



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

between

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

and

XXX (“Contractor”)

TABLE OF CONTENTS

RECITALS	1
Article 1 – General Provisions	3
1.1 Purpose	3
1.2 Applicable Laws and Regulations	3
1.3 Relationship of the Parties	4
1.4 General Duties of the Exchange	4
1.4.1 Confidentiality of Contractor Documents.....	5
1.5 General Duties of the Contractor	6
1.6 Transition between the Exchange and Other Coverage	7
1.7 Coordination with Other Programs.....	7
1.8 Changes in Requirements	7
1.9 Evaluation of Contractor Performance	7
1.10 Required Notice of Contractor Changes	8
1.11 Nondiscrimination.....	9
1.12 Conflict of Interest; Integrity.....	10
1.13 Other Financial Information.....	10
1.14 Other Laws	10
1.15 Contractor’s Representations and Warranties	11
1.16 Fraud, Waste and Abuse; Ethical Conduct	11
1.17 Current Enrollee Notification	12
Article 2 – Eligibility And Enrollment	13
2.1 Eligibility and Enrollment Responsibilities	13
2.1.1 Exchange Responsibilities	13
2.1.2 Contractor Responsibilities	13
2.1.3 Collection Practices.....	14
2.2 Individual Exchange.....	15
2.2.1 Open Enrollment and Special Enrollment Periods.....	15
2.2.2 Individual Exchange Coverage Effective Dates	15
2.2.3 Premiums for Coverage in the Individual Exchange	15
2.2.4 Terminations of Coverage.....	16
2.2.5 Notice to Provider Regarding Enrollee’s Grace Period Status	16
2.2.6 Agents in the Individual Exchange	17
2.3 Enrollment and Marketing Coordination and Cooperation	18
2.4 Enrollee Materials and Branding Documents	20

Article 3 – QHP Issuer Program Requirements	22
3.1 Basic Requirements.....	22
3.1.1 Licensed in Good Standing.....	22
3.1.2 Certification	24
3.1.3 Accreditation	24
3.1.4 Plan Naming Conventions.....	25
3.1.5 Operational Requirements and Liquidated Damages.....	25
3.2 Benefit Standards.....	26
3.2.1 Essential Health Benefits	26
3.2.2 Standard Benefit Designs.....	26
3.2.3 Offerings Outside of the Exchange	27
3.2.4 Pediatric Dental Benefits	27
3.2.5 Segregation of Funds	27
3.2.6 Prescription Drugs	28
3.3 Network Requirements	29
3.3.1 Service Areas.....	29
3.3.2 Network Adequacy	30
3.3.3 Essential Community Providers	30
3.3.4 Special Rules Governing American Indians and Alaskan Natives.....	32
3.3.5 Network Stability	33
3.4 Participating Providers	34
3.4.1 Provider Contracts	34
3.4.2 Provider Credentialing	35
3.4.3 Enrollee Costs; Disclosure.....	35
3.4.4 Provider Directory.....	36
3.5 Premium Rate Setting	36
3.5.1 Rating Variations.....	36
3.5.2 Individual Exchange Rates	36
3.5.3 Rate Methodology	37
3.5.4 Provider Rates.....	38
3.6 Customer Service Standards	38
3.6.1 Basic Customer Service Requirements	38
3.6.2 Enrollee Appeals and Grievances.....	39
3.6.3 Applications and Notices	39
3.6.4 Customer Service Call Center.....	39
3.6.5 Customer Service Transfers	40
3.6.6 Customer Care	41
3.6.7 Notices	41
3.6.8 Issuer-Specific Information	41
3.6.9 Enrollee Materials: Basic Requirements	42
3.6.10 New Enrollee Enrollment Packets.....	42
3.6.11 Summary of Benefits and Coverage.....	43
3.6.12 Electronic Listing of Participating Providers	43

3.6.13	Access to Medical Services Pending ID Card Receipt.....	44
3.6.14	Explanation of Benefits.....	44
3.6.15	Secure Plan Website for Enrollees and Providers.....	44
3.6.16	Standard Reports.....	44
3.6.17	Contractor Staff Training about the Exchange.....	45
3.6.18	Customer Service Training Process.....	45
Article 4 – Quality, Network Management and Delivery System Standards.....		46
4.1	Exchange Quality Initiatives.....	46
4.2	Quality Management Program.....	46
4.3	Utilization Management.....	47
4.4	Transparency and Quality Reporting.....	47
4.5	Quality Rating System.....	47
4.6	Quality Improvement Strategy.....	47
4.7	Data Submission Requirements.....	48
Article 5 – Financial Provisions.....		49
5.1	Individual Exchange.....	49
5.1.1	Rates and Payments.....	49
5.1.2	Financial Consequences of Non-Payment of Premium.....	49
5.1.3	Individual Exchange Participation Fees.....	50
Article 6 – Performance Standards.....		52
6.1	Standards.....	52
6.2	Penalties and Credits.....	52
6.3	No Waiver.....	52
Article 7 – Contract Term; Recertification and Decertification.....		53
7.1	Agreement Term.....	53
7.2	Agreement Termination.....	53
7.2.1	Exchange Termination.....	53
7.2.2	Contractor Termination.....	54
7.2.3	Notice of Termination.....	54
7.2.4	Remedies in Case of Contractor Default or Breach.....	55
7.2.5	Contractor Insolvency.....	55
7.3	Recertification.....	56
7.3.1	Recertification Process.....	56
7.3.2	Non-Recertification Election.....	56
7.4	Decertification.....	57
7.5	Effect of Termination.....	57

7.6	Coverage Following Termination and Decertification.....	59
Article 8 –Insurance and Indemnification		61
8.1	Contractor Insurance	61
8.1.1	Required Coverage	61
8.1.2	Workers’ Compensation	62
8.1.3	Subcontractor Coverage	62
8.1.4	Continuation of Required Coverage	62
8.1.5	Premium Payments and Disclosure	62
8.2	Indemnification	63
Article 9 – Privacy and Security.....		64
9.1	Privacy and Security Requirements for Personally Identifiable Data.....	64
9.2	Protection of Information Assets	70
Article 10 – Recordkeeping		73
10.1	Clinical Records	73
10.2	Financial Records	73
10.3	Storage	74
10.4	Back-Up	74
10.5	Examination and Audit Results	74
10.6	Notice	75
10.7	Confidentiality	75
10.8	Tax Reporting	76
10.9	Electronic Commerce	76
Article 11 – Intellectual Property		77
11.1	Warranties.....	77
11.2	Intellectual Property Indemnity.....	78
11.3	Federal Funding.....	79
11.4	Ownership and Cross-Licenses.....	79
11.5	Survival.....	80
Article 12 – Special Terms and Conditions		81
12.1	Dispute Resolution	81
12.2	Attorneys’ Fees	81
12.3	Notices	82

12.4	Amendments.....	82
12.5	Time is of the Essence	83
12.6	Publicity.....	83
12.7	Force Majeure	83
12.8	Further Assurances	83
12.9	Binding Effect	84
12.10	Titles/Section Headings.....	84
12.11	Severability.....	84
12.12	Entire Agreement/Incorporated Documents/Order of Precedence	84
12.13	Waivers	85
12.14	Incorporation of Amendments to Applicable Laws.....	85
12.15	Choice of Law, Jurisdiction, and Venue.....	85
12.16	Counterparts	85
12.17	Days.....	85
12.18	Ambiguities Not Held Against Drafter	85
12.19	Clerical Error.....	86
12.20	Administration of Agreement	86
12.21	Performance of Requirements.....	86
Article 13 – Definitions		87

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

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

RECITALS

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

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

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

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

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

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

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

ARTICLE 1 – GENERAL PROVISIONS

1.1 Purpose

This Agreement sets forth the expectations of the Exchange and Contractor with respect to:

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

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

1.2 Applicable Laws and Regulations

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

b) Contractor is subject to the obligations imposed on Contractor under applicable laws, rules and regulations of the Federal Affordable Care Act, the California Affordable Care Act, and any other applicable Federal, State or local laws, rules and regulations. The parties to this Agreement recognize and acknowledge there may be material changes to the above-referenced rules and regulations and other applicable Federal, State, or local laws, rules and regulations. Should such an event arise, the parties agree that revisions to this Agreement may be necessary to align provisions contained herein with the changes made to these laws. Nothing in this Agreement limits such obligations imposed on Contractor, including any failure to

reference a specific State or Federal regulatory requirement applicable to the Exchange or Contractor. In those instances where the Exchange imposes a requirement in accordance with the California Affordable Care Act or as otherwise authorized by California law that exceeds a requirement of the Federal Affordable Care Act or other Federal law, the State law and Exchange requirement shall control unless otherwise required by law, rules and regulations.

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

1.3 Relationship of the Parties

- a) Independent contractors. The parties acknowledge that in performance of the duties under this Agreement the Exchange and the Contractor are acting and performing as independent contractors. Nothing in this Agreement shall be construed or deemed to create a relationship of employer or employee or partner or joint venture or principal and agent between the Exchange and Contractor. In accordance with State and Federal law, the Exchange is not operating on behalf of Contractor or any subcontractor of Contractor. Neither Contractor nor its Participating Providers, authorized subcontractors, or any agents, officers, or employees of Contractor shall be deemed as agents, officers, employers, partners, or associates of the Exchange.
- b) Subcontractors. Contractor shall require any subcontractor or assignee to comply with applicable requirements in this Agreement. Nothing in this Agreement shall limit Contractor's ability to hold subcontractor liable for performance under a contract between Contractor and its subcontractor(s). Contractor's obligations pursuant to this Agreement and applicable laws, rules and regulations shall not be waived or released if Contractor subcontracts or otherwise delegates services of this contract. Contractor shall exercise due diligence in the selection of subcontractors and monitor services provided by subcontractors for compliance with the terms of this Agreement and applicable laws, rules or regulatory requirements or orders.

1.4 General Duties of the Exchange

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

- a) Certification of QHP Issuers (45 C.F.R. Part 155, Subpart K);
- b) Consultation with stakeholders (45 C.F.R. § 155.130);

- c) Consumer assistance tools and programs, including but not limited to operation of a toll-free call center (45 U.S.C. § 18031 (d) and 45 C.F.R. § 155.205);
- d) Eligibility and enrollment determinations in the Individual Exchange (45 C.F.R. Part 155, Subparts D, E, H, I);
- e) Financial support for continued operation of the Exchange (45 C.F.R. § 155.160);
- f) Navigator program standards, in accordance with Federal rules, designed to raise awareness of the Exchange by providing consumer access to education and other resources regarding eligibility, enrollment, and program specifications (45 C.F.R. § 155.210);
- g) Non-interference with Federal law and nondiscrimination standards (45 C.F.R. § 155.120);
- h) Notices to Enrollees (45 C.F.R. § 155.230);
- i) Oversight, financial, and quality activities (45 C.F.R. § 155.200);
- j) Participation of brokers to enroll Qualified Individuals in QHPs (45 C.F.R. § 155.220);
- k) Ensuring that individuals can pay premiums owed directly to QHP issuers and ensuring compliance with related Federal requirements (45 C.F.R. § 155.240);
- l) Privacy and security of personally identifiable information (45 C.F.R. § 155.260);
- m) Use of standards and protocols for electronic transactions (45 C.F.R. § 155.270);
- n) Operation and management of CalHEERS. The Exchange also has a duty, as part of its management of CalHEERS, to determine how CalHEERS presents information about cost, quality, and provider availability for consumers to inform their selection of issuer and benefit design in the Exchange. The Exchange shall solicit comment from Contractor on the design but retains final authority to make design and presentation decisions in its sole discretion; and
- o) The Exchange agrees to provide a dedicated team member responsible for working with Contractor to resolve any and all issues that arise from implementation of the Exchange.

1.4.1 Confidentiality of Contractor Documents

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

1.5 General Duties of the Contractor

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

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

- a) Contractor maintains the legal capacity to contract with the Exchange and complies with the requirements for participation in the Exchange pursuant to this Agreement and applicable Federal and State laws, rules and regulations;
- b) A dedicated liaison is available as the primary contact person to coordinate and cooperate with the Exchange in the implementation of this Agreement and the contact person and/or other personnel are available to the Exchange as needed to fulfill Contractor's duties under this Agreement.
- c) QHPs identified in Attachment 1 are offered in accordance with the terms and conditions of this Agreement and compliance with the Affordable Care Act and the California Affordable Care Act and implementing regulations, and with applicable Federal and State laws, rules and regulations, as may be amended from time to time as required under applicable laws, rules and regulations, or as otherwise authorized under this Agreement;
- d) Notify the Exchange of:
 - i. all routine or non-routine surveys and audits conducted by a regulatory agency concerning Contractor's Covered California lines of business;
 - ii. any material concerns identified by Contractor or by a regulatory agency that may impact Contractor's performance under this Agreement; and
- e) Provide Covered California with copies of any preliminary or final reports, findings, or orders related to Subsection (d) of this Section 1.5, within 48 hours of Contractor receiving them from a regulatory agency; and
- f) Participate in quarterly, in-person meetings between the Exchange and Contractor at the Exchange's headquarters to report and review program performance results, including all Services and components of the program, i.e., clinical, financial, contractual reporting requirements, customer service, appeals, and any other program recommendations.

1.6 Transition between the Exchange and Other Coverage

In order to further the Exchange's mission regarding continued access to health insurance coverage, Contractor shall establish policies and practices to maximize smooth transitions and continuous coverage for Enrollees to and from the Medi-Cal program and other governmental health care programs and coverage provided by Employers, including coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the California Continuation Benefits Replacement Act, Health and Safety Code § 1366.20 et seq. ("Cal-COBRA").

1.7 Coordination with Other Programs

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

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

1.8 Changes in Requirements

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

1.9 Evaluation of Contractor Performance

The Exchange shall evaluate Contractor's performance with respect to fulfillment of its obligations under this Agreement on an ongoing basis, including, but not limited to, during the

90-day period prior to each anniversary of the Agreement Effective Date set forth in Section 7.1 so long as the Agreement remains in effect. In the event evaluations conducted by the Exchange reveal a significant problem or pattern of non-compliance with terms of this Agreement as reasonably determined and documented by the Exchange, the Exchange shall have the right, without limitation, to conduct reasonable additional reviews of Contractor's compliance and operational performance. Such evaluations shall also be considered in connection with decisions relating to re-certification and de-certification in accordance with the terms set forth at Article 7.

1.10 Required Notice of Contractor Changes

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

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

- a) Contractor is in breach of any of its obligations under this Agreement;
- b) Change in the majority ownership, control, or business structure of Contractor;
- c) Change in Contractor's business, partnership or corporate organization that may reasonably be expected to have a material impact on Contractor's performance of this Agreement or on the Exchange's rights under this Agreement;
- d) Breach by Contractor of any term set forth in this Agreement or Contractor otherwise ceases to meet the requirements for a QHP Issuer, including those set forth at and 45 C.F.R. § 156.200 et seq. (Subpart C Article 3-Qualified Health Plan Minimum Certification Standards);
- e) Immediate notice in the event that Contractor files any federal bankruptcy action or state receivership action, any federal bankruptcy or state receivership action is commenced against Contractor, Contractor is adjudicated bankrupt, or a receiver is appointed and qualifies; and
- f) Changes in Contractor's Provider Network by notice consistent with Section 3.3.
 - i. Contractor shall notify the Exchange with respect to any material changes to its Essential Community Provider (ECP) contracting arrangements consistent with Section 3.3; and

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

1.11 Nondiscrimination

- a) Services and Benefits. During the performance of this Agreement, Contractor shall not, and shall require Participating Providers and other subcontractors, as well as their agents and employees to not, in accordance with the Affordable Care Act Section 1557 (42 U.S.C. § 18116), cause an individual to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.), or Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), or subject to any other applicable State and Federal laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity offered through the Exchange.
- b) Employment and Workplace. Contractor shall not, and shall require Participating Providers and other subcontractors, as well as their agents and employees to not, unlawfully discriminate, harass or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (40 or over), marital status, genetic information, sexual orientation, gender identity, or use of family and medical care leave. Contractor shall, and shall require Participating Providers and other subcontractors, as well as their agents and employees, to evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. Contractor shall, and shall require Participating Providers and subcontractors, as well as their agents and Employees, to comply with the provisions of the Fair Employment and Housing Act (Government Code § 12900 et seq.) and the applicable regulations promulgated thereunder (2 CCR § 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code § 12990, set forth in CCR Chapter 5 of Division 4 of Title 2, including, 2 CCR § 8103 et seq., are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor shall, and shall require Participating Providers and other subcontractors to give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Contractor shall include the nondiscrimination and compliance provisions of this clause in all subcontracts to perform work under this Agreement.

1.12 Conflict of Interest; Integrity

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

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

1.13 Other Financial Information

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

1.14 Other Laws

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

- a) Americans with Disabilities Act. Contractor shall comply with the Americans with Disabilities Act (ADA) of 1990, (42 U.S.C. § 12101 et seq.), which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA, unless specifically exempted.
- b) Drug-Free Workplace. Contractor shall comply with the requirements of the Drug-Free Workplace Act of 1990 (Government Code § 8350 et seq.).
- c) Child Support Compliance Act. Contractor shall fully comply with all applicable State and Federal laws relating to child and family support enforcement, including, but not limited to, disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with § 5200) of Part 5 of Division 9 of the Family Code.

- d) Domestic Partners. Contractor shall fully comply with Public Contract Code § 10295.3 with regard to benefits for domestic partners.
- e) Environmental. Contractor shall comply with environmental laws, rules and regulations applicable to its operations, including, those relating to certifies compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30, commencing with § 42460 of the Public Resources Code, relating to hazardous and solid waste.
- f) Other Laws. Contractor shall comply with any and all other State and Federal laws, rules and regulations applicable to this Agreement, to the operation of the Exchange, and to Contractor's provision of Services under this Agreement.

1.15 Contractor's Representations and Warranties

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

- a) Violate any provision of the charter documents of Contractor;
- b) Violate any laws, rules, regulations, or any judgment, decree, order, regulation or rule of any court or governmental authority applicable to Contractor; or
- c) Violate, or be in conflict with, or constitute a default under, or permit the termination of, or require the consent of any person under, any agreement to which Contractor may be bound, the occurrence of which in the aggregate would have a material adverse effect on the properties, business, prospects, earnings, assets, liabilities, or condition (financial or otherwise) of Contractor.

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

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

1.16 Fraud, Waste and Abuse; Ethical Conduct

Contractor shall maintain and enforce policies, procedures, processes, systems, and internal controls (i) to reduce fraud, waste and abuse, and (ii) to enhance compliance with other applicable laws, rules and regulations in connection with the performance of Contractor's obligations under this Agreement. Contractor shall maintain an effective compliance program that meets the

requirements of applicable laws, rules and regulations. Contractor shall provide evidence of such compliance program as reasonably requested by the Exchange. Contractor shall timely communicate to the Exchange any material concerns identified by Contractor or by a regulatory agency related to regulatory compliance that may impact performance under this Agreement.

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

Contractor shall maintain and enforce a code of ethical conduct and make it available to the Exchange upon request.

Contractor shall refer potential fraud activities identified through fraud detection and response measures to the Exchange. Contractor shall follow the established Carrier Referral Process posted on the carrier extranet site provided by the Exchange.

Contractor shall not terminate Enrollee coverage for fraud without prior review and approval from the Exchange.

1.17 Current Enrollee Notification

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

ARTICLE 2 – ELIGIBILITY AND ENROLLMENT

2.1 Eligibility and Enrollment Responsibilities

2.1.1 Exchange Responsibilities

- a) The Exchange shall be solely responsible for the determination of eligibility and enrollment of individuals in the Exchange in accordance with applicable Federal and State laws, rules and regulations.
- b) The Exchange shall determine eligibility and enroll eligible individuals in the Exchange pursuant to its management and participation in CalHEERS, a project jointly sponsored by the Exchange and DHCS with the assistance of the Office of Systems Integration. The Exchange and CalHEERS shall develop, implement, and maintain processes to make the eligibility and enrollment decisions regarding the Exchange and other California health care programs and submit that information to Contractor in a timely manner in accordance with Federal and State laws, rules and regulations, and the terms set forth in this Agreement.
- c) The Exchange shall notify Contractor regarding each eligible applicant who has completed an application for enrollment and selected Contractor as the QHP Issuer. The Exchange shall transmit information required for Contractor to enroll the applicant within five (5) business days of receipt of verification of eligibility and selection of Contractor's QHP.
- d) The Exchange shall send enrollment information to Contractor on a daily basis and Contractor shall reconcile specified enrollment information received from the Exchange with Contractor's enrollment data on a monthly basis through the Reconciliation Process.
- e) The Exchange shall utilize the Dispute Process pursuant to Section 2.1.2 d) to resolve issues related to the Reconciliation Process.

2.1.2 Contractor Responsibilities

- a) Contractor shall comply with all Federal and State eligibility and enrollment laws and regulations, including, but not limited to, the Affordable Care Act § 1411 et seq. (42 U.S.C. § 18081 et seq.), 45 C.F.R. § 155.400 et seq., Government Code § 100503, and 10 CCR § 6400 et seq.
- b) Contractor shall comply with all Exchange eligibility and enrollment determinations, including those made through CalHEERS and that result from an applicant's appeal of an Exchange determination. Contractor shall implement appeals decisions and provide the Exchange with evidence the appeal resolution has been implemented within ten (10) days of receiving all necessary data elements from the Exchange required to implement the appeals decision. Contractor shall immediately notify the Exchange if it receives an appeal decision that does not have all necessary data elements required for the Contractor to implement the appeal decision. In the event that an Enrollee requires immediate care, the QHP Issuer will

work closely with the Exchange to implement the appeals decision as soon as reasonably possible. Contractor shall accept all Enrollees assigned by the Exchange except as otherwise authorized by policies and procedures of the Exchange or upon the approval of the Exchange.

- c) Contractor shall participate in the Reconciliation Process to review and compare the Exchange enrollment reconciliation file, distributed monthly, against the Contractor's membership enrollment and financial databases. Contractor shall prepare a comparison extract in accordance with the file validations and resolution timelines, as mutually agreed upon in the "Data Integrity Reconciliation Process Guide."
- d) Contractor shall participate in the Dispute Process established by the Exchange to resolve issues related to the Reconciliation Process. Contractor shall submit a supplemental file to dispute identified discrepancies found in the Exchange enrollment reconciliation file in accordance with the defined list of fields and technical requirements established by the Exchange through the "Data Integrity Reconciliation Dispute Process Guide."
- e) Contractor shall rely upon the accuracy of current eligibility and enrollment information furnished by the Exchange during the term of this Agreement; provided, however, that Contractor shall: (i) reconcile premium payment information with enrollment and eligibility information received from the Exchange on a monthly basis, and (ii) Contractor shall only accept changes to eligibility information submitted by Enrollees when the Exchange notifies or confirms such change to Contractor.

2.1.3 Collection Practices

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

2.2 Individual Exchange

2.2.1 Open Enrollment and Special Enrollment Periods

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

2.2.2 Individual Exchange Coverage Effective Dates

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

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

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

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

2.2.3 Premiums for Coverage in the Individual Exchange

Contractor shall not be entitled to collect from Enrollees or receive funds above the premium amounts except with respect to cost-sharing amounts or to the extent that such payment (i) is expressly authorized under the QHPs, such as out-of-network services that comply with the notice requirements set forth at Section 3.4.3, or (ii) relates to a charge for non-sufficient funds or transaction fees initiated by Enrollee at rates that are reasonable and customary for such transactions. Contractor shall not pursue collections of any said fees from the Exchange.

Contractor shall not pursue collection of any delinquent premiums from the Exchange for an Enrollee enrolled in the Individual Exchange who is responsible for directly paying his or her premium to Contractor.

In the case of partial month enrollments Contractor shall follow the methodology specified in 10 CCR § 6500 (i).

The premium for coverage lasting less than one month shall equal the product of:

- i. The premium for one month of coverage divided by the number of days in the month; and
- ii. The number of days for which coverage is being provided in the month.

The same methodology shall apply to proration of APTC and CSR amounts for a coverage lasting less than one month.

Premiums charged to individuals includes the assessment of the Participation Fee.

2.2.4 Terminations of Coverage

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

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

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

The Exchange and Contractor must send a termination transaction to the other party within ten (10) business days of any individual Enrollee termination.

2.2.5 Notice to Provider Regarding Enrollee's Grace Period Status

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

provider who is an assigned Primary Care Provider for that Enrollee, and providers who have an outstanding prior authorization to provide services to the APTC Enrollee.

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

2.2.6 Agents in the Individual Exchange

- a) Compensation. The provisions of this Section apply to Agents who sell Contractor's QHPs through the Individual Exchange.
- b) Compensation Methodology. Contractor must pay a commission to Agents to ensure Contractor is fairly and affirmatively offering all of its products at each metal level during both Open and Special Enrollment Periods. Contractor shall be solely responsible for compensating Agents who sell Contractor's QHP through the individual market of the Exchange. Contractor shall use a standardized Agent compensation program with levels and terms that shall result in the same aggregate compensation amount to Agents whether products are sold within or outside of the Exchange. Contractor shall provide the Exchange with a description of its standard Agent compensation program, standard Agent contract, and policies on an annual basis.
- c) Incentive Compensation Program. In order to enhance consistency in sales efforts for products offered inside and outside of the Exchange, Contractor shall add the Agent's sale of Contractor's QHPs through the Exchange to the Agent's sale of Contractor's individual policies outside the Exchange to determine Agent's aggregate sales that are used by Contractor to determine incentive or other compensation payable by Contractor to Agent, to the extent such aggregation is necessary to determine Agent compensation under Contractor's applicable Agent agreement or compensation program. Contractor shall not change the Agent commission structure or rates during the Plan Year. Contractor must pay the same commission during the Open and Special Enrollment Periods for each Plan Year. Contractor shall not vary Agent commission levels by metal tier. Contractor shall approve and pay Agent commissions on all new Agent-of-record and change of Agent-of-record delegations as outlined in contract Sections 2.2.6 (f) and 2.2.6 (g). Contractor shall provide information as may reasonably be required by the Exchange from time to time to monitor Contractor's compliance with the requirements set forth in this Section. Contractor's standard Agent compensation and incentive compensation programs entered into or in effect prior to January 1, 2014 shall not be subject to the requirements of this Section.
- d) Agent Appointments. Contractor shall maintain a reasonable appointment process for appointing Agents who contract with Contractor to sell Contractor's QHPs to individuals through the Exchange. Such appointment process shall include: (i) providing or arranging for education programs to assure that Agents are trained to sell Contractor's QHPs through the Exchange, (ii) providing or arranging for programs that enable Agents to become certified by the Exchange; provided, however, that certification by the Exchange shall not be a required condition for an Agent to sell Contractor's QHPs outside of the Exchange, and

(iii) confirmation of Agent's compliance with State laws, rules and regulations applicable to Agents, including those relating to confidentiality and conflicts of interest, and such other qualifications as determined in Contractor's reasonable discretion.

- e) Agent Conduct. Contractor shall implement policies and procedures to ensure that only Agents who have been duly certified by the Exchange and maintain that certification may receive compensation for enrolling individuals in the Exchange.
- f) Agent of Record. At initial enrollment, individuals may notify the Exchange of an Agent delegation. The Exchange shall send notice of the delegation to the Contractor via the 834 enrollment file. Upon receipt of the 834 enrollment file, Contractor shall approve the delegation (unless an Agent is not licensed or not appointed) and has five (5) days to update their system. The Exchange recognizes that Contractor may contract with insurance agencies who employ or contract with Agents. The Exchange further understands that Contractor may delegate an employed or contracted Agent writing business for the benefit of an Agency. If requested, the Contractor shall send an Agent of Record Exception Report which includes any changes the Exchange requested, but were not made.
- g) Change to Agent of Record. Individuals may notify the Exchange of an Agent delegation change. The Exchange shall send notice of the delegation change to the Contractor via the 834 maintenance file. Upon receipt of the notification, Contractor shall approve the delegation (unless an Agent is not licensed or not appointed) and has five (5) days to update their system to reflect this change upon receipt of all required information from the Exchange. Contractor shall notify the existing agent of the delegation change within ten (10) business days. If requested, the Contractor shall send an Agent of Record Exception Report which includes any changes the Exchange requested, but were not made. The Exchange recognizes that Contractor may contract with insurance agencies who employ or contract with Agents. The Exchange further understands that Contractor may delegate an employed or contracted Agent writing business for the benefit of an Agency.
- h) Carrier Scorecard. The Exchange will administer an annual Agent survey that rates the services Contractor provides to Agents, including those services required in this Section 2.2.6. The Exchange will solicit comments from the QHP Issuers to develop the Agent Survey prior to finalization. The Exchange will utilize the results of this survey to identify areas of improvement and work with QHP Issuers to improve performance.

2.3 Enrollment and Marketing Coordination and Cooperation

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

The Exchange will take such action as it deems necessary and feasible to develop and implement programs and activities to support Contractor in its marketing and enrollment efforts, in

accordance with applicable laws, rules and regulations. Such activities may include making available the following programs and resources for use by Contractor:

- a) A subsidy calculator available by electronic means to facilitate a comparison of QHPs that is consistent with tools the Exchange will use for its own eligibility screenings, to ensure that preliminary eligibility screenings use the same tool;
- b) Education, marketing, and outreach programs that will seek to increase enrollment through the Exchange and inform consumers, including Contractor's current Enrollees, that there is a range of QHPs available in the Exchange in addition to Contractor's QHPs;
- c) A standard interface through which Contractor may electronically accept the initial binding payment (via credit card, debit card, ACH, or other mutually acceptable means) to effectuate coverage in the Individual Exchange;
- d) Complete documentation and reasonable testing timelines for interfaces with the Exchange's eligibility and enrollment system;
- e) Eligibility and enrollment training for Contractor's staff and for licensed Agents and brokers;
- f) Joint marketing programs to support renewal, retention, and enrollment in the Exchange of existing members of Contractor's health insurance plans who are eligible for the Federal subsidies;
- g) Joint marketing activities of the Exchange, Contractor, and other Health Insurance Issuers designed to drive awareness and enrollment in the Exchange;
- h) The Exchange will treat as confidential, all Contractor marketing plans and materials consistent with Section 1.4.1;
- i) The Exchange's annual marketing plans, including Open Enrollment Period (OEP), Special Enrollment Period (SEP), and retention and renewal efforts; and
- j) Customer service support that will include substantially extended customer service hours during Open Enrollment Periods.

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

- a) Following the Exchange making the technology available and within a reasonable time after the receipt of notice from the Exchange about the technology, and determination of its compatibility with Contractor's system, the Contractor shall prominently display the subsidy calculator on its website;
- b) Educate its Agents on Contractor's QHPs offered in the Exchange, work with the Exchange to efficiently educate its Agents and brokers about the Exchange's individual marketplace, and inform Agents that a prospective Enrollee's health status is irrelevant to advice provided with respect to health plan selection other than informing individuals about their estimated out-of-pocket costs;
- c) Provide education and awareness regarding eligibility for Federal tax credits, plan offerings and benefits available through the Exchange in connection with any applicable outreach to Contractor's existing members, as mutually agreed;

- d) Cooperate with the Exchange to develop and implement an Enrollee retention plan;
- e) Submit to the Exchange a marketing plan at least thirty (30) days prior to Open Enrollment that details the anticipated budget, objectives, strategy, creative messaging, and ad placement by medium promoting acquisition activities. Marketing plans for Retention and Renewal efforts should be submitted to the Exchange within thirty (30) days after Open Enrollment begins;
- f) Submit to the Exchange actualized spend amounts for: (1) OEP within thirty (30) days after OEP closes, and (2) SEP for the calendar year, thirty (30) days after the calendar year ends, and (3) retention and renewal, thirty (30) days after OEP begins. The Exchange shall treat as confidential consistent with Section 1.4.1; and
- g) Have successfully tested interfaces with the Exchange's eligibility and enrollment system, or be prepared to complete successful interface tests by dates established by the Exchange.

2.4 Enrollee Materials and Branding Documents

- a) Exchange Logo. Contractor shall include the Exchange logo on premium invoices, ID cards, and Enrollee termination notices. The Contractor shall include the Exchange logo and other information in notices and other materials based upon the mutual agreement of the Exchange and Contractor as to which materials should include the Exchange logo. Contractor shall comply with the Exchange co-branding requirements related to the format and use of the Exchange logo as outlined in the Covered California Brand Style Guide. The Exchange shall make the updated Brand Style Guide available to Contractor online and notify Contractor when updates are made.
- b) Cobranded Marketing Materials. Contractor must submit all cobranded marketing materials to Covered California at least ten (10) days prior to releasing materials publicly. The materials provided to Covered California under this Section will not require prior-approval by Covered California before the Contractor distributes such materials; provided, however, that Contractor shall make a good faith effort to incorporate any changes proposed by Covered California with respect to such materials.
- c) Enrollee Materials. Upon request, Contractor shall provide the Exchange with at least one (1) copy, unless otherwise specified, of any information Contractor intends to send or make available to all the Exchange Enrollees, including, but not limited to, Evidence of Coverage (EOC) and disclosure forms, Enrollee newsletters, new Enrollee materials, health education materials, and special announcements. The materials provided to the Exchange under this Section will not require prior-approval by the Exchange before the Contractor distributes such materials; provided, however, that Contractor shall duly evaluate any changes proposed by the Exchange with respect to such materials. Contractor shall maintain an electronic file that is open to the Exchange, or email all Enrollee materials to the Exchange. Such files shall be accessible by the Exchange as required by applicable laws, rules and regulations, and as otherwise mutually agreed upon by the parties.

- d) Distribution of Enrollment Materials. Contractor agrees to distribute to prospective Enrollees the Open Enrollment publications developed and printed by the Exchange for Enrollees prior to the Open Enrollment Period at a time mutually agreed to by the Contractor and the Exchange. Contractor shall be responsible for the mailing cost associated with these publications.
- e) Marketing Materials. In order to promote the effective marketing and enrollment of individuals inside and outside the Exchange, Contractor shall provide the Exchange with marketing material and all related collateral used by Contractor for the Exchange and non-Exchange plans on an annual basis and at such other intervals as may be reasonably requested by the Exchange. The Exchange shall treat such marketing materials as confidential information consistent with Section 1.4.1.
- f) Identification Cards. Contractor shall issue identification cards to Enrollees in a form that shall be agreed to by the Exchange. Identification cards should include the product name matching the naming convention on the Exchange website and provider directory. Contractor shall submit card design to the Exchange annually at least thirty (30) days prior to Open Enrollment.
- g) Mailing Addresses; Other Information. The Exchange and Contractor shall coordinate with respect to the continuous update of changes in an Enrollee's address or other relevant information.
- h) Evidence of Coverage Booklet on Contractor's Website. During each year of this Agreement which carries over into a subsequent Plan Year, Contractor shall make the Evidence of Coverage booklet, including any documents referenced in the Evidence of Coverage, for the next benefit year available on Contractor's website no later than the first day of the Open Enrollment Period provided that Contractor has received any revisions in the material that is to be included in the Evidence of Coverage from the Exchange and the applicable Regulator in sufficient time to allow for posting on the first day of Open Enrollment. The Evidence of Coverage booklet for the then-current benefit year shall remain on Contractor's website through December 31 of the then-current benefit year.
- i) Marketing Plans. Contractor and the Exchange recognize that Enrollees and other health care consumers benefit from efforts relating to outreach activities designed to increase health awareness and encourage enrollment. The parties shall share marketing plans on an annual basis and with respect to periodic updates of material changes. The marketing plans of the Exchange and Contractor shall include proposed and actual marketing approaches, messaging and channels, and provide samples of any planned marketing materials and related collateral as well as planned, and when completed, expenses for the marketing budget. The Contractor shall include this information for both the Exchange and the outside individual market. The Exchange shall treat all marketing information provided under this Section as confidential information consistent with Section 1.4.1. The obligation of the Exchange to maintain confidentiality of this information shall survive termination or expiration of this Agreement.

ARTICLE 3 – QHP ISSUER PROGRAM REQUIREMENTS

3.1 Basic Requirements

3.1.1 Licensed in Good Standing

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

Table 3.1.1	Definition of Good Standing	Agency
<u>Verification that issuer holds a state health care service plan license or insurance certificate of authority.</u>		
• Approved for lines of business sought in the Exchange (e.g. commercial, small group, individual)		DMHC and CDI
• Approved to operate in what geographic service areas		DMHC and CDI
• Most recent financial exam and medical survey report reviewed		DMHC
• Most recent market conduct exam reviewed		CDI
<u>Affirmation of no material¹ statutory or regulatory violations, including penalties levied, during the year prior to the date of the Agreement or throughout the term of Agreement in relation to any of the following, where applicable:</u>		
• Financial solvency and reserves reviewed		DMHC and CDI
• Administrative and organizational capacity acceptable		DMHC
• Benefit Design		
• State mandates (to cover and to offer)		DMHC and CDI
• Essential health benefits (State required)		DMHC and CDI
• Basic health care services		DMHC and CDI
• Copayments, deductibles, out-of-pocket maximums		DMHC and CDI
• Actuarial value confirmation (using the Federal Actuarial Value Calculator as applicable.)		DMHC and CDI
• Network adequacy and accessibility standards are met		DMHC and CDI
• Provider contracts		DMHC and CDI
• Language Access		DMHC and CDI
• Uniform disclosure (summary of benefits and coverage)		DMHC and CDI
• Claims payment policies and practices		DMHC and CDI
• Provider complaints		DMHC and CDI
• Utilization review policies and practices		DMHC and CDI
• Quality assurance/management policies and practices		DMHC and CDI
• Enrollee/Member grievances/complaints and appeals policies and practices		DMHC and CDI
• Independent medical review		DMHC and CDI
• Marketing and advertising		DMHC and CDI
• Guaranteed issue individual and small group		DMHC and CDI
• Rating Factors		DMHC and CDI
• Medical Loss Ratio		DMHC and CDI
• Premium rate review		DMHC and CDI
• Geographic rating regions		
• Rate development and justification is consistent with ACA requirements		DMHC and CDI

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

3.1.2 Certification

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

3.1.3 Accreditation

- a) Contractor agrees to maintain a current accreditation throughout the term of the Agreement from one of the following accrediting bodies: (i) Utilization Review Accreditation Commission (URAC); (ii) National Committee on Quality Assurance (NCQA); (iii) Accreditation Association for Ambulatory Health Care (AAAHC). Contractor shall authorize the accrediting agency to provide information and data to the Exchange relating to Contractor's accreditation, including the most recent accreditation survey and other data and information maintained by accrediting agency as required under 45 C.F.R. § 156.275.
- b) Contractor shall be currently accredited and maintain its NCQA, URAC or AAAHC health plan accreditation throughout the term of the Agreement. Contractor shall notify the Exchange of the date of any accreditation review scheduled during the term of this Agreement and the results of such review. Upon completion of any health plan accreditation review conducted during the term of this Agreement, Contractor shall provide the Exchange with a copy of the Assessment Report within forty-five (45) days of report receipt.
- c) If Contractor receives a rating of less than "accredited" in any category, loses an accreditation, or fails to maintain a current and up to date accreditation, Contractor shall notify the Exchange within ten (10) business days of such rating(s) change. Contractor will implement strategies to raise the Contractor's rating to a level of at least "accredited" or to reinstate accreditation. Contractor will submit a written corrective action plan (CAP) to the Exchange within forty-five (45) days of receiving its initial notification of the change in category ratings.
- d) Following the initial submission of the corrective action plans ("CAPs"), Contractor shall provide a written report to the Exchange on at least a quarterly basis regarding the status and progress of the submitted corrective action plan(s). Contractor shall request a follow-up review by the accreditation entity at the end of twelve (12) months and submit a copy of the follow-up Assessment Report to the Exchange within thirty (30) days of receipt, if applicable.
- e) In the event Contractor's overall accreditation is suspended, revoked, or otherwise terminated, or in the event Contractor has undergone review prior to the expiration of its current accreditation and reaccreditation is suspended, revoked, or not granted at the time of expiration, the Exchange reserves the right to terminate any agreement by and between Contractor and the Exchange or suspend enrollment in Contractor's QHPs, to ensure the Exchange is in compliance with the federal requirement that all participating issuers maintain a current approved accreditation pursuant to 45 C.F.R. § 156.275(a).

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

3.1.4 Plan Naming Conventions

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

3.1.5 Operational Requirements and Liquidated Damages

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

SERFF Template Completion

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

CalHEERS Test and Load Deadlines

Contractor must participate in CalHEERS testing and provide certification of plan data and documents in the CalHEERS pre-production environment. The pre-production environment is the test environment where the parties can validate templates and documents prior to the Renewal and Open Enrollment Periods. Following Contractor's certification of the QHPs in the pre-production environment, any subsequent upload required to correct Contractor's errors in the production environment will result in liquidated damages in the amount of \$25,000 beginning with uploads for the 2017 Plan Year, and each year thereafter. One upload, for purposes of this paragraph, includes all plan data and documents that must be resubmitted to correct Contractor's errors. Liquidated damages will not apply to additional uploads resulting from errors in the instructions provided by the Exchange, or changes required by Covered California or Contractor's regulator.

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

Deadlines for Regulatory Approval

The Exchange reserves the right to require that the Contractor receive regulatory approval for Licensure, rates, products, Summary of Benefits and Coverage, Evidence of Coverage documents, policy documents, Network, and Service Area prior to participating in the CalHEERS pre-production environment.

Communication with Plan Manager and the Exchange

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

3.2 Benefit Standards

3.2.1 Essential Health Benefits

Each QHP offered by Contractor under the terms of this Agreement shall provide essential health benefits in accordance with the Benefit Plan Design requirements described in the Covered California Patient-Centered Benefit Plan Designs as approved by the Board for the applicable Plan Year, and as required under this Agreement, and applicable laws, rules and regulations, including California Health and Safety Code § 1367.005, California Insurance Code § 10112.27, California Government Code § 100503(e), and as applicable, 45 C.F.R. § 156.200(b).

3.2.2 Standard Benefit Designs

- a) During the term of this Agreement, Contractor shall offer the QHPs identified in Attachment 1 and provide the benefits and services at the cost-sharing and actuarial cost levels described in the Covered California Patient-Centered Benefit Plan Designs as approved by the Board for the applicable Plan Year.
- b) During the term of this Agreement, for any Plan Year that the cost of the cost-sharing reduction program is built into the premium for Contractor's Silver-level QHPs, Contractor shall offer a non-mirrored Silver-level plan, that is not a QHP, outside of Covered California that complies with the benefits and services at the cost-sharing and actuarial cost level described in the plan design at Attachment 3 ("Silver 70 Off-Exchange Plan, Non-Mirrored Silver Plan Design"). This plan must not have any rate increase or cost attributable to the cost of the cost-sharing reduction program.

3.2.3 Offerings Outside of the Exchange

- a) Contractor acknowledges and agrees that as required under State and Federal law, QHPs and plans that are identical in benefits, service area, and cost sharing structure offered by Contractor outside the Exchange must be offered at the same premium rate whether offered inside the Exchange or outside the Exchange directly from the issuer or through an Agent.
- b) In the event that Contractor sells products outside the Exchange, Contractor shall fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals seeking coverage outside the Exchange consistent with California law.
- c) For purposes of this section, “product” does not include contracts entered into pursuant to Part 6.2 (commencing with § 12693) of Division 2 of the Insurance Code between the Department of Health Care Services (DHCS) and health care service plans for Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with § 14000) of, or Chapter 8 (commencing with § 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the DHCS and health care service plans for enrolled Medi-Cal beneficiaries.

3.2.4 Pediatric Dental Benefits

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

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

3.2.5 Segregation of Funds

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

3.2.6 Prescription Drugs

- a) Formulary changes. Except in cases where patient safety is an issue, Contractor shall give affected Exchange Enrollees, and their prescribing physician(s), sixty (60) days written notice prior to the removal of a drug from formulary status, unless it is determined that a drug must be removed for safety purposes more quickly. If Contractor is not reasonably able to provide sixty (60) days written notice, the Contractor must provide affected Enrollees with a sixty (60) day period to access the drug as if was still on the formulary, that begins on the date the drug is removed from the formulary. This notice requirement shall apply only to single source brand drugs and the notice shall include information related to the appropriate substitute(s). The notice shall also comply with all requirements of the Health and Safety Code and Insurance Code, including provisions prohibiting Contractor from limiting or excluding coverage for a drug to a Plan Enrollee in cases where the drug had been previously approved for coverage by Contractor for a medical condition of the Plan Enrollee, except under specified conditions. To the extent permitted in State and Federal law, an exception to the notice requirement will be allowed when Contractor continues to cover a drug prescribed for a Plan Enrollee without interruption and under the same conditions, including copayment and limits that existed prior to the removal of the drug from formulary status.
- b) Internet Link to Formularies. Contractor shall comply with applicable State and Federal laws relating to prescription drug formularies, including posting the formularies for each product offered on the Contractor's website as required by Health and Safety Code § 1367.205 and Insurance Code § 10123.192. Contractor shall provide to the Exchange and regularly update information necessary for the Exchange to link to the Contractor's drug formularies for each of the QHPs Contractor offers so that the Exchange can ensure it complies with its obligation under Government Code § 100503.1.
- c) Contractor shall have an opt-out retail option for mail order drugs to allow consumers to receive in-person assistance, and this option shall have no additional cost. However, as specified in the standard benefit designs, Contractor may offer mail order prescriptions at a reduced cost-share.
- d) Contractor shall provide consumers with an estimate of the range of costs for specific drugs.
- e) Contractor shall have a sufficient number of customer service representatives available during call center hours for consumers and advocates to obtain clarification on formularies and consumer cost-shares for drug benefits.

3.3 Network Requirements

3.3.1 Service Areas

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

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

- b) Withdrawal. Contractor shall not withdraw from any geographic region (as defined in Health and Safety Code § 1357.512 and California Insurance Code § 10753.14) for the individual market or modify any portion of its Service Area where Contractor provides Covered Services to Enrollees without providing prior written notice to, and obtaining prior written approval from the Exchange, which shall not be unreasonably denied, and to the extent required, the Health Insurance Regulator with jurisdiction over Contractor.
- c) Service Area Eligibility. In order to facilitate the Exchange’s compliance with State and Federal law, Contractor shall monitor information it receives directly, or indirectly or through its subcontractors to assure continued compliance with eligibility requirements related to participation of Qualified Individuals in the Individual Exchange, including requirements related to residency in the Contractor’s service area.

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

3.3.2 Network Adequacy

- a) Network standards. Contractor's QHPs shall comply with the network adequacy standards established by the applicable Health Insurance Regulator responsible for oversight of Contractor, including, those set forth at Health and Safety Code § 1367.03 and 28 CCR § 1300.67.2 (if Contractor is a licensed health care service plan) or Insurance Code § 10133.5 and 10 CCR § 2240 et seq. (if Contractor is regulated by CDI), and, as applicable, other laws, rules, and regulations, including, those set forth at 45 C.F.R. § 156.230. Contractor shall cooperate with the Exchange to implement network changes as necessary to address concerns identified by the Exchange.
- b) Participating Provider Stability. Contractor shall maintain policies and procedures that are designed to preserve and enhance Contractor's network development by facilitating the recruitment and retention of Participating Providers necessary to provide access to Covered Services. Such policies and procedures shall be consistent with applicable laws, rules and regulations, and will include an ongoing assessment of turnover rates of its Participating Providers to ensure that the turnover rates do not disrupt the delivery of quality care.
- c) Notice of material network changes.

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

- i. Contractor shall notify the Exchange of any pending material change in the composition of its provider network within any of the regions it covers, or its participating provider contracts, of and throughout the term of this Agreement at least 60 days prior to any change or immediately upon Contractor's knowledge of the change if knowledge is acquired less than 60 days prior to the change, and cooperate with the Exchange in planning for the orderly transfer of plan members; and
- ii. Contractor shall ensure that Exchange Enrollees have access to care when there are changes in the provider network, including but not limited to, mid-year contract terminations between Contractor and Participating Providers.

3.3.3 Essential Community Providers

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

- i. Reporting requirements for the ECP standard are contained within the required monthly provider data submission pursuant to Section 3.4.4 and are as follows:
 - 1. Contractor to demonstrate provider agreements with at least 15% of 340B non-hospital providers in each applicable rating region.
 - 2. Contractor to demonstrate provider agreements that reflect a mix of essential community providers (hospital and non-hospital) reasonably distributed to serve the low-income, vulnerable, or medically underserved populations.
- ii. Reporting requirements for Exchange qualified Alternate Standard Contractors are contained within the annual Application for certification and are as follows:
 - 1. Contractor to produce access map to demonstrate low income, medically underserved enrollee access to health care services. Low income, vulnerable, or medically underserved individuals shall be defined as those Covered California enrollees who fall below 200 percent of the Federal Poverty Level (FPL). Maps shall demonstrate the extent to which provider sites are accessible to and have services that meet the needs of specific underserved populations, including:
 - a. Individuals with HIV/AIDS
 - b. American Indians and Alaska Natives
 - c. Low income and underserved individuals seeking women’s health and reproductive health services
 - d. Other specific populations served by Essential Community Providers in the service area such as STD Clinics, Tuberculosis Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low income, medically underserved individuals.
 - b) Sufficient geographic distribution. The Exchange shall determine whether Contractor meets the requirement of a sufficient geographic distribution of care, including ECPs, and other providers in its reasonable discretion, in accordance with the conditions set forth in the Application, and based on a consideration of various factors, including: (i) the nature, type, and distribution of Contractor’s ECP contracting arrangements in each geographic rating region in which Contractor’s QHPs provides Covered Services to Enrollees, (ii) the balance of hospital and non-hospital ECPs in each geographic rating region, (iii) the inclusion in Contractor’s provider contracting network of at least 15% of entities in each applicable geographic rating region that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B) (“340B Entity”), (iv) the inclusion of at least one ECP hospital in each region, (v) the inclusion of Federally Qualified Health Centers, and county hospitals, and (vi) other factors as mutually agreed upon by the Exchange and the Contractor regarding Contractor’s ability to serve the low income population.
 - c) Low-income populations shall be defined for purposes of the ECP requirements as families living at or below 200% of Federal Poverty Level. ECPs shall consist of participating entities in the following programs: (i) 340B Entity, (ii) California Disproportionate Share Hospital

Program, per the Final DSH Eligibility List for the current fiscal year, (iii) Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs, (iv) Community Clinic or health centers licensed as either a “community clinic” or “free clinic”, by the State under Health and Safety Code § 1204(a), or is a community clinic or free clinic exempt from licensure under Health and Safety Code § 1206, and (v) Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program. The Exchange will post a non-exhaustive essential community provider list annually.

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

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

- e) Indian Health Care Providers. For Contractor’s provider contracts entered into on or after January 1, 2015, Contractor shall reference the Centers for Medicare & Medicaid Services “Model QHP Addendum for Indian Health Care Providers” (“Addendum”) available by search at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces> . Contractor is encouraged to adopt the Addendum whenever it contracts with those Indian health care providers specified in the Addendum. Adoption of the Addendum is not required; it is offered as a resource to assist Contractor in including specified Indian providers in its provider networks.

3.3.4 Special Rules Governing American Indians and Alaskan Natives

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

- a) Contractor shall cover Covered Services furnished through a health care provider pursuant to a referral under contract for directly furnishing an item or service to an American Indian with no cost-sharing as described in the Affordable Care Act § 1402(d)(2).
- b) Contractor shall not impose any cost-sharing on such individuals under three hundred (300) percent of federal poverty level (“FPL”) in accordance with the Affordable Care Act § 1401(d)(1). The Exchange will have a transparent process to identify Alaskan Natives

and American Indians, including a specific identification of those under 300% of FPL so the Contractor has information necessary to comply with Federal law.

- c) Contractor shall provide monthly Special Enrollment Periods for American Indians or Alaskan Natives enrolled through the Exchange.
- d) Contractor shall comply with other applicable laws, rules and regulations relating to the provision of Covered Services to American Indians, including, the Indian Health Care Improvement Act Sections 206 (25 U.S.C. 1621e) and 408 (25 U.S.C. 1647a).

3.3.5 Network Stability

- a) Contractor shall implement policies and practices designed (i) to reduce the potential for disruptions in Contractor's provider networks, and (ii) to minimize the amount of uncertainty, disruption, and inconvenience of Enrollees in the execution of the transition of care as required under State laws, rules and regulations in connection with any such disruption. Contractor agrees to maintain adequate records, reasonably satisfactory to the Exchange, documenting its policies and its compliance with these requirements by Contractor and Participating Providers.
- b) Block Transfers. If Contractor experiences a termination of a Provider Group(s) or hospital(s) that constitutes a block transfer as defined in Health and Safety Code § 1373.65 and Title 28, C.C.R. § 1300.67.1.3, Contractor shall provide the Exchange with copies of the written notices the Contractor proposes to send to affected Enrollees, in compliance with the notice requirements of Health and Safety Code § 1373.65, prior to mailing the notices to Enrollees.
- c) Network Disruptions. If Contractor experiences provider network disruptions or other similar circumstances that make it necessary for Enrollees to change QHPs or Participating Providers, Contractor agrees to provide prior notice to the Exchange and Health Insurance Regulator, in accordance with advance notice, meeting, and other requirements set forth in applicable laws, rules, and regulations, including Insurance Code § 10199.1 and Health and Safety Code §§ 1367.23 and 1366.1.
- d) Enrollee transfers. In the event of a change in Participating Providers or QHPs related to network disruption, block transfers, or other similar circumstances, Contractor shall, and shall require Participating Providers to, cooperate with the Exchange in planning for the orderly transfer of Enrollees as necessary and as required under applicable laws, rules and regulations including, those relating to continuity of care.

3.4 Participating Providers

3.4.1 Provider Contracts

- a) Contractor shall include in all of its contracts with Participating Providers the requirement for all Covered Services to be provided by duly licensed, certified or accredited Participating Providers consistent with the scope of their license, certification or accreditation and in accordance with applicable laws, rules, regulations, the standards of medical practice in the community, and the terms set forth in agreements entered into by and between Contractor and Participating Providers (“Provider Agreement”).
- b) Contractor shall include in each Provider Agreement a requirement that Participating Providers comply with all other applicable laws, rules and regulations.
- c) Contractor shall use commercially reasonable efforts to require the provisions of Subsection (d) to be included in each: (i) Provider Agreement entered into by and between Contractor and a Participating Provider, and (ii) any subcontracting arrangement entered into by a Participating Provider.
- d) Provision of Covered Services. Contractor shall undertake commercially reasonable efforts to ensure that each Participating Provider Agreement and each subcontracting arrangement entered into by each Participating Provider complies with the applicable terms and conditions set forth in this Agreement, as mutually agreed upon by the Exchange and Contractor, and which may include the following:
 - i. Coordination with the Exchange and other programs and stakeholders;
 - ii. Relationship of the parties as independent contractors (Section 1.3(a)) and Contractor’s exclusive responsibility for obligations under the Agreement (Section 1.3(b));
 - iii. Participating Provider directory requirements (Section 3.4.4);
 - iv. Implementation of processes to enhance stability and minimize disruption to provider network (Section 3.3.5);
 - v. Notices, network requirements, and other obligations relating to costs of out-of-network services and other benefits (Section 3.4.3);
 - vi. Provider credentialing, including, maintenance of licensure and insurance (Section 3.4.2);
 - vii. Customer service standards (Section 3.6);
 - viii. Utilization review and appeal processes (Section 4.3);
 - ix. Maintenance of a corporate compliance program (Section 1.2);
 - x. Enrollment and eligibility determinations and collection practices (Article 2);

- xi. Appeals and grievances (Section 3.6.2);
- xii. Enrollee and marketing materials (Section 2.4);
- xiii. Disclosure of information required by the Exchange, including, financial and clinical (Section 1.13), Quality, Network Management and Delivery System Standards (Article 4), and other data, books, and records (Article 10));
- xiv. Nondiscrimination (Section 1.11);
- xv. Conflict of interest and integrity (Section 1.12);
- xvi. Other laws (Section 1.14);
- xvii. Quality, Network Management and Delivery System Standards to the extent applicable to Participating Providers (Article 4), including, disclosure of contracting arrangements with Participating Providers as required pursuant to Attachment 7;
- xviii. Performance Measures, to the extent applicable to Participating Providers (Article 6);
- xix. Continuity of care, coordination and cooperation upon termination of Agreement and transition of Enrollees (Section 3.3.5 and Article 7);
- xx. Security and privacy requirements, including compliance with HIPAA (Article 9); and
- xxi. Maintenance of books and records (Article 10).

3.4.2 Provider Credentialing

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

3.4.3 Enrollee Costs; Disclosure

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

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

Contractor shall require its Participating Providers to inform every Enrollee in a manner that allows the Enrollee the opportunity to act upon a Participating Provider's proposal or

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

3.4.4 Provider Directory

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

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

3.5 Premium Rate Setting

3.5.1 Rating Variations

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

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

3.5.2 Individual Exchange Rates

For the Individual Exchange, rates shall be established through an annual negotiation process between the Contractor and the Exchange for the following calendar year. The parties

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

In the Exchange's review of the detailed rationale for each plan's rate development, it has generally taken the view that absent extraordinary circumstances, as determined by the Exchange, profit margins over the range that have historically been considered to be reasonable would be unacceptable. The Exchange understands that considerable uncertainty exists with respect to potential enrollment changes and certain Federal laws and policies that may impact premium rates for the 2018 Plan Year. The Exchange recognizes that "pricing for this uncertainty" could lead health plans to increase premiums in amounts that would have immediate and significant harmful impacts on consumers. In the context of this uncertainty and in recognition of Contractor's establishing prices for the 2018 year to allow for that heightened uncertainty, should Contractor incur additional losses in Plan Year 2018 due to shifts in Federal policy and other uncertainties, the Exchange may allow Contractor, over the course of the next three years (Plan Years 2019, 2020, and 2021) to increase its profit margin to recoup such losses. Likewise, should Contractor receive profits due to shifts in Federal policy and other uncertainties, Contractor should factor such profits into a reduction of its premium rates over the next one to three Plan Years. These adjustments shall be consistent with applicable State and Federal laws, including the medical-loss ratio laws. The Exchange will utilize the annual negotiation process in future years to consider the duration and amount to supplement Contractor's profit margins that may be appropriate to recoup such losses for the purpose of building or maintaining adequate reserves; or to deduct the unanticipated profits for the 2018 Plan Year from Contractor's profit margins. In doing so, the Exchange will consider the Contractor's documented historic profit margin with the Exchange and the need for Contractor to maintain sufficient regulatory reserves. The parties understand that California's insurance regulators – the Department of Managed Health Care and the California Department of Insurance – conduct their own independent review of rates subsequent to the parties' negotiation. In the event the Contractor seeks to invoke this contract provision, the Exchange would convey to the regulator its perspective on the reasonableness of profit margins and reserves given the exceptional circumstances.

3.5.3 Rate Methodology

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

the assumptions made in forecasting and may be supported by information from the Plan's actuarial systems pertaining to the Exchange-specific account.

3.5.4 Provider Rates

To the extent permitted by law and by Contractor's contracts with Participating Providers, Contractor agrees that the information to be provided to the Exchange under this Agreement may include information relating to contracted rates between Contractor and Participating Providers that is treated as confidential information by Health Insurance Regulators pursuant to Insurance Code § 10181.7(b) and Health and Safety Code § 1385.07(b).

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

3.6 Customer Service Standards

3.6.1 Basic Customer Service Requirements

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

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

Contractor shall meet all State requirements for language assistance services applicable to its commercial lines of business. The Exchange and Contractor will continue to evaluate on an ongoing basis the adequacy of language services provided for verbal and written communications and consider the adoption of additional standards as appropriate. Contractor shall maintain call statistics for languages other than English similar to 1.4 and 1.5 in Group 1 of Attachment 14. The Contractor shall provide this information to the Exchange upon request.

3.6.2 Enrollee Appeals and Grievances

- a) Internal Grievances and Appeals. Contractor shall maintain an internal review process to resolve an Enrollee's written or oral expression of dissatisfaction regarding the Contractor and Participating Providers, including appeals of claim and benefit determinations, and complaints relating to the scope of Covered Services required to be covered under the QHP. Contractor's processes shall comply with State and Federal laws, rules and regulations relating to Enrollee rights and appeals processes, specifically including grievance requirements set forth at Health and Safety Code § 1368, regardless of the Health Insurance Regulator for the Contractor's QHPs.
- b) External Review. Contractor shall comply with State and Federal laws, rules and regulations relating to the external review process, including independent medical review, available to Enrollees for Covered Services.

3.6.3 Applications and Notices

- a) Contractor shall provide applications, forms, and notices to applicants and Enrollees in plain language and in a manner that is accessible and timely to individuals: (1) living with disabilities, including accessible websites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act, or (2) with limited English language proficiency.
- b) Contractor shall provide applications, forms, and notices, including correspondence, in a manner that is accessible and timely to individuals who are limited English proficient as required by Health and Safety Code §§ 1367.04, 1367.041, 1367.042, and Insurance Code §§ 10133.8, and 10133.11. Contractor shall inform individuals of the availability of the services described in this section and otherwise comply with notice requirements imposed under applicable laws, rules and regulations, including, those set forth at 45 C.F.R. § 156.250 and Government Code § 100503(k).

3.6.4 Customer Service Call Center

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

- b) Contractor's call center shall be staffed at levels reasonably necessary to handle call volume and achieve compliance with Performance Standards set forth in Article 6. Contractor shall staff the Call Center with highly trained individuals to provide detailed benefit information, answer Enrollee questions about QHP benefits and coverage, and to resolve claim and benefit issues.
- c) Contractor shall use a telephone system that includes welcome messages in English, Spanish, and other languages as required by State and Federal laws, rules, and regulations.
- d) Contractor shall make oral interpreter services available at no cost for non-English speaking or hearing-impaired Enrollees during regular business hours as required by Federal and State law. Contractor shall monitor the quality and accessibility of call center services on an ongoing basis. Contractor shall report to the Exchange monthly, in a format determined by the Exchange, on the volume of calls received by the call center and Contractor's rate of compliance with related Performance Standards as outlined in Attachment 14.
- e) Contractor shall meet all State requirements for language assistance services for all of its commercial lines of business.

3.6.5 Customer Service Transfers

- a) During Contractor's regularly scheduled customer service hours, Contractor shall have the capability to accept and handle calls transferred from the Exchange and respond to callers requesting additional information from Contractor. Contractor shall maintain staff resources to comply with Performance Standards and sufficient to facilitate a live transfer (from the Exchange to Contractor) of customers who call the Exchange with escalated issues or complaints that need to be addressed by Contractor. The Exchange shall maintain staff resources sufficient to facilitate a live transfer (from Contractor to the Exchange) of customers who call Contractor with escalated issues, complaints, or address changes that need to be addressed by the Exchange. Contractor and the Exchange shall establish a designated customer service team available to handle the live transfer of escalated calls.
- b) Examples of issues or complaints include but are not limited to premium billing or claims issues; benefit coverage questions (before and after enrollment); complaints; network or provider details; and Issuer-specific questions or issues.
- c) Contractor shall refer Enrollees and applicants with questions regarding premium tax credits and Exchange eligibility determinations to the Exchange's website or Service Center, as appropriate.
- d) Contractor shall work with the Exchange to develop a mechanism to track handling and resolution of calls referred from the Exchange to Contractor (such as through the use of call reference numbers).

3.6.6 Customer Care

- a) Contractor shall comply with the applicable requirements of the Americans with Disabilities Act and provide culturally competent customer service to all the Exchange Enrollees in accordance with the applicable provisions of 45 C.F.R. § 155.205 and § 155.210, which refer to consumer assistance tools and the provision of culturally and linguistically appropriate information and related products.
- b) Contractor shall comply with HIPAA rules and other laws, rules and regulations respecting privacy and security, as well as establish protocols for handling the Exchange customers who have documented domestic violence or other security concerns. Contractor shall monitor compliance and file these protocols with the Exchange upon execution of the contract, and subsequently, upon modifications to the protocols.

3.6.7 Notices

- a) For all forms of notices required under Federal and State law to be sent to Enrollees regarding rates, benefit design, network changes, or security/HIPAA references, Contractor shall submit an electronic copy to the Exchange at least five (5) business days in advance of the message transaction. If Contractor is unable to notify the Exchange in advance due to Federal or State notice requirements, Contractor shall send the Exchange notification simultaneously.
- b) Contractor shall provide a link to the Exchange website on its website.
- c) When Contractor provides direct contacts for getting membership assistance, Contractor shall also include the Exchange website for Exchange-related issues.
- d) Contractor shall use standardized member renewal language, developed by the Exchange, and approved by DMHC and CDI for all Enrollee renewal notices.
- e) All legally required notices sent by Contractor to Enrollees shall be translated into and available in languages other than English as required under applicable Federal and State laws, rules and regulations, including, Health and Safety Code §§ 1367.04, 1367.041, 1367.042, and Insurance Code §§ 10133.8, 10133.10, 10133.11.
- f) Contractor shall release notices in accordance with Federal and State law. All such notices shall meet the accessibility and readability standards in the Exchange regulations (45 C.F.R. Parts 155 and 156) located in 10 CCR §§ 6400 et seq.

3.6.8 Issuer-Specific Information

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

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

3.6.9 Enrollee Materials: Basic Requirements

- a) Contractor shall provide or make available to Enrollees Plan materials required under the terms of the Agreement and applicable laws, rules and regulations. Such materials shall be available in languages as required by Federal and State law and receive any necessary regulatory approvals from the relevant Regulators, be provided to the Exchange as directed by the Exchange, and shall include information brochures, a summary of the Plan that accurately reflects the coverage available under the Plan (a Summary of Benefits and Coverage), and related communication materials. Contractor shall, upon request by the Exchange, provide copies of Enrollee communications and give the Exchange the opportunity to comment and suggest changes in such material.
- b) Enrollee materials shall be available in English, Spanish and other languages as required by applicable laws, rules and regulations. Contractor shall comply with Federal and State laws, rules and regulations regarding language access. To the extent possible, Enrollee materials shall be written in plain language, as that term is defined in applicable laws, rules and regulations. Plan materials that require Exchange notification before usage are those that communicate specific eligibility and enrollment and other key information to Enrollees. Such materials may include, but are not limited to:
 - i. Welcome letters;
 - ii. Enrollee ID card with the same product name as used in the Covered California and QHP Issuer websites;
 - iii. Billing notices and statements;
 - iv. Notices of actions to be taken by QHP Issuer that may impact coverage or benefit letters;
 - v. Termination Grievance process materials;
 - vi. Drug formulary information;
 - vii. Uniform Summary of Benefits and Coverage; and
 - viii. Other materials required by the Exchange.

3.6.10 New Enrollee Enrollment Packets

- a) Contractor shall mail or provide online enrollment packets to all new Individual Exchange Enrollees in individual Exchange QHPs within ten (10) business days of receiving complete and accurate enrollment information from the Exchange and the binder payment. Contractor may deliver Enrollee materials pursuant to other methods that are consistent with:

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

- i. Welcome letter;
- ii. Enrollee ID card, in a form approved by the Exchange;
- iii. If Enrollee ID card is not included in the enrollment packet, Contractor must send a notice to the Enrollee that states the ID card will be sent separately, when the Enrollee should expect to receive it, and provide the information necessary for the Enrollee to receive services and for providers to file claims;
- iv. Summary of Benefits and Coverage;
- v. Pharmacy benefit information;
- vi. Nurse advice line information; and
- vii. Other materials required by the Exchange.

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

3.6.11 Summary of Benefits and Coverage

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

3.6.12 Electronic Listing of Participating Providers

Contractor shall create and maintain a continually updated electronic listing of all Participating Providers and make it available online for Enrollees, potential Enrollees, and Participating

Providers, 24 hours a day, 7 days a week as required by Federal and State laws, rules, and regulations, including requirements to identify Providers who are not accepting new Enrollees.

3.6.13 Access to Medical Services Pending ID Card Receipt

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

3.6.14 Explanation of Benefits

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

3.6.15 Secure Plan Website for Enrollees and Providers

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

- a) Upon implementation by Contractor, benefit descriptions, information relating to Covered Services, cost sharing, and other information available;
- b) Ability for Enrollees to view their claims status such as denied, paid, unpaid;
- c) Ability to respond via e-mail to customer service issues posed by Enrollees and Participating Providers;
- d) Ability to provide online eligibility and coverage information for Participating Providers;
- e) Support for Enrollees to receive Plan information by e-mail; and
- f) Enrollee education tools and literature to help Enrollees understand health costs and research condition information.

3.6.16 Required Reports

Contractor shall submit required reports as defined in this contract. For the contractor's convenience, all required reports are listed in the "Contract Reporting Requirements" table found on Covered California's Extranet site:

<https://planmanagement.coveredca.com/Resources/Forms/AllItems.aspx> in the Resources folder, Contract Reporting Compliance subfolder.

Upon request, Contractor shall submit standard reports as described below in a mutually agreed upon manner and time:

- a) Enrollee customer service reports including phone demand and responsiveness, initial call resolution, response to written correspondence, and number/accuracy/timeliness of ID card distribution;
- b) Contractor shall provide utilization data regarding its nurse advice line based on its current standard reporting. Contractor and the Exchange shall work together in good faith to identify mutually agreeable information for Contractor to provide to the Exchange that will be useful in identifying patterns of utilization, including regarding health conditions or symptoms that are frequent topics of calls from Contractor's members;
- c) Use of Plan website;
- d) Quality assurance activities;
- e) Enrollment reports; and
- f) Premiums collected.

3.6.17 Contractor Staff Training about the Exchange

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

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

3.6.18 Customer Service Training Process

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

ARTICLE 4 – QUALITY, NETWORK MANAGEMENT AND DELIVERY SYSTEM STANDARDS

4.1 Exchange Quality Initiatives

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

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

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

4.2 Quality Management Program

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

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

4.3 Utilization Management

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

4.4 Transparency and Quality Reporting

- a) Pursuant to 45 C.F.R. § 156.220, Contractor shall provide the Exchange and Enrollees with information reasonably necessary to provide transparency in Contractor's coverage, and report to the Exchange and Enrollees, the data as required by the Exchange. This includes information relating to claims payment policies and practices, periodic financial disclosures, enrollment, disenrollment, claims denials, rating practices, cost-sharing, payments with respect to any out-of-network coverage, and Enrollee rights. Contractor shall provide information required under this Section to the Exchange and Enrollees in plain language.
- b) Contractor shall timely respond to an Enrollee's request for cost sharing information and shall make cost sharing information available to individuals through the internet and pursuant to other means for individuals without internet access in a timely manner.

4.5 Quality Rating System

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

4.6 Quality Improvement Strategy

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

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

4.7 Data Submission Requirements

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

ARTICLE 5 – FINANCIAL PROVISIONS

5.1 Individual Exchange

5.1.1 Rates and Payments

- a) Schedule of Rates. The Exchange and Contractor have agreed upon monthly premium rates (“Monthly Rates”) payable to Contractor as compensation for Services provided under this Agreement. The Monthly Rates for the Individual Exchange for Plan Year 2017 are set forth at Attachment 8 (“Monthly Rates - Individual Exchange”) and will be updated annually for Plan Years 2018 and 2019 in Attachment 9. The parties acknowledge and agree that the premium amounts set forth under the Monthly Rates are actuarially determined to ensure that premium revenues and cost sharing contributions will provide the total dollar amount necessary to support (i) the provision of Covered Services by Contractor through its QHPs, (ii) administrative expenses and reasonable reserves required by Contractor to meet the requirements outlined in this Agreement and in accordance with applicable laws, rules, and regulations, and (iii) the payment by Contractor of the Participation Fee, as further described in Section 5.1.3.
- b) Updates. If the Term of this Agreement is longer than one year and Contractor’s QHPs are certified for another year, the Monthly Rates for each subsequent year of the Agreement will be established no more frequently than annually in accordance with the procedures set forth at and Section 3.5 and Attachment 9 (“Rate Updates - Individual Exchange”).
- c) Collection and Remittance. Contractor understands that Contractor is responsible for collection and the Enrollee is responsible for remittance of the agreed-upon premium rates to Contractor in a timely manner. Contractor understands that individual Enrollees will remit their monthly premium payments directly to Contractor and the Exchange will not aggregate premiums. The failure by an Enrollee to timely pay premiums may result in a termination of coverage pursuant to the terms set forth at Section 2.2.4. Contractor further understands that the premium payment collected by Contractor includes amounts allocated to the Participation Fee due to the Exchange. The Participation Fees shall be billed by the Exchange to Contractor and payable by Contractor to the Exchange in accordance with the requirements set forth at Section 5.1.3.

5.1.2 Financial Consequences of Non-Payment of Premium

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

shall be conducted in accordance with requirements in this Agreement consistent with applicable laws, rules and regulations.

- b) Enrollee Terminations. In the event Contractor terminates an Enrollee's coverage in a QHP due to non-payment of premiums, loss of eligibility, fraud or misrepresentation, change in Enrollees selection of QHP, decertification of Contractor's QHP or as otherwise authorized under Section 2.2.4, Contractor must include the applicable regulator-approved appeals language, and any Exchange-required appeals language, in its notice of termination of coverage to the Enrollee.
- c) Grace Period. Contractor acknowledges and agrees that applicable laws, rules, and regulations, including the Affordable Care Act and implementing regulations specify a grace period for individuals who receive advance payments of the premium tax credit through the Exchange and that the Knox-Keene Act and Insurance Code set a grace period for other individuals with respect to delinquent payments. Contractor agrees to abide by the requirements set forth at Section 2.2.4 and required under applicable laws, rules, and regulations with respect to these grace periods.

5.1.3 Individual Exchange Participation Fees

- a) Contractor understands and agrees that: (i) under the Affordable Care Act and the California Affordable Care Act, the Exchange may generate funds through a participation fee ("Participation Fees") on Contractor's QHPs, and (ii) Contractor is responsible for the timely payment of any Participation Fees to the Exchange.
- b) Contractor recognizes that the total cost of all Participation Fees for the Exchange must be spread across Contractor's entire book of business in the single risk pool (both inside and outside the Exchange) for the Individual Market.
- c) The Participation Fee payable to the Exchange during each month of the 2019 Plan Year shall be equal to three point seven-five (3.75) percent of the gross premium attributable to each Enrollee in Contractor's QHPs for such month. The Participation Fee will be assessed by the Exchange and payable monthly by Contractor based on the Exchange's gross premium records attributable to Enrollees in Contractor's QHPs sold through the Individual Exchange for 2017-2019. In the case of partial month enrollments, Participation Fees will be adjusted based on the methodology specified in 10 CCR § 6500 (i).

The Participation Fee will be reviewed each year as part of the Exchange's annual budget process. Should the Exchange need to collect or refund any premiums for year 2014-2018, the Participation Fee shall be calculated pursuant to the QHP Issuer Agreement that was in place during the applicable Plan Year or years.

- d) The Exchange will send invoices through email to Contractor monthly for Participation Fees due to the Exchange for the preceding month. The Exchange will provide the Contractor a Member Level Detail file to support that invoice. Contractor's Participation Fee invoice will be based on Contractor's QHP enrollments in the preceding month based on the Exchange's

records and may be adjusted to reflect changes in enrollment that may have occurred in prior months (including additions, terminations, and cancellations of enrollment or changes in gross premiums). Participation Fee payments will be due 15 days from the date the invoice is emailed to Contractor. For invoices paid after 15 days from the date the invoice is emailed, Contractor will be subject to a 1% late fee on the unpaid balance as of that date. The Exchange may only charge one late fee per invoice. The Exchange, in its sole discretion, may waive the late fee for any month if good cause exists for Contractor's failure to make the payment by the due date. Participation Fee payments will be applied to the oldest outstanding invoice or overall balance, including prior month late fees, whichever is greater.

- e) CalHEERS will serve as the system of record for Participation Fee billings. In the event a Contractor finds a discrepancy in the Participation Fees billed or deducted by the Exchange, Contractor will resolve the underlying enrollment issues through the daily 834 interface, or monthly member reconciliation described in Section 2.1.2. If the Contractor still disputes the findings of the Exchange, Contractor may pursue additional remedies in accordance with Section 12.1.
- f) Subject to the provisions of Section 10.5, Contractor agrees to a periodic audit or other examination by the Exchange or its designee regarding the computation and payment of Participation Fees. In the case of material non-compliance with Participation Fee payments, Contractor shall implement any necessary corrective action. The Exchange may perform follow up audits or examinations more frequently than annually to monitor Contractor's implementation of such corrective actions.
- g) Contractor acknowledges that the Exchange is required under Government Code § 100520(c) to maintain a prudent reserve as determined by the Exchange.

ARTICLE 6 – PERFORMANCE STANDARDS

6.1 Standards

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

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

6.2 Penalties and Credits

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

6.3 No Waiver

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

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

ARTICLE 7 – CONTRACT TERM; RECERTIFICATION AND DECERTIFICATION

7.1 Agreement Term

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

7.2 Agreement Termination

7.2.1 Exchange Termination

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

- a) Contractor fails to fulfill an obligation that is material to its status as a QHP Issuer or its performance under the Agreement;
- b) Contractor no longer holds a license or certificate that is required for Contractor to perform its obligations under this Agreement or Contractor otherwise fails to maintain compliance with the “good standing” requirements pursuant to Section 3.1.1 and which impairs Contractor’s ability to provide Services under the Agreement;
- c) Contractor breaches any material term, covenant, warranty, or obligation under this Agreement that is not cured or substantially cured to the reasonable satisfaction of the Exchange within forty-five (45) days after receipt of notice of default from the Exchange; provided, however, that such cure period may not be required and the Exchange may terminate the Agreement immediately if the Exchange determines pursuant to subparagraph (e) below that Contractor’s breach threatens the health and safety of Enrollees;
- d) Contractor knowingly has a director, officer, partner, or person with a beneficial ownership of more than five percent (5%) of Contractor’s equity or has an employment, consulting, or other subcontractor agreement for the provision of Services under this Agreement who is, or has been: (A) excluded, debarred, or suspended from participating in any federally funded health care program, (B) suspended, or debarred from participation in any state contract or procurement process, or (C) convicted of a felony or misdemeanor (or entered a plea of nolo contendere) related to a crime or violation involving the acquisition or dispersal of funds or delivery of Covered Services to beneficiaries of any State or Federal health care program;
- e) The Exchange reasonably determines that (i) the welfare of Enrollees is in jeopardy if this Agreement continues, as such determination shall be made in the reasonable discretion of the Exchange based on consideration of professionally recognized standards and benchmarks, requirements imposed by accreditation agencies, and applicable laws, rules, and regulations; or (ii) Contractor fails to comply with a change in laws, rules or regulations occurring during the term of this Agreement and/or does not take any and all actions that may be required to

amend the Agreement and otherwise establish and document compliance with any such changes; and (iii) the Exchange reasonably determines, based on consultation with legal counsel and/or other regulators and/or other State-based or Federal health benefit exchanges, that it may be at risk of being found noncompliant with Federal or State laws, rules, or regulations.

7.2.2 Contractor Termination

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

- a) The Exchange breaches any material term, covenant, warranty, or obligation under this Agreement that is not cured or substantially cured to the reasonable satisfaction of the Contractor within forty-five (45) days after receipt by the Exchange of notice from the Contractor; or
- b) The Exchange fails to comply with a change in laws, rules or regulations occurring during the term of this Agreement or does not take any and all actions that may be required to amend the Agreement and otherwise establish and document compliance with any such changes, and Contractor reasonably determines, based on consultation with legal counsel and/or other regulators and/or other State-based or Federal health benefit exchanges, that it may be at risk of being found noncompliant with Federal or State laws, rules, or regulations.

7.2.3 Notice of Termination

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

In case a party elects to terminate this Agreement in whole or in part under Section 7.2, the notifying party shall give the other party ninety (90) days written notice of termination for default, specifying the default or defaults justifying the termination. The termination shall become effective after the expiration of such notice period if the defaults specified by the notifying party in its notice remain uncured at that time; provided, however, that the Exchange may require Contractor to discontinue the provision of certain Services if the Exchange determines that the continuing provision of services may cause harm to Enrollees, Participating Providers, or other stakeholders.

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

7.2.4 Remedies in Case of Contractor Default or Breach

- a) In addition to the termination provisions in Section 7.2.1, the Exchange shall have full discretion to institute any of the following remedies, in accordance with Subsection (b) of this Section, in case of Contractor's breach, whether material or not, or default:
 - i. Changing the order in which Contractor's QHPs are displayed in CalHEERS;
 - ii. Removing Contractor's provider directory from the Covered California website;
 - iii. Freezing Contractor's Enrollment during Open or Special Enrollment Periods;
 - iv. Recovery of damages to the Exchange caused by the breach or default; and
 - v. Specific performance of particular covenants made by Contractor hereunder.
- b) Prior to instituting any of the remedies in Subsection (a), the Exchange shall provide written notice to Contractor that Contractor is in breach or default of this Agreement, identify the basis for such breach or default, and provide Contractor with a thirty (30) day period to cure. During the cure period, the parties agree to meet and confer in an effort to informally resolve the breach or default. Contractor shall have thirty (30) days from the date Contractor received notice of the breach or default to fully cure the breach or default, unless the parties mutually agree to a longer cure period. If Contractor has not cured the breach or default within the thirty (30) day period, or a longer cure period that has been mutually agreed upon, the Exchange may institute any of the remedies identified in Subsection (a) of this section. All remedies of the Exchange under this Agreement for Contractor default or breach are cumulative to the extent permitted by law.
- c) This section shall not apply to any contractual requirements that are associated with a performance guarantee in Attachment 14 or for failure to meet any quality targets in Attachment 7.

7.2.5 Contractor Insolvency

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

7.3 Recertification

7.3.1 Recertification Process

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

7.3.2 Non-Recertification Election

- a) Contractor election. Contractor shall provide the Exchange with notice on or before July 1 of each Plan Year whether Contractor will elect to not seek recertification of its QHPs for the following Plan Year (“Non-Recertification Election”). Contractor shall comply with conditions set forth in this Section 7.3.2 with respect to continuation of coverage and transition of Enrollees to new QHPs following the Exchange’s receipt of Contractor’s Non-Recertification Election.
- b) Continuation and Transition of Care. Except as otherwise set forth in this Section 7.3.2, Contractor shall continue to provide Covered Services to Enrollees in accordance with the terms set forth in the Agreement from and after Contractor’s Non-Recertification Election up through the termination of coverage for Enrollees, as such termination of coverage shall be determined in accordance with the requirements of this section.

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

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

- c) Individual Exchange. The following provisions shall apply to the Individual Exchange:
 - i. Following the Exchange’s receipt of the Non-Recertification Election, Contractor must continue to participate in the enrollment and eligibility assignment process, and may be assigned new Enrollees through the end of the calendar year;
 - ii. Contractor will provide coverage for Enrollees assigned to Contractor until the earlier of (i) the end of the calendar year, or (ii) the Enrollee’s transition to another QHP during a Special Enrollment Period.

7.4 Decertification

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

7.5 Effect of Termination

- a) This Agreement shall terminate on the Expiration Date unless otherwise terminated earlier in accordance with the provisions set forth in this Agreement.
- b) Contractor's QHPs shall be deemed decertified and shall cease to operate as QHPs as defined at 10 CCR § 6410 immediately upon termination or expiration of this Agreement in the event uninterrupted continuation of agreement between the Exchange and Contractor is not achieved pursuant to either: (i) an extension of the term of the Agreement based upon the mutual agreement of the parties that is documented pursuant to a written amendment, or (ii) Contractor and the Exchange enter into a new agreement that is effective immediately upon the expiration of this Agreement. There shall be no automatic renewal of this Agreement or recertification of Contractor's QHPs upon expiration of the term of this Agreement. Contractor may appeal the decertification of its QHP that will result in connection with the termination of this Agreement and such appeal shall be conducted pursuant to the Exchange's process and in accordance with applicable laws, rules and regulations.
- c) All duties and obligations of the Exchange and Contractor shall cease upon termination of the Agreement and the decertification of Contractor's QHPs that shall occur upon the termination of this Agreement, except as set forth below or otherwise provided in the Agreement:
 - i. Each party shall remain liable for any rights, obligations, or liabilities that have accrued or arise from activities carried on by it under this Agreement prior to the effective date of termination.
 - ii. Any information of the other party that is in the possession of the other party will be returned promptly, or upon the request of owner of such property, destroyed using reasonable measures to protect against unauthorized access to or use of the information in connection with its destruction, following the earlier of: (i) the termination of this Agreement, (ii) receipt of a written request to return or destroy the Information Assets, or (iii) the termination of the business relationship between the parties. If both parties agree that return or destruction of information is not feasible or necessary, the receiving party will continue to extend the protections outlined in this Agreement to all assets in its possession and will limit further use of that information to those purposes that make the return or destruction of the information or assets. The Exchange reserves the right to inspect the storage, processes, and destruction of any Information Assets provided under this Agreement.

- d) Contractor shall comply with the requirements set forth at Section 7.3.2 in the event that Contractor makes a Non-Recertification Election.
- e) Contractor shall cooperate fully to effect an orderly transfer of Covered Services to another QHP during (i) any notice period set forth at Sections 7.2.3, 7.2.5, or 7.3.2, and (ii) if requested by the Exchange to facilitate the transition of care or otherwise required under Section 7.6, following the termination of this Agreement. Such cooperation shall include the following:
 - i. Upon termination, Contractor, if offering a HMO, shall complete the processing of all claims for benefit payments under the QHP for Covered Services other than Capitated Services, and if offering a PPO, shall complete the processing of all medical claims for benefit payments under Contractor's QHP for Covered Services rendered on or before the termination date.
 - ii. Contractor will provide communications developed or otherwise approved by the Exchange to communicate new QHP information to Enrollees in accordance with a timeline to be established by the Exchange.
 - iii. In order to ensure the proper transition of Services provided prior to, and subsequent to, termination, Contractor will forward to any new QHP Issuer the electronic and direct paper claims that are received by Contractor, but which relate to Services provided by new contractor. Any such information shall be subject to compliance with applicable laws, rules and regulations and shall be sent at such time periods and in the manner requested by the Exchange for a period of up to three (3) months following the termination date.
 - iv. Contractor shall provide customer service to support the processing of claims for Covered Services rendered on or before the termination date for a period of two (2) months or such other longer period reasonably requested by the Exchange at a cost to be mutually agreed upon per Enrollee.
 - v. If so instructed by the Exchange in the termination notice, Contractor shall promptly discontinue the provision of Services requested by the Exchange to be discontinued as of the date requested by the Exchange.
 - vi. Contractor will perform reasonable and necessary acts requested by the Exchange and as required under applicable laws, rules, regulations, consistent with industry standards to facilitate transfer of Covered Services herewith to a succeeding Contractor. Contractor shall comply with requirements reasonably imposed by the Exchange relating to (i) the discontinuation of new enrollment or re-enrollment in Contractor's QHP, (ii) the transfer of Enrollee coverages to another QHP prior to the commencement date, (iii) the expiration of existing quotes, and (iv) such other protocols that may reasonably be established by the Exchange.

- vii. Contractor will reasonably cooperate with the Exchange and any successor QHP Issuer in good faith with respect to taking such actions that are reasonably determined to be the best interest of the QHP Issuer, and Enrollees.
- f) Contractor shall cooperate with the Exchange's conduct of an accounting of amounts paid or payable and Enrollees enrolled during the month in which termination is effective in order to assure an appropriate determination of premiums earned by and payable to Contractor for Services rendered prior to the date of termination, which shall be accomplished as follows:
 - 1) Mid-Month Termination: For a termination of this Agreement that occurs during the middle of any month, the premium for that month shall be apportioned on a pro rata basis. Contractor shall be entitled to premiums from Enrollees for the period of time prior to the date of termination and Enrollees shall be entitled to a refund of the balance of the month. Contractor shall follow the methodology specified in 10 CCR § 6500 (i) for the refund of any excess premiums paid.

The same methodology shall apply to proration of APTC and CSR amounts for a coverage lasting less than one month.
 - 2) Responsibility to Complete Contractual Obligations: Contractor is responsible for completing submission and corrections to Encounter Data for Covered Services received by Enrollees during the period of the Agreement. Contractor is responsible for submitting any outstanding financial or other reports required for Covered Services rendered or Claims paid during the term of the Agreement.
- g) Contractor shall (i) provide such other information to the Exchange, Enrollees and/or the succeeding QHP Issuer, and/or (ii) take any such further action as is required to effect an orderly transition of Enrollees to another QHP in accordance with requirements set forth under this Agreement and/or necessary to the continuity and transition of care in accordance with applicable laws, rules, and regulations.

7.6 Coverage Following Termination and Decertification

- a) Upon the termination of the Agreement or decertification of one or more of Contractor's QHPs, Contractor shall cooperate fully with the Exchange in order to effect an orderly transition of Enrollees to another QHP as directed by the Exchange. This cooperation shall include: (i) attending post-termination meetings, (ii) providing or arranging for the provision of Covered Services as may be deemed necessary by Participating Providers to assure the appropriate continuity of care, and (iii) communicating with affected Enrollees in cooperation with the Exchange and the succeeding contractor as applicable, as reasonably requested by the Exchange.
- b) In the event the termination or expiration of the Agreement requires the transfer of some or all Enrollees into any other health plan, the terms of coverage under Contractor's QHP shall not be carried over to the replacement QHP, but rather the transferred Enrollees shall be entitled

only to the extent of coverage offered through the replacement QHP as of the effective date of transfer to the new QHP.

- c) Notwithstanding the foregoing, the coverage of Enrollee under Contractor's QHP may be extended to the extent that an Enrollee qualifies for an extension of benefits including, those to effect the continuity of care required due to hospitalization or disability. For purposes of this Agreement, "disability" means that the Enrollee has been certified as being totally disabled by the Enrollee's treating physician, and the certification is approved by Contractor. Such certification must be submitted for approval within thirty (30) days from the date coverage is terminated. Recertification of Enrollee's disability status must be furnished by the treating Provider not less frequently than at sixty (60) calendar day intervals during the period that the extension of benefits is in effect. The extension of benefits shall be solely in connection with the condition causing total disability. This extension, which is contingent upon payment of the applicable premiums, shall be provided for the shortest of the following periods:
- i. Until total disability ceases;
 - ii. For a maximum period of twelve (12) months after the date of termination, subject to plan maximums;
 - iii. Until the Enrollee's enrollment in a replacement plan; or
 - iv. Recertification.

ARTICLE 8 –INSURANCE AND INDEMNIFICATION

8.1 Contractor Insurance

8.1.1 Required Coverage

- a) Without limiting the Exchange’s right to obtain indemnification or other forms of remedies or relief from Contractor or other third-parties, Contractor shall, at its sole cost and expense, obtain, and during the term of this Agreement, maintain in full force and effect, the insurance coverage described in this section and as otherwise required by law, including, without limitation, coverage required to be provided and documented pursuant to § 1351 (o) of the Health and Safety Code and relating to insurance coverage or self-insurance: (i) to respond to claims for damages arising out of the furnishing of Covered Services, (ii) to protect against losses of facilities where required by the director, and (iii) to protect against workers’ compensation claims arising out of work-related injuries that might be brought by the employees and staff of Contractor. All insurance shall be adequate to provide coverage against losses and liabilities attributable to the acts or omissions of Contractor in performance of this Agreement and to otherwise protect and maintain the resources necessary to fulfill Contractor’s obligations under this Agreement. The minimum acceptable limits shall be as indicated below:
- i. Commercial general liability or equivalent self-insurance covering the risks of bodily injury (including death), property damage, and personal injury, including coverage for contractual liability, with a limit of not less than \$1 million per occurrence/\$2 million general aggregate;
 - ii. Comprehensive business automobile liability (owned, hired, or non-owned vehicles used by Contractor in connection with performance of its obligations under this Agreement) covering the risks of bodily injury (including death) and property damage, including coverage for contractual liability, with a limit of not less than \$1 million per accident;
 - iii. Employers liability insurance covering the risks of Contractor’s employees and employees’ bodily injury by accident or disease with limits of not less than \$1 million per accident for bodily injury by accident, and \$1 million per employee for bodily injury by disease, and \$1 million disease policy limit;
 - iv. Umbrella policy providing excess limits over the primary general liability, automobile liability, and employer’s liability policies in an amount not less than \$10 million per occurrence and in the aggregate;
 - v. Crime coverage at such levels consistent with industry standards and reasonably determined by Contractor to cover occurrences falling in the following categories: computer and funds transfer fraud; forgery; money and securities; and employee theft; and

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

8.1.2 Workers' Compensation

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

8.1.3 Subcontractor Coverage

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

8.1.4 Continuation of Required Coverage

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

8.1.5 Premium Payments and Disclosure

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

8.2 Indemnification

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

- a) Arise out of or are due to a breach by Contractor of any of its representations, warranties, covenants or other obligations contained in this Agreement; or
- b) Are caused by or resulting from Contractor's acts or omissions constituting bad faith, willful misfeasance, negligence, or reckless disregard of its duties under this Agreement or applicable laws, rules, and regulations; or
- c) Accrue or result to any of Contractor's subcontractors, material men, laborers, or any other person, firm, or entity furnishing or supplying services, material, or supplies in connection with the performance of this Agreement.

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

- a) Providing Contractor with reasonable written notice of any claim for which indemnification is sought;
 - b) Allowing Contractor to control the defense and settlement of such claim; provided, however, that the Contractor consults with the Exchange regarding the defense of the claim and any possible settlements and agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on the Exchange without the Exchange's prior written consent, which will not be unreasonably withheld; and,
 - c) Cooperating fully with the Contractor in connection with such defense and settlement.
- Indemnification under this section is limited as described herein.

ARTICLE 9 – PRIVACY AND SECURITY

9.1 Privacy and Security Requirements for Personally Identifiable Data

- a) HIPAA Requirements. Contractor agrees to comply with applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), including the Administrative Simplification Provisions of HIPAA, as codified at 42 U.S.C. § 1320d et seq., the Health Information Technology for Economic and Clinical Health Act of 2009 (“HITECH”), and any current and future regulations promulgated under HITECH or HIPAA, all as amended from time to time and collectively referred to herein as the “HIPAA Requirements”. Contractor agrees not to use or further disclose any Protected Health Information, other than as permitted or required by the HIPAA Requirements and the terms of this Agreement.
- b) Exchange Requirements. With respect to Contractor Exchange Functions, Contractor agrees to comply with following privacy and security requirements and standards applicable to Personally Identifiable Information which have been established and implemented by the Exchange in accordance with the requirements of 45 C.F.R. Part 155 (collectively, “the Exchange Requirements”):
 - i. Uses and Disclosures. Pursuant to the terms of this Agreement, Contractor may receive from the Exchange Protected Health Information and/or Personally Identifiable Information in connection with Contractor Exchange Functions that is protected under applicable Federal and State laws and regulations. Contractor shall not use or disclose such Protected Health Information or Personally Identifiable Information obtained in connection with Contractor Exchange Functions other than as is expressly permitted under the Exchange Requirements and only to the extent necessary to perform the functions called for within this Agreement.
 - ii. Fair Information Practices. Contractor shall implement reasonable and appropriate fair information practices to ensure:
 1. Individual Access. Contractor shall provide access to, and permit inspection and copying of Protected Health Information and Personally Identifiable Information in either an electronic or hard copy format as specified by the individual and as required by law, within thirty (30) days of such request from the individual. If the Contractor denies access, in whole or in part, the Contractor must provide a written denial within the time limits for providing access, which includes the basis for the denial and a statement of the individual’s review rights, if applicable. In the event any individual requests access to Protected Health Information or Personally Identifiable Information maintained by the Exchange or another health plan directly from Contractor, Contractor shall within five (5) days forward such request to the Exchange and the relevant health plan as needed.

2. Amendment. Contractor shall provide an individual with the right to request an amendment of inaccurate Protected Health Information and Personally Identifiable Information. Contractor shall respond to such individual within sixty (60) days of such a request either by making the correction and informing the individual of such correction or notifying the individual in writing that the request was denied, which notice shall provide an explanation for the denial and explain that the individual may submit a statement of disagreement with the denial.
3. Openness and Transparency. Contractor shall make available to individuals applicable policies, procedures, and technologies that directly affect such individuals and/or their Protected Health Information and Personally Identifiable Information.
4. Choice. Contractor shall provide individuals with a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their Protected Health Information and Personally Identifiable Information.
5. Limitations. Contractor represents and warrants that all Protected Health Information and Personally Identifiable Information shall be collected, used, and/or disclosed under this Agreement only to the extent necessary to accomplish a specified purpose under the terms of this Agreement or as permitted by the Exchange Requirements and never to discriminate inappropriately.
6. Data Integrity. Contractor shall implement policies and procedures reasonably intended to ensure that Protected Health Information and Personally Identifiable Information in its possession is complete, accurate, and current, to the extent necessary for the Contractor's intended purposes, and has not been altered or destroyed in an unauthorized manner.
7. Safeguards. Contractor shall have in place administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Protected Health Information and Personally Identifiable Information that it creates, receives, maintains, or transmits pursuant to the Agreement and to prevent the use or disclosure of Protected Health Information and/or Personally Identifiable Information other than as provided for in this Agreement, or as required by law. In furtherance of compliance with such requirements, Contractor shall:
 - a. Encrypt all Protected Health Information and/or Personally Identifiable Information that is in motion or at rest, including but not limited to data on portable media devices, using commercially reasonable means, consistent with applicable Federal and State laws, regulations and agency guidance, including but not limited to the U.S. Department of Health and Human Services Guidance Specifying the Technologies and Methodologies That Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements or issued by the National Institute for Standards and Technology ("NIST") concerning the protection of identifiable data such as Protected Health Information and/or Personally Identifiable Information.

Data centers shall be encrypted or shall otherwise comply with industry data security best practices;

- b. Implement a contingency plan for responding to emergencies and/or disruptions to business that in any way affect the use, access, disclosure, or other handling of Protected Health Information and/or Personally Identifiable Information;
 - c. Maintain and exercise a plan to respond to internal and external security threats and violations;
 - d. Maintain an incident response plan;
 - e. Maintain technology policies and procedures that provide reasonable safeguards for the protection of Protected Health Information and Personally Identifiable Information stored, maintained, or accessed on hardware and software utilized by Contractor and its subcontractors and Agents;
 - f. Mitigate to the extent practicable, any harmful effect that is known to Contractor of any Security Incident related to Protected Health Information and/or Personally Identifiable Information or of any use or disclosure of Protected Health Information and/or Personally Identifiable Information by Contractor or its subcontractors or Agents in violation of the requirements of this Agreement or applicable privacy and security laws and regulations and agency guidance;
 - g. Destroy Protected Health Information and Personally Identifiable Information in a manner consistent with applicable State and Federal laws, regulations, and agency guidance on the destruction of Protected Health Information and Personally Identifiable Information; and
 - h. Comply with all applicable Exchange policies within Section 9.2. Protection of Information Assets, including, but not limited to, executing non-disclosure agreements and other documents required by such policies. Contractor shall also require any subcontractors and Agents to comply with all such Exchange policies.
- c) California Requirements. With respect to all provisions of information under this Agreement, Contractor agrees to comply with all applicable California state health information privacy and security laws applicable to Personally Identifiable Information, including but not limited to the confidentiality of the Medical Information Act, the California Insurance Information and Privacy Protection Act, and the Information Practices Act, all collectively referred to as “California Requirements.”
- d) Interpretation. Notwithstanding any other provisions in this section, to the extent a conflict arises between the permissibility of a use or disclosure of Protected Health Information or Personally Identifiable Information under the HIPAA Requirements, the Exchange Requirements, or California Requirements with respect to Contractor Exchange Functions, the applicable requirements imposing the more stringent privacy and security standards to such uses and disclosures shall apply. In addition, any ambiguity in this Agreement regarding the

privacy and security of Protected Health Information and/or Personally Identifiable Information shall be resolved to permit the Exchange and Contractor to comply with the most stringent of the applicable privacy and security laws or regulations.

e) Breach Notification.

- i. Contractor shall report to the Exchange any Breach or Security Incident reasonably calculated to result in the Breach of PII or PHI created or received in connection with Contractor Exchange Functions in accordance with the provisions set forth herein. For purposes of this Paragraph (e), a “Breach” shall, in accordance with the HIPAA Breach Notification Rule, mean the impermissible use or disclosure of PII or PHI within Contractor’s custody or control which is reasonably calculated to compromise the security or privacy of any such PII or PHI [45 CFR § 164.400-414]. For purposes of this Paragraph (e), a “Security Incident” shall, in accordance with the HIPAA Security Rule, mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or the interference with system operations in an information system [45 CFR § 164.304].
- ii. Contractor shall, without unreasonable delay, but no later than within three (3) business days after Contractor’s discovery of a Breach or Security Incident reasonably calculated to result in a Breach of PII or PHI subject to this agreement, submit an initial report regarding any such Breach or Security Incident to the Exchange. Reports shall be made on a form made available to Contractor by the Exchange.
- iii. Contractor shall cooperate with the Exchange in investigating any such Breach or Security Incident and in meeting the Exchange’s obligations, if any, under applicable State and Federal security breach notification laws, regulatory obligations, or agency requirements. If the cause of the Breach or Security Incident is attributable to Contractor or its Agents or subcontractors, Contractor shall be responsible for Breach notifications and reporting as required under applicable Federal and State laws, regulations, and agency guidance. Such notification(s) and required reporting shall be done in cooperation with the Exchange.
- iv. To the extent possible, Contractor’s initial report shall include: (a) the names of the individual(s) whose Protected Health Information and/or Personally Identifiable Information has been, or is reasonably believed by Contractor to have been accessed, acquired, used, or disclosed. In the event of a Security Incident, Contractor shall provide such information regarding the nature of the information system intrusion and any systems potentially compromised; (b) a brief description of what happened including the date of the incident and the date of the discovery of the incident, if known; (c) a description of the types of Protected Health Information and/or Personally Identifiable Information that were involved in the incident, as applicable; (d) a brief description of what Contractor is doing or will be doing to investigate, to mitigate harm to the individual(s) and to its information systems, and to protect against recurrences; and (e) any other information that the Exchange determines it needs to include in notifications to the individual(s) or relevant regulatory authorities under applicable privacy and security requirements.

- v. Within three (3) days of conducting its investigation, unless an extension is granted by the Exchange, Contractor shall file a final report, which shall identify and describe the results and outcome of Contractor's above-referenced investigation and mitigation efforts. Contractor shall make all reasonable efforts to obtain the information listed above and shall provide an explanation if any information cannot be obtained. Contractor and the Exchange will cooperate in developing content for any public statements.

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

- i. Subcontractors and Agents. Contractor shall enter into an agreement with any Agent or subcontractor that will have access to Protected Health Information and/or Personally Identifiable Information that is received from, or created or received by, Contractor on behalf of the Exchange or in connection with this Agreement, or any of its contracting Plans pursuant to which such Agent or subcontractor agrees to be bound by the same or more stringent restrictions, terms and conditions as those that apply to Contractor pursuant to this Agreement with respect to such Protected Health Information and Personally Identifiable Information.
- ii. Exchange Operations. Unless otherwise agreed to by the Contractor and the Exchange, Contractor shall provide de-identified patient medical and pharmaceutical information needed by the Exchange to effectively oversee and administer the Plans. As used in this Subsection (f), the term "de-identified" shall have the meaning set forth in 45 C.F.R. § 164.514.
- iii. Records and Audit. Contractor agrees to make its internal practices, books and records relating to the use and disclosure of Protected Health Information and/or Personally Identifiable Information received from the Exchange, or created or received by Contractor on behalf of the Exchange or in connection with this Agreement available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Contractor's and/or the Exchange's compliance with HIPAA Requirements. In addition, Contractor shall provide the Exchange with information concerning its safeguards described throughout this section and/or other information security practices as they pertain to the protection of Protected Health Information and Personally Identifiable Information, as the Exchange may from time to time request. Failure of Contractor to complete or to respond to the Exchange's request for information within the reasonable timeframe specified by the Exchange shall constitute a material breach of this Agreement. In the event of a Breach or Security Incident related to Protected Health Information and/or Personally Identifiable Information or any use or disclosure of Protected Health Information and/or Personally Identifiable Information by Contractor in violation of the requirements of this Agreement, the Exchange will be permitted access to Contractor's facilities in order to review policies, procedures, and controls relating solely to compliance with the terms of this Agreement.

- iv. Electronic Transactions Rule. In conducting any electronic transaction that is subject to the Electronic Transactions Rule on behalf of any Plan, Contractor agrees to comply with all applicable requirements of the Electronic Transactions Rule set forth in 45 C.F.R. Part 162. Contractor agrees to require that any Agent, including a subcontractor, of Contractor that conducts standard transactions with Protected Health Information and/or Personally Identifiable Information of the Plan comply with all applicable requirements of the Electronic Transactions Rule.
- v. Minimum Necessary. Contractor agrees to request and use only the minimum necessary type and amount of Protected Health Information required to perform its services and will comply with any regulations promulgated under the HIPAA Requirements and agency guidance concerning the minimum necessary standard pertaining to Protected Health Information. Contractor will collect, use, and disclose Personally Identifiable Information only to the extent necessary to accomplish a specified purpose under this Agreement.
- vi. Indemnification. Contractor shall indemnify, hold harmless, and defend the Exchange from and against any and all costs (including mailing, labor, administrative costs, vendor charges, and any other costs the Exchange determines to be reasonable), losses, penalties, fines, and liabilities arising from or due to a Breach or other non-permitted use or disclosure of Protected Health Information and/or Personally Identifiable Information by Contractor or its subcontractors or Agents, including without limitation, (1) damages resulting from any action under applicable (a) HIPAA Requirements, (b) the Exchange Requirements or (c) California Requirements, and (2) the costs of the Exchange actions taken to: (i) notify the affected individual(s) and other entities of and to respond to the Breach; (ii) mitigate harm to the affected individual(s); and (iii) respond to questions or requests for information about the Breach or other impermissible use or disclosure of Protected Health Information and/or Personally Identifiable Information.
- g) Privacy Policy. The Exchange shall notify Contractor of any limitation(s) in its Privacy Policy, to the extent that such limitation may affect Contractor's use or disclosure of Protected Health Information and/or Personally Identifiable Information.
- h) Reporting Violations of Law. Contractor may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(2), other provisions within the HIPAA Requirements, or any other applicable State or Federal laws or regulations.
- i) Survival. Notwithstanding anything to the contrary in the Agreement, the provisions of this Section 9.1 on the Protection of Personally Identifiable Information shall survive termination of the Agreement with respect to information that relates to Contractor Exchange functions until such time as all Personally Identifiable Information and Protected Health Information is destroyed by assuring that hard copy Personally Identifiable Information and Protected Health Information will be shredded and electronic media will be cleared, purged, or destroyed consistent with National Institute of Standards and Technology Guidelines for Media

Sanitization, or is returned to the Exchange, in a manner that is reasonably acceptable to the Exchange.

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

9.2 Protection of Information Assets

- a) The following terms shall apply as defined below:
- i. "Information Assets" means any information, including Confidential Information, necessary to the operation of either party that is created, stored, transmitted, processed, or managed on any hardware, software, network components, or any printed form, or is communicated orally. "Information Assets" does not include information that has been transferred from the Disclosing Party to the Receiving Party under applicable laws, regulations, and agency guidance, and that is being maintained and used by the Receiving Party solely for purposes that are not Contractor Exchange Functions.
 - ii. "Confidential Information" includes, but is not limited, to any information (whether oral, written, visual, or fixed in any tangible medium of expression), relating to either party's services, operations, systems, programs, inventions, techniques, suppliers, customers and prospective customers (excluding the Exchange), cost and pricing data, trade secrets, know-how, processes, plans, reports, designs, and any other information of or relating to the business or either party, including Contractor's programs, but does not include information that (a) is described in the Evidence of Coverage booklets; (b) was known to the Receiving Party before it was disclosed to the Receiving Party by the Disclosing Party, (c) was or becomes available to the Receiving Party from a source other than the Disclosing Party, provided such fact is evidenced in writing and the source is not bound by a confidentiality obligation regarding such information to Disclosing Party, or (d) is developed by either party independently of the other party's Confidential Information, provided that such fact can be adequately documented.
 - iii. "Disclosing Party" means the party who sends Information Assets that it owns to the other party for the purposes outlined in this Agreement.

- iv. "Receiving Party" means the party who receives Information Assets owned by the other party.
- b) The Receiving Party shall hold all Information Assets of the Disclosing Party in confidence and will not use any of the Disclosing Party's Information Assets for any purpose, except as set forth in this Agreement, or as otherwise required by law, regulation, or compulsory process.
- c) The Receiving Party must take all reasonable and necessary steps to prevent the unauthorized disclosure, modification, or destruction of the Disclosing Party's Information Assets. The Receiving Party must, at a minimum, use the same degree of care to protect the Disclosing Party's Information Assets that it uses to protect its own Information Assets.
- d) The Receiving Party agrees not to disclose the Disclosing Party's Information Assets to anyone, except to employees or third parties who require access to the Information Assets pursuant to this Agreement, but only where such third parties have signed agreements regarding the Information Assets containing terms that are equivalent to, or stricter than, the terms of this section, or as otherwise required by law.
- e) In the event the Receiving Party is requested to disclose the Disclosing Party's Information Assets pursuant to a request under the California Public Records Act (PRA), a summons, subpoena, or in connection with any litigation, or to comply with any law, regulation, ruling, or government or public agency request, the Receiving Party shall, to the extent it may do so lawfully, give the Disclosing Party five (5) business days' notice of such requested disclosure and afford the Disclosing Party the opportunity to review the request before Receiving Party discloses the Information Assets. The Disclosing Party shall, in accordance with applicable law, have the right to take such action as it reasonably believes may be necessary to protect the Information Assets, and such action shall not be restricted by the dispute resolution process of this Agreement. If such request is pursuant to the PRA, the Exchange shall give Contractor five (5) business days' notice to permit Contractor to consult with the Exchange prior to disclosure of any Confidential Information. This subdivision shall not apply to restrict disclosure of any information to the State or in connection with a dispute between the Exchange and Contractor or any audit or review conducted pursuant to this Agreement.
- f) The Receiving Party shall notify the Disclosing Party in writing of any unauthorized disclosure, modification, or destruction of the Disclosing Party's Information Assets by the Receiving Party, its officers, directors, employees, contractors, Agents, or third parties. The Receiving Party shall make this notification promptly upon becoming aware of such disclosure, modification, or destruction, but in any event, not later than four (4) days after becoming aware of the unauthorized disclosure, modification, or destruction. After such notification, the Receiving Party agrees to cooperate reasonably, at the Receiving Party's expense, with the Disclosing Party to remedy or limit the unauthorized disclosure, modification, or destruction, and/or its effects.

- g) The Receiving Party understands and agrees the Disclosing Party may suffer immediate, irreparable harm in the event the Receiving Party fails to comply with any of its obligations under this section, that monetary damages will be inadequate to compensate the Disclosing Party for such breach and that the Disclosing Party shall have the right to enforce this section by injunctive or other equitable remedies. The provisions of this section shall survive the expiration, or termination, for any reason, of this Agreement.
- h) To the extent that information subject to this section on Protection of Information Assets is also subject to HIPAA Requirements, the Exchange Requirements or California Requirements in Section 9.1(b) and (c), such information shall be governed by the provisions of Section 9.1. In the event of a conflict or inconsistency between the requirements of the various applicable sections and attachments of this Agreement, including Section 9.1 and this Section 9.2, Contractor shall comply with the provisions that provide the greatest protection against access, use, or disclosure.
- i) Survival. Notwithstanding anything to the contrary in the Agreement, the provisions of this Section 9.2 on Information Assets shall survive termination of the Agreement until such time as all Information Assets provided by the Exchange to Contractor, or created, received, or maintained by Contractor on behalf of the Exchange, is destroyed by assuring that hard copy Information Assets will be shredded and electronic media will be cleared, purged, or destroyed consistent with National Institute of Standards and Technology Guidelines for Media Sanitization or is returned to the Exchange, in a manner that is reasonably acceptable to the Exchange.

ARTICLE 10 – RECORDKEEPING

10.1 Clinical Records

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

10.2 Financial Records

- a) Except as otherwise required to be maintained for a longer period by law or this Agreement, financial records, supporting documents, statistical records and all other records pertinent to amounts paid to or by Contractor in connection with this Agreement shall be retained by Contractor for at least ten (10) years from the date of the final claims payment. Contractor shall maintain accurate books, accounts, and records and prepare all financial statements in accordance with Generally Accepted Accounting Principles, applicable laws, rules and regulations, and requirements imposed by any governmental or regulatory authority having jurisdiction over Contractor.
- b) Contractor shall maintain adequate data customarily maintained and reasonably necessary to properly document each of its transactions with Participating Providers, the Exchange, and Enrollees during the period this Agreement remains in force and will keep records of claims, including medical review and high dollar special audit claims, for a period of ten (10) years or for such length of time as required by Federal or State law, whichever is longer. Subject to compliance with applicable laws, rules and regulations, including, those relating to confidentiality and privacy, at the end of the ten (10) year retention period, at the option of the Exchange, records shall either be transferred to the Exchange at its request or destroyed.
- c) Contractor shall maintain historical claims data and other records and data relating to the utilization of Covered Services by Enrollees on-line for two (2) years from date that the Agreement is terminated with respect to Covered Services provided to Enrollees during the term of this Agreement. These records shall include, but are not limited to, the data elements necessary to produce specific reports mutually agreed upon by the Exchange and Contractor and in such form reasonably required by the Exchange that is consistent with industry

standards and requirements of Health Insurance Regulators regarding statistical, financial, and/or data reporting requirements, including information relating to diagnosis, treatment, amounts billed (allowed and paid), dates of service, procedure numbers, deductible, out-of-pocket, and other cost sharing for each claim.

10.3 Storage

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

10.4 Back-Up

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

10.5 Examination and Audit Results

- a) Contractor shall immediately submit to the Exchange the results of final financial, market conduct, or special audits/reviews performed by the Department of Managed Health Care, California Department of Health Care Services, California Department of Insurance, US Department of Health and Human Services, and/or any other regulatory entity within the State of California that has jurisdiction where Contractor serves Enrollees.
- b) Contractor agrees to subject itself to the Exchange for audits/reviews, either by the Exchange or its designee, or the Department of General Services, the Bureau of State Audits or their designee, as they deem necessary to determine the correctness of premium rate setting, the Exchange's payments to Agents based on the Contractor's report, questions pertaining to Enrollee premium payments and advance premium tax credit payments and participation fee payments Contractor made to the Exchange. Contractor also agrees to all audits subject to applicable State and Federal law regarding the confidentiality of and release of confidential Protected Health Information of Enrollees.

- c) Contractor agrees that the Exchange, the Department of General Services, the Bureau of State Audits, or their designated representative, shall, subject to applicable State and Federal law regarding the confidentiality and release of Protected Health Information of Enrollees, have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement.
- d) Contractor agrees to take corrective actions of an audit/review findings within ninety (90) days. In the instance Contractor cannot complete the corrective action of a finding within ninety (90) days, it shall submit a status report to the Exchange stating why it cannot correct the finding within the specified time frame and shall propose another date for correction. In all instances, Contractor and the Exchange will do their best to resolve an audit/review finding within one hundred sixty (160) days. Should Contractor disagree with the Exchange's management decision on an audit/review finding, it may appeal such management decision to the Exchange Executive Director whose decision is final and binding on the parties, in terms of administrative due process.

10.6 Notice

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

10.7 Confidentiality

The Exchange understands and agrees that Contractor shall only be obligated to provide access to such information to the extent that: (1) access to such information is permitted by applicable State and Federal law and regulation, including, but not limited to, State and Federal law or regulation relating to confidential or private information; and (2) it would not cause Contractor to breach the

terms of any contract to which Contractor is a party. Contractor shall use efforts reasonably acceptable to obtain any necessary consents relating to Contractor's access to information.

10.8 Tax Reporting

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

10.9 Electronic Commerce

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

ARTICLE 11 – INTELLECTUAL PROPERTY

11.1 Warranties

- a) Contractor represents, warrants and covenants to the best of its knowledge that:
- i. It has secured and will secure all rights and licenses necessary for its performance of this Agreement, including but not limited to consents, waivers, releases from all authors of or owners of any copyright interests in music or performances used, individuals, and talent (radio, television, and motion picture talent), owners of any interest in and to real estate site, locations, property, or props that may be used or shown.
 - ii. To the best of the Contractor’s knowledge, neither Contractor’s performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary or contractual right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.
 - iii. Neither Contractor’s performance nor any part of its performance will violate the right of privacy of, or constitute false or misleading advertising or a libel or slander against any person or entity.
 - iv. It has not granted and shall not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to the Exchange in this Agreement.
 - v. It has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation, or maintenance of computer software in violation of copyright laws.
 - vi. It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor’s performance of this agreement.
- b) EXCEPT AS EXPRESSLY STATED ELSEWHERE IN THIS AGREEMENT, THE EXCHANGE AND CONTRACTOR MAKE NO WARRANTY AND EXPRESSLY DISCLAIM ANY WARRANTY, EXPRESS OR IMPLIED, THAT THEIR INTELLECTUAL PROPERTY OR THE INTELLECTUAL PROPERTY RESULTING FROM THIS AGREEMENT IS MERCHANTABLE, FIT FOR A PARTICULAR PURPOSE,

OR DOES NOT INFRINGE UPON ANY PATENT, TRADEMARK, COPYRIGHT OR THE LIKE, NOW EXISTING OR SUBSEQUENTLY ISSUED.

11.2 Intellectual Property Indemnity

- a) Subject to Subsection (c) hereof, Contractor agrees to indemnify and hold the Exchange harmless from any expense, loss, damage, or injury; to defend at its own expense any and all claims, suits, and actions; and to pay any judgments or settlements against the Exchange to the extent they arise or are due to infringement of third-party intellectual property rights enforceable in the U.S., misuse of third-party confidential or trade secret information, failure to obtain necessary third-party consents, waivers or releases, violation of the right of privacy or publicity, false or misleading advertising, libel or slander, or misuse of social media, by Contractor or any Contractor Intellectual Property. Contractor's indemnification obligations under this section are subject to Contractor receiving prompt notice of the claim after the Exchange becomes aware of such claim and being given the right to control the defense of such claim. Should any Intellectual Property licensed by the Contractor to the Exchange under this Agreement become the subject of an Intellectual Property infringement claim or other claim for which Contractor is obligated to indemnify the Exchange, Contractor will promptly take steps reasonably and in good faith to preserve the Exchange's right to use the licensed Intellectual Property in accordance with this Agreement at no expense or disruption to the Exchange, except as otherwise stated in this Agreement. The Exchange shall have the right to monitor and appear through its own counsel (at Exchange's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for the Exchange to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property, as its sole remedy.
- b) Notwithstanding anything to the contrary in this Agreement, any such indemnification obligation of Contractor shall not extend to any infringement or alleged infringement to the extent that such infringement or alleged infringement resulted from (i) specific instructions to use certain Intellectual Property given to Contractor by the Exchange; (ii) the Exchange's unauthorized modification of Contractor Intellectual Property; (iii) the Exchange's use of Contractor Intellectual Property in combination with any service or product not supplied, recommended or approved by Contractor, or used by the Exchange in a manner for which it was not authorized; or (iv) Intellectual Property created or derived by the Exchange.
- c) Contractor agrees that damages alone would be inadequate to compensate the Exchange for breach of any term of this Article by Contractor. Contractor acknowledges the Exchange would suffer irreparable harm in the event of such breach and agrees the Exchange shall be entitled to seek equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

11.3 Federal Funding

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

11.4 Ownership and Cross-Licenses

- a) Intellectual Property Ownership. As between Contractor and the Exchange, each Party shall remain at all times the sole and exclusive owner of all right, title and interest in and to the Intellectual Property that it owned or used prior to entry into this Agreement, or that it developed in the course of performance of this Agreement. Any Intellectual Property created by either Party in the performance of this Agreement shall not be considered a “work made for hire” of the other Party, as “work made for hire” is defined in the United States Copyright Act, 17 U.S.C. § 101. Any rights not licensed to the other Party hereunder are expressly reserved exclusively by the originating Party.
- b) License of Intellectual Property. Each Party (a “Licensor”) grants the other Party (a “Licensee”) the non-exclusive, royalty-free, paid-up, worldwide, irrevocable, right, during the term of this Agreement, to use the Licensor’s Intellectual Property solely for the purposes of this Agreement and to carry out the Party’s functions consistent with its responsibilities and authority as set forth in the enable legislation and regulations. Such licenses shall not give the Licensee any ownership interest in or rights to the Intellectual Property of the Licensor. Each Licensee agrees to abide by all third-party license and confidentiality restrictions or obligations applicable to the Licensor’s Intellectual Property of which the Licensor has notified the Licensee in writing.
- c) Definition of Intellectual Property. For purposes of this Agreement, “Intellectual Property” means recognized protectable rights and interests such as: patents (whether or not issued), copyrights, trademarks, service marks, applications for any of the foregoing, inventions, Confidential Information, trade secrets, trade dress, domain names, logos, insignia, color combinations, slogans, moral rights, right of publicity, author’s rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or hereafter come into existence, and all registrations, renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction. For the avoidance of doubt, Protected Health Information and Personally Identifiable Information are not included in the definition of Intellectual Property, and are addressed under Article 9.

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

11.5 Survival

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

ARTICLE 12 – SPECIAL TERMS AND CONDITIONS

12.1 Dispute Resolution

- a) If any dispute arising out of or in connection with this Agreement is not resolved within thirty (30) days, or such other reasonable period of time determined by Contractor and the Exchange staff normally responsible for the administration of this Agreement, the parties shall attempt to resolve the dispute through the submission of the matter for executive level involvement. The executive officer of each party or his or her designated representative shall meet and confer to attempt to resolve the dispute. If the parties agree, a neutral third party mediator may be engaged to assist in dispute resolution at either the line employee level or the executive level, or both. If after expending reasonable efforts at executive level resolution of the dispute, no resolution can be reached within thirty (30) days or such other reasonable period determined by Contractor and the Exchange, then either party may seek its rights and remedies in a court of competent jurisdiction or otherwise available under this Agreement or applicable laws, rules and regulations.
- b) Each party shall document in writing the nature of each dispute and the actions taken to resolve any disputes utilizing this dispute resolution procedure. Each party shall act in good faith to resolve such disputes. Neither party may seek its rights and remedies in court respecting any such notice of termination for default without first following the dispute resolution process stated in this Section.
- c) The Exchange and Contractor agree that the existence of a dispute notwithstanding, they will continue without delay to carry out all their responsibilities under this Agreement which are not affected by the dispute.
- d) Either party may request an expedited resolution process if such party determines that irreparable harm will be caused by following the timelines set forth in Section 12.1(a). If the other party does not consent to such expedited process, the requesting party will hire, at its sole cost and expense, an independent mediator to determine whether such an expedited process is necessary to avoid or reduce irreparable harm. In the event that the mediator determines that irreparable harm may result from delays required under the thirty (30) day period required under Section 12.1(a), the parties will engage in an expedited process that will require the parties to resolve the dispute within five (5) business days or such other period as mutually agreed upon by the parties.
- e) This Section shall survive the termination or expiration of this Agreement.

12.2 Attorneys' Fees

In the event of any litigation between the parties to enforce or interpret the provisions of this Agreement, the non-prevailing party shall, unless both parties agree, in writing, to the contrary, pay the reasonable attorneys' fees and costs of the prevailing party arising from such litigation, including outside attorneys' fees and allocated costs for services of in-house counsel, and court

costs. These attorneys' fees and costs shall be in addition to any other relief to which the prevailing party may be entitled.

12.3 Notices

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

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

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

For Contractor:

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

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

12.4 Amendments

- a) By the Exchange. In the event that any law or regulation is enacted or any decision, opinion, interpretive policy, or guidance of a court or governmental agency is issued (any of the foregoing, a "Change in Law") that the Exchange determines, based on its consultation with legal counsel, other regulators or other state-based or Federal health benefit exchanges:
- (i) affects or may affect the legality of this Agreement or any provision hereof or cause this Agreement or any provision hereof to prevent or hinder compliance with laws, rules or regulations, or
 - (ii) adversely affects or may adversely affect the operations of the Exchange or the ability of the Exchange or Contractor to perform its respective obligations hereunder or receive the benefits intended hereunder, the Exchange may, by written notice to Contractor, amend this Agreement to comply with or otherwise address the Change in Law in a manner reasonably determined by the Exchange to carry out the original intent of the parties to the extent practical in light of such Change in Law. Such amendment shall become effective upon sixty (60) days' notice, or such lesser period as required for compliance or consistency with

the Change in Law or to avoid the adverse effect of the Change in Law. If Contractor objects to such amendment, it must notify the Exchange in writing within twenty (20) days of receipt of notice from the Exchange. If the parties are unable to agree on an amendment within thirty (30) days thereafter, the Exchange may terminate this Agreement effective immediately.

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

12.5 Time is of the Essence

Time is of the essence in this Agreement.

12.6 Publicity

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

12.7 Force Majeure

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

12.8 Further Assurances

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

12.9 Binding Effect

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

12.10 Titles/Section Headings

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

12.11 Severability

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

12.12 Entire Agreement/Incorporated Documents/Order of Precedence

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

- a) The terms of this Agreement, including obligations set forth in other documents that are referenced herein;
- b) All attached documents, which are expressly incorporated herein;
- c) Terms and conditions set forth in the Application, to the extent that such terms are expressly incorporated by reference in specific sections of this Agreement and/or otherwise not inconsistent with the Agreement or Proposal; and,
- d) The Proposal, which is expressly incorporated herein to the extent that such terms are not superseded by the terms set forth in this Agreement.
- e) In the event there are any inconsistencies or ambiguities among the terms of this Agreement and incorporated documents, the following order of precedence shall be used:
 - 1) Applicable laws, rules and regulations;
 - 2) The terms and conditions of this Agreement, including attachments; and
 - 3) Application.

12.13 Waivers

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

12.14 Incorporation of Amendments to Applicable Laws

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

12.15 Choice of Law, Jurisdiction, and Venue

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

12.16 Counterparts

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

12.17 Days

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

12.18 Ambiguities Not Held Against Drafter

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

12.19 Clerical Error

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

12.20 Administration of Agreement

- a) The Exchange may adopt policies, procedures, rules and interpretations that are consistent with applicable laws, rules and regulations and deemed advisable by the Exchange to promote orderly and efficient administration of this Agreement. The parties shall perform in accordance with such policies and procedures; provided, however, that any changes to policies and procedures that are not disclosed to Contractor prior to the Agreement Effective Date shall not result in additional obligations and risks to Contractor existing at the Agreement Effective Date except as otherwise mutually agreed upon by the parties.
- b) The Exchange shall provide ninety (90) days prior written notice by letter, newsletter, electronic mail, or other media of any material change (as defined below) in Exchange's policies, procedures or other operating guidance applicable to Contractor's performance of Services. The failure by Contractor to object in writing to any material change within thirty (30) days following the Contractor's receipt of such notice shall constitute Contractor's acceptance of such material change. For purposes of this section, "material change" shall refer to any change that could reasonably be expected to have a material impact on the Contractor's compensation, Contractor's performance of Services under this Agreement, or the delivery of Covered Services to Enrollees.

12.21 Performance of Requirements

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

ARTICLE 13 – DEFINITIONS

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

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

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

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

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

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

Application – The application for certification for Plan Years 2017-2019.

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

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

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

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

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

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

CCR – The California Code of Regulations.

CDI – The California Department of Insurance.

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

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

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

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

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

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

DHCS – The California Department of Health Care Services.

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

DMHC – The California Department of Managed Health Care.

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

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

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

Employee – A “qualified employee,” as defined in 45 C.F.R. § 155.20.

Employer – A “qualified employer,” as defined in § 1312(f)(2) of the Affordable Care Act.

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

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

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

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

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

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

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

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

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

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

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

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

Health Information Technology for Economic and Clinical Health Act (HITECH Act) – The Health Information Technology for Economic and Clinical Health Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009, and the regulations issued pursuant thereto or as thereafter amended.

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

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

Health Insurance Regulators – CDI and DMHC, as applicable.

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

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

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

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

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

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

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

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

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

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

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

Open Enrollment or Open Enrollment Period – The fixed time period as set forth in 45 C.F.R. § 155.410, Health and Safety Code § 1399.849 (c)(3), and Insurance Code § 10965.3 (c)(3) for individual applicants and Enrollees to initiate enrollment or to change enrollment from one health benefits plan to another. For benefit years beginning on or after January 1, 2019, references to Open Enrollment include the allowance for special enrollment periods for all individuals as described in Health and Safety Codes § 1399.849(c)(3), and Insurance Code § 10965.3(c)(3).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Reconciliation Process – The Exchange and CalHEERS engage in a cyclically occurring Reconciliation Process with each QHP and QDP Issuer participating in the individual market. The Reconciliation Process is leveraged to monitor and facilitate all eligibility and enrollment reconciliation efforts with the QHP and QDP Issuers as defined in the “Data Integrity Reconciliation Process Guide.” As a component of the Reconciliation Process, the Dispute Process provides a platform for Issuer enrollment and eligibility disputes to be assessed. Assessment of each enrollment dispute includes focused analysis of operational cause, risk, and enterprise-wide impact. **Regulations** – The regulations adopted by the Exchange Board. (California Code of Regulations, Title 10, Chapter 12, §t 6400, et seq.)

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

Risk-Based Capital or RBC – The approach to determine the minimum level of capital needed for protection from insolvency based on an organization’s size, structure, and retained risk. Factors in the

RBC formula are applied to assets, premium, and expense items. The factors vary depending on the level of risk related to each item. The higher the risk related to the item, the higher the factor, and vice versa.

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

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

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

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

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

State – The State of California

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

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

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

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