>11-14</td><td>75%</td><td></td></tr>
<tr><td>15-18</td><td>75%</td><td></td></tr>
<tr><td rowspan="6">Examinations/Oral Health Evaluations (OHE)

Measure includes members enrolled for at least 11 of the 12 months of 2014 (denominator) who received comprehensive or periodic oral health evaluation (D1020 or D1050) in 2014 (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 2014.</td><td>Age Group</td><td>Expectation</td><td>Performance</td></tr>
<tr><td>2-3</td><td>75%</td><td></td></tr>
<tr><td>4-6</td><td>75%</td><td></td></tr>
<tr><td>7-10</td><td>75%</td><td></td></tr>
<tr><td>11-14</td><td>75%</td><td></td></tr>
<tr><td>15-18</td><td>75%</td><td></td></tr>
<tr><td rowspan="6">Preventive Dental Services (PDS).

Measure includes members enrolled for at least 11 of the 12 months in 2014 (denominator) who received any preventive dental service (D1000-D1999) in 2014 (numerator).</td><td>Age Group</td><td>Expectation</td><td>Performance</td></tr>
<tr><td>2-3</td><td>75%</td><td></td></tr>
<tr><td>4-6</td><td>75%</td><td></td></tr>
<tr><td>7-10</td><td>75%</td><td></td></tr>
<tr><td>11-14</td><td>75%</td><td></td></tr>
<tr><td>15-18</td><td>75%</td><td></td></tr>
</table>

<table>
<tr><th colspan="2">Chart 3 (continued): Covered California Performance Standards for Contractor
Quality and Delivery System Standards</th></tr>
<tr><th>Utilization Measures</th><th>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.</th></tr>
<tr><td>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).</td><td>Measurement begins 2014, first Reporting Year 2016

<table>
<tr><th>Age Group</th><th>Expectation</th><th>Performance</th></tr>
<tr><td>2-3</td><td>n/a</td><td></td></tr>
<tr><td>4-6</td><td>75%</td><td></td></tr>
<tr><td>7-10</td><td>75%</td><td></td></tr>
<tr><td>11-14</td><td>75%</td><td></td></tr>
<tr><td>15-18</td><td>75%</td><td></td></tr>
</table></td></tr>
<tr><td>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 2014 (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 2014 (numerator).</td><td>
<table>
<tr><th>Age Group</th><th>Report in 2014</th><th>Set Performance Standards in 2015</th></tr>
<tr><td>2-3</td><td></td><td></td></tr>
<tr><td>4-6</td><td></td><td></td></tr>
<tr><td>7-10</td><td></td><td></td></tr>
<tr><td>11-14</td><td></td><td></td></tr>
<tr><td>15-18</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Use of Dental Treatment Services (UDTS).

Measure includes members enrolled for at least 11 of the 12 months of 2014 (denominator) who received any dental treatment other than diagnostic or preventive services (D2000-D9999) in 2014 (numerator).</td><td>Report only, monitor trends over time

<table>
<tr><th>Age Group</th><th></th></tr>
<tr><td>2-3</td><td></td></tr>
<tr><td>4-6</td><td></td></tr>
<tr><td>7-10</td><td></td></tr>
<tr><td>11-14</td><td></td></tr>
<tr><td>15-18</td><td></td></tr>
</table></td></tr>
<tr><td>Overall Utilization of Dental Services (OUDS).

Measure includes members enrolled <s>in</s> in for at least 11 of the 12 months of 2014 (denominator) who received any dental service (D0100-D9999), including preventive services, during 2014 (numerator).</td><td>
<table>
<tr><th>Age Group</th><th>Expectation</th><th>Performance</th></tr>
<tr><td>2-3</td><td>75%</td><td></td></tr>
<tr><td>4-6</td><td>75%</td><td></td></tr>
<tr><td>7-10</td><td>75%</td><td></td></tr>
<tr><td>11-14</td><td>75%</td><td></td></tr>
<tr><td>15-18</td><td>75%</td><td></td></tr>
</table></td></tr>
</table>

Chart 3 (continued): Covered California Performance Standards for Contractor Quality and Delivery System Standards	
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 members enrolled for at least 11 of the 12 months in 2014 who reached their Out-of-Pocket Maximum of $1,000 by the end of the calendar year.	Expectation: report only Quarter 1 2105
Percentage of members enrolled for at least 11 of the 12 months in 2014 who satisfied the deductible by the end of the calendar year.	Expectation: report only Quarter 1 2015
Quality and Network Management-Risk Assessment; Attachment 7, Section 2.03.	Year 1- Track only; Year 2-3 performance measure based on Year 1 determined performance with preliminary target of exceeding SADP 50th percentile to avoid penalty
Quality and Network Management-Preventive Health and Wellness; Attachment 7, Section 3.01.	Year 1- Track only; Year 2-3 performance measure based on Year 1 determined performance with preliminary target of exceeding SADP 50th percentile to avoid penalty
Quality and Network Management-At Risk Enrollees; Attachment 7, Section 4.03	Year 1- Track only; Year 2-3 performance measure based on Year 1 determined performance with preliminary target of exceeding SADP 50th percentile to avoid penalty

Attachment 15 Business Associate Agreement

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (this "Agreement") dated _________, 2013 between the California Health Benefit Exchange ("Covered Entity") and __________ ("Business Associate") is entered into in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as codified at 42 U.S.C. §1320d-d8, and its implementing regulations at 45 C.F.R. Parts 160, 162 and 164 (the "HIPAA Regulations") and attendant guidance; and the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and its attendant regulations and guidance (the "HITECH Act"). HIPAA, the HIPAA Regulations and the HITECH Act are sometimes referred to collectively herein as "HIPAA Requirements."

I. Purpose of the Agreement.

Business Associate provides certain services on behalf of Covered Entity that require the Covered Entity to disclose certain identifiable health information to Business Associate. The parties desire to enter into this Agreement to permit Business Associate to have access to such information and comply with the business associate requirements of HIPAA, the HIPAA Regulations, and the HITECH Act, as each may be amended from time to time in accordance with the terms and conditions set forth in this Agreement.

II. Definitions.

Unless otherwise specified in this Agreement, all capitalized terms used in this Agreement not otherwise defined have the meaning established for such terms under 45 C.F.R. Parts 160 and 164 and the HITECH Act, each as amended from time-to-time.

III. Terms and Conditions.

Business Associate and Covered Entity (hereinafter, the "Parties") agree to the terms and conditions set forth herein.

A. Business Associate Obligations.

1. Applicable Law. The terms and conditions set forth in this Agreement shall become effective on the later of the Effective Date of this Agreement, April 14, 2003, or any new mandatory compliance date established for HIPAA, the HIPAA Regulations and/or the HITECH Act. The parties acknowledge and agree that HIPAA, the HIPAA Regulations and the HITECH Act may be amended and additional guidance and/or regulations may be issued after the date of the execution of this Agreement and may affect the Parties' obligations under this Agreement ("Future Directives"). The Parties agree to abide by such Future Directives as these Future Directives may affect the obligations of the Parties under the Covered California Qualified Health Plan contract (Exchange Agreement) and/or this Agreement. If Future Directives affect the obligations of the Parties, then Covered Entity shall notify Business Associate of Future Directives in writing within thirty (30) days before Future Directives are effective. The notification of Business Associate by Covered Entity of Future Directives that affect the obligations of the Parties related to the Business Associate relationship shall be considered amendments to this Agreement binding on both parties. Covered Entity's failure to notify Business Associate of Future Directives shall not relieve Business Associate of any obligations it may otherwise have under HIPAA Requirements.

2. Permitted Uses and Disclosures. Business Associate shall not, and shall ensure that its directors, officers, employees, contractors and agents do not, further use or disclose patient individually identifiable health information ("Protected Health Information" or "PHI") received from or created for the Covered Entity in any manner that would violate HIPAA, the HIPAA Regulations, the HITECH Act or Future Directives. Business Associate agrees to abide by the HIPAA Requirements with respect to the use or disclosure of Protected Health Information it creates, receives from, maintains, or electronically transmits for the Covered Entity. Business Associate further agrees that it will not use or disclose Protected Health Information beyond the purposes set forth in the Agreement or as required by law as defined in 45 C.F.R §164.103. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in the Exchange Agreement between the Parties, provided that such use or disclosure would not violate HIPAA, the HIPAA Regulations or the HITECH Act if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

3. Compliance with Business Associate Agreement and HITECH Act. Effective February 17, 2010, Business Associate may use and disclose PHI that is created or received by Business Associate from or on behalf of Covered Entity if such use or disclosure, respectively, is authorized by this Agreement and complies with each applicable requirement of 45 C.F.R. § 164.504(e) and the HITECH Act. The additional requirements of Subtitle D of the HITECH Act that relate to privacy and that apply to covered entities also will apply to Business Associate and are incorporated into this Agreement by reference.

4. Use of Protected Health Information for Administrative Activities. Notwithstanding Section III.A.2 above, Business Associate may use or disclose Protected Health Information for management and administrative activities of Business Associate or to comply with the legal responsibilities of Business Associate; provided, however, the disclosure or use must be required by law or Business Associate must obtain reasonable assurances from the third party that receives the Protected Health Information that they will (i) treat the Protected Health Information confidentially and will only use or further disclose the Protected Health Information in a manner consistent with the purposes that the Protected Health Information was provided by Business Associate; and (ii) promptly report any breach of the confidentiality of the Protected Health Information to Business Associate. Provided further that, Business Associate will notify Covered Entity immediately upon receipt of a request for any disclosure of Protected Health Information required by law.

5. Accounting. Business Associate agrees to document disclosures of Protected Health Information and collect information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528 and, if required by and upon the effective date of, Section 13405(c) of the HITECH Act and related regulatory guidance.

(a) Business Associate agrees to provide to Covered Entity or an Individual upon Covered Entity's request, information collected in accordance with this Section, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528 and, if required by and upon the effective date of, Section 13405(c) of the HITECH Act and related regulatory guidance.

6. Restriction. Effective February 17, 2010, and notwithstanding 45 C.F.R. § 164.522(a)(1)(ii), Business Associate must comply with an Individual's request under 45 C.F.R. § 164.522(a)(1)(i)(A) that Business Associate restrict the disclosure of Protected Health Information of the Individual if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

7. Fundraising. Any written fundraising communication occurring on or after February 17, 2010 that is a health care operation shall, in a clear and conspicuous manner and consistent with guidance to be provided by the Secretary, provide an opportunity for the recipient of the communications to elect not to receive any further such communication. An election not to receive any further such communication shall be treated as a revocation of authorization under Section 45 C.F.R. § 164.508. However, no communication pursuant to this Section may be made by Business Associate without prior written authorization by Covered Entity.

8. S**ale of Protected Health Information.** Upon the effective date of Section 13405(d) of the HITECH Act , Business Associate shall not directly or indirectly receive remuneration in exchange for Protected Health Information that is created or received by Business Associate from or on behalf of Covered Entity unless: (1) pursuant to an authorization by the Individual in accordance with 45 C.F.R. § 164.508 that includes a specification for whether the Protected Health Information can be further exchanged for remuneration by the entity receiving Protected Health Information of that Individual; or (2) as provided for and consistent with Section 13405(d)(2) of the HITECH Act and regulations to be issued by the Secretary, upon the effective date of such regulations. However, in no instance may Business Associate receive remuneration pursuant to this Section without prior written authorization by Covered Entity.

9. Marketing. A communication occurring on or after February 17, 2010 by Business Associate that is described in the definition of marketing in 45 C.F.R. § 164.501(1)(i), (ii) or (iii) for which Covered Entity receives or has received direct or indirect payment (excluding payment for treatment) in exchange for making such communication, shall not be considered a health care operation unless: (1) such communication describes only a drug or biologic that is currently being prescribed for the recipient of the communication and any payment received in exchange for making such a communication is reasonable in amount; or (2) the communication is made by Business Associate on behalf of the Covered Entity and the communication is otherwise consistent with this Agreement. However, no communication pursuant to this Section may be made by Business Associate without prior written authorization by Covered Entity.

10. Safeguarding the Privacy of Protected Health Information. Business Associate agrees that it shall utilize physical, administrative and technical safeguards to ensure that Protected Health Information is not used or disclosed in any manner inconsistent with this Agreement or the purposes for which Business Associate received Protected Health Information from or created Protected Health Information for the Covered Entity. Business Associate further agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Protected Health Information that Business Associate creates, receives, maintains or transmits electronically on behalf of Covered Entity under the Agreement. Upon request, Business Associate shall provide the Covered Entity with a written description of the physical, administrative and technical safeguards adopted by Business Associate to meet its obligations under this Section.

11. Security Safeguards. Business Associate acknowledges that, effective February 17, 2010, 45 C.F.R. §§ 164.308, 164.310, 164.312 and 164.316 will apply to Business Associate in the same manner that such sections apply to covered entities and are incorporated into this Agreement by reference. The additional requirements of the HITECH Act that relate to security and that apply to covered entities also will apply to Business Associate and are incorporated into this Agreement by reference. Business Associate agrees to implement the technical safeguards provided in guidance issued annually by the Secretary for carrying out the obligations under the Code of Federal Regulation sections cited in this Section and the security standards in Subpart C of Part 164 of Title 45 of the Code of Federal Regulations.

12. Employee Training. Business Associate shall train its workforce members who assist in the performance of functions and activities under this Agreement, and who access or disclose Protected Health Information, on information privacy and security requirements. Business Associate shall impose appropriate disciplinary measures on members who intentionally violate Business Associate's privacy and security requirements, including termination of employment if appropriate.

13. Sanctions. Business Associate understands that a failure to comply with HIPAA, the HITECH Act and the HIPAA Regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA Regulations.

14. Breach Notification. Business Associate agrees to implement response programs and record-keeping systems to enable Business Associate to comply with the requirements of this Section and 13402 of the HITECH Act and the regulations implementing such provisions, currently Subpart D of Part 164 of Title 45 of the Code of Federal Regulations, when Business Associate detects or becomes aware of unauthorized access to information systems or documents that contain Protected Health Information. Business Associate agrees to mitigate any effects of the inappropriate use or disclosure of Protected Health Information by Business Associate.

(a) Business Associate agrees to notify Covered Entity, by facsimile or telephone, of any breach or suspected breach of its security related to areas, locations, systems, documents or electronic systems which contain unsecured Protected Health Information, including, without limitation, any Security Incident, instance of theft, fraud, deception, malfeasance, or use, access or disclosure of Protected Health Information which is inconsistent with the terms of this Agreement (an "Incident") immediately upon having reason to suspect that an Incident may have occurred, and typically prior to beginning the process of verifying that an Incident has occurred or determining the scope of any such Incident, and regardless of the potential risk of harm posed by the Incident. Notice shall be provided to the Covered Entity's representative designated in this Agreement. Upon discovery of a breach or suspected Incident, Business Associate shall take:

(i) Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and

(ii) Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

(b) In the event of any such Incident, Business Associate shall further provide to Covered Entity, in writing, such details concerning the Incident as Covered Entity may request, and shall cooperate with Covered Entity, its regulators and law enforcement to assist in regaining possession of such unsecured Protected Health Information and prevent its further unauthorized use, and take any necessary remedial actions as may be required by Covered Entity to prevent other or further Incidents. Business Associate and Covered Entity will cooperate in developing the content of any public statements.

(c) If Covered Entity determines that it may need to notify any Individual(s) as a result of such Incident that is attributable to Business Associate's breach of its obligations under this Agreement, Business Associate shall bear all reasonable direct and indirect costs associated with such determination including, without limitation, the costs associated with providing notification to the affected Individuals, providing fraud monitoring or other services to affected Individuals and any forensic analysis required to determine the scope of the Incident.

(d) In addition, Business Associate agrees to update the notice provided to Covered Entity under Section 14(a) of this Agreement of such Incident to include, to the extent possible and as soon as possible working in cooperation with Covered Entity, the identification of each Individual whose unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during the Incident and any of the following information Covered Entity is required to include in its notice to the Individual pursuant to 45 C.F.R. § 164.404(c):

(i) A brief description of what happened, including the date of the Incident and the date of discovery of the Incident, if known;

(ii) A description of the types of unsecured Protected Health Information that were involved in the Incident (e.g., Social Security number, full name, date of birth, address, diagnosis);

(iii) Any steps the Individual should take to protect themselves from potential harm resulting from the Incident;

(iv) A brief description of what is being done to investigate the Incident, mitigate the harm and protect against future Incidents; and

(v) Contact procedures for Individuals to ask questions or learn additional information which shall include a toll-free number, an e-mail address, Web site, or postal address (provided, Subsection v is only applicable if Covered Entity specifically requests Business Associate to establish contact procedures).

(e) Such additional information must be submitted to Covered Entity immediately at the time the information becomes available to Business Associate.

(f) If the cause of a breach of Protected Health Information is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required notifications and reporting of the breach as specified in 42 U.S.C. § 17932 and its implementing regulations, including, without limitation, individual notifications, notification to media outlets and to the Secretary of the Department of Health & Human Services. If a breach of unsecured Protected Health Information involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. Such notification(s) and required reporting shall be done in cooperation with Exchange and subject to Exchange's review and approval. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to Covered Entity in addition to Business Associate, Business Associate shall notify Covered Entity, and Covered Entity and Business Associate may take appropriate action to prevent duplicate reporting.

15. Subcontractors and Agents of Business Associate. Business Associate agrees to enter into written contracts with any of its agents or independent contractors (collectively, "subcontractors") who receive Protected Health Information from Business Associate or create, maintain, or transmit electronically, Protected Health Information on behalf of the Covered Entity, as a subcontractor to Business Associate, and such contracts shall obligate Business Associate's subcontractors to abide by the same conditions and terms as are required of Business Associate under this Agreement. Upon request, Business Associate shall provide the Covered Entity with a copy of any written agreement or contract entered into by Business Associate and its subcontractors to meet the obligations of Business Associate under this Section.

(a) Business Associate shall, upon knowledge of a material breach by a subcontractor of the subcontractor's obligations under its contract with Business Associate, either notify such subcontractor of such breach and provide an opportunity for subcontractor to cure the breach; or, in the event subcontractor fails to cure such breach or cure is not possible, Business Associate shall immediately terminate the contract with subcontractor.

(b) To the extent that any of Business Associate's subcontractors will have access to any Protected Health Information that is received, created, maintained or transmitted electronically, Business Associate shall require such agents and subcontractors to agree to implement reasonable and appropriate safeguards to protect such electronic Protected Health Information.

16. Availability of Information to Covered Entity and Individuals. Business Associate agrees to provide access and information as follows:

(a) Business Associate shall provide access as may be required, and in the time and manner designated by Covered Entity (upon reasonable notice and during Business Associate's normal business hours) to Protected Health Information in a Designated Record Set, to Covered Entity (or, as directed by Covered Entity), to an Individual, in accordance with 45 C.F.R. § 164.524. Designated Record Set means the group of records maintained for Covered Entity that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for Covered Entity health plans; or those records used to make decisions about individuals on behalf of Covered Entity. Business Associate shall use the forms and processes developed by Covered Entity for this purpose and shall respond to requests for access to records transmitted by Covered Entity within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

(b) If Business Associate maintains an Electronic Health Record with Protected Health Information, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable Covered Entity to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. § 17935(e).

(c) If Business Associate receives data from Covered Entity that was provided to Covered Entity by the Social Security Administration, upon request by Covered Entity, Business Associate shall provide Covered Entity with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

17. Access by Covered Entity and Secretary of U.S. Department of Health & Human Services. Business Associate agrees to allow Covered Entity and the Secretary of the U.S. Department of Health & Human Services ("Secretary") access to its books, records and internal practices with respect to the disclosure of Protected Health Information for the purposes of determining the Business Associate's compliance with the HIPAA Privacy Regulations. If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Agreement, Business Associate shall notify Covered Entity and provide Covered Entity with a copy of any Protected Health Information that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such Protected Health Information to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. § 17934(c).

B. Termination of Agreement.

1. Termination Upon Material Breach. The Covered Entity may, in its sole discretion, terminate the Exchange Agreement, including this Agreement, upon determining that Business Associate violated a material term of this Agreement. If the Covered Entity makes such a determination, it shall inform Business Associate in writing that the Covered Entity is exercising its right to terminate this Agreement under this Section III.B and such termination shall take effect immediately upon Business Associate receiving such notification of termination. In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA Regulations, if Business Associate knows of a material breach or violation by Covered Entity, it shall take all actions required under the HITECH Act and HIPAA Regulations.

2. Reasonable Steps to Cure Material Breach. At the Covered Entity's sole option, the Covered Entity may, upon written notice to Business Associate, allow Business Associate an opportunity to take prompt and reasonable steps to cure any violation of any material term of this Agreement to the complete satisfaction of the Covered Entity within ten (10) calendar days of the date of written notice to Business Associate. Business Associate shall submit written documentation acceptable to the Covered Entity of the steps taken by Business Associate to cure any material violation. If Business Associate fails to cure a material breach within the specified time period, then the Covered Entity shall be entitled to terminate this Agreement under Section III.B above, if feasible.

3. Amendment. Covered Entity may in its sole discretion terminate the Exchange Agreement, including this Agreement upon thirty (30) calendar days written notice in the event (i) Business Associate does not promptly enter into negotiations to amend this Agreement when requested by Covered Entity pursuant to Section III.A.1 and Section III.F of this Agreement, or (ii) Business Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of Protected Health Information that Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA Regulations and/or the HITECH Act.

4. Return of Protected Health Information to Covered Entity Upon Termination. Upon termination of the Agreement for any reason, Business Associate shall return all Protected Health Information to the Covered Entity. The Covered Entity may request in writing that Business Associate destroy all Protected Health Information upon termination of this Agreement rather that returning Protected Health Information to the Covered Entity. If the return or destruction of Protected Health Information is not feasible upon termination of the Agreement, then Business Associate shall explain in writing, directed to the Covered Entity's Chief Privacy Officer, why such return or destruction is not

feasible. If such return or destruction is not feasible, then Business Associate agrees that it shall extend its obligations under this Agreement to protect the Protected Health Information. The Business Associate shall limit its use or disclosure of such Protected Health Information to only those purposes that make it infeasible to return or destroy the Protected Health Information and shall maintain such Protected Health Information only for that period of time that return or destruction of Protected Health Information remains infeasible.

5. Conflicts. The terms and conditions of this Agreement will override and control over any conflicting term or condition of other agreements between the Parties. All non-conflicting terms and conditions of such agreements shall remain in full force and effect.

6. No Third-Party Beneficiary Rights. Nothing express or implied in this Agreement is intended or shall be interpreted to create or confer any rights, remedies, obligations or liabilities whatsoever in any third party.

7. Notice. Except as otherwise provided in Section I.A.14(a), any notice permitted or required by this Agreement will be considered made on the date personally delivered in writing or mailed by certified mail, postage prepaid, to the other party at the address set forth in the execution portion of this Agreement.

8. Amendment. The Parties agree to take such action as is necessary to implement the standards, requirements, and regulations of HIPAA, the HIPAA Regulations, the HITECH Act, and other applicable laws relating to the security or confidentiality of health information. Upon Covered Entity's request, Business Associate agrees to promptly enter into negotiations with Covered Entity concerning the terms of any amendment to the Agreement consistent with the standards, requirements and regulations of HIPAA, the HIPAA Regulations, the HITECH Act or other applicable laws.

9. Relationship of the Parties. The Parties hereto acknowledge that Business Associate shall be and have the status of independent contractor in the performance of its obligations under the terms of this Agreement as to Covered Entity. Nothing in this Agreement shall be deemed or construed to create a joint venture or partnership between Covered Entity and Business Associate, nor create an agency relationship between Covered Entity and Business Associate.

10. Indemnification by Business Associate. Business Associate shall protect, indemnify and hold harmless the Covered Entity, its officers and employees from all claims, suits, actions, attorney's fees, costs, expenses, damages, penalties, judgments or decrees arising out of the failure by Business Associate to comply with the requirements of this Agreement, the HIPAA Requirements and all Future Directives; provided however that such indemnification shall be conditioned upon the Covered Entity's giving prompt notice of any claims to Business Associate after discovery thereof and cooperating fully with Business Associate concerning the defense and settlement of claims.

C. Miscellaneous.

1. Exception to Limitations and Exclusions. Business Associate's obligations under this Agreement and any breach by Business Associate of the obligations in this Agreement shall not be subject to any limitations on damages suffered by Covered Entity that may be specified in any agreement, invoice, statement of work or similar document setting forth the services Business Associate is providing to Covered Entity ("Contract"). No limitation or exclusion in any Contract shall limit Covered Entity's rights to recover from Business Associate damages, losses or sanctions suffered by Covered Entity to the extent of amounts recovered by, or sanctions awarded to, a third party which are caused by Business Associate's breach of the obligations in this Agreement, regardless of how such amounts or sanctions awarded to such third party are characterized.

2. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to Covered Entity at no cost to Covered Entity to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Covered Entity, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA Regulations, the HITECH Act or other laws relating to security and privacy, which involve inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

3. Modification. This Agreement will be modified only by a written document signed by each party.

4. Waiver. The waiver by Business Associate or Covered Entity of a breach of this Agreement will not operate as a waiver of any subsequent breach. No delay in acting with regard to any breach of this Agreement will be construed to be a waiver of the breach.

5. Assignment. This Agreement will not be assigned by Business Associate without prior written consent of the Covered Entity. This Agreement will be for the benefit of, and binding upon, the parties hereto and their respective successors and permitted assigns.

6. Interpretation. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA Regulations and applicable state or federal laws. The parties agree that any ambiguity in the terms and conditions of this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.

7. Governing Law. The interpretation and enforcement of this Agreement will be governed by the laws of the State of California. Exclusive venue shall be in Sacramento County, California.

8. Headings. The section headings contained in this Agreement are for reference purposes only and will not affect the meaning of this Agreement.

9. Counterparts. This Agreement may be executed in counterparts, each of which will be deemed to be an original, but all of which together will constitute one and the same.

IN WITNESS WHEREOF, Covered Entity and Business Associate execute this Agreement to be effective on the last date written below, or, if no date is inserted, the Execution Date of the other Agreement referenced above (the "Effective Date").

COVERED HEALTH ENTITY: The California Health Benefit Exchange	BUSINESS ASSOCIATE: ___________________
By: ______________________	By: ______________________
Printed Name: ______________________	Printed Name: ______________________
Title: ______________________	Title: ______________________
Date: ______________________	Date: ______________________
Notice Address: ______________________ ______________________ ______________________	Notice Address: ______________________ ______________________ ______________________
Telephone: ______________________	Telephone: ______________________
Fax: ______________________	Fax: ______________________
Email: ______________________	Email: ______________________