



**COVERED CALIFORNIA
QUALIFIED HEALTH PLAN ISSUER CONTRACT FOR 2016**

between

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

and

("Contractor")

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

THIS QUALIFIED HEALTH PLAN ISSUER CONTRACT (this or the “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, Employers and Employees;

B. The Application process conducted by the Exchange is based on the assessment of certain requirements, criteria and standards that: (i) the Exchange determines are reasonable and necessary for bidding Health Insurance Issuers to market, offer, and sell Qualified Health Plans through the Exchange, (ii) are set forth in the Application and/or (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 and small employer – both in terms of premium and at point of care, (2) “value” competition based upon quality, service, and price, (3) competition based upon meaningful 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, and/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 and employers 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 Law and Regulation

- 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 qualified health plan certification set forth at 45 C.F.R. Part 156 et seq. (Subpart C: Qualified Health Plan Minimum Certification Standards).
- b) Contractor is subject to the obligations imposed on Contractor under applicable laws, rules and regulations of the Federal Affordable Care Act, the California Affordable Care Act, and any other applicable Federal, State or local laws, rules and regulations. Nothing in this Agreement limits such obligations imposed on Contractor, including any failure to reference a specific state or Federal regulatory requirement applicable to the Exchange or Contractor. In those instances where the Exchange imposes a requirement in accordance with the California

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

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

1.3 Relationship of the Parties

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

1.4 General Duties of the Exchange

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

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

- c) Consumer assistance tools and programs, including but not limited to operation of a toll-free call center (45 U.S.C. § 18031 (d) and 45 C.F.R. § 155.205);
- d) Eligibility and enrollment determinations, as well as exemption determinations in the Individual Exchange and Covered California for Small Business (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 or employers in QHPs (45 C.F.R. § 155.220);
- k) Ensuring that individuals can pay premiums owed directly to qualified health plan issuers and ensuring compliance with related Federal requirements (45 C.F.R. § 155.240);
- l) Privacy and security of personally identifiable information (45 C.F.R. § 155.260);
- m) Use of standards and protocols for electronic transactions (45 C.F.R. § 155.270);
- n) Establishment of Covered California for Small Business to assist employers and facilitate enrollment of employees into QHPs (45 C.F.R. Subpart H, §155.700 et seq.);
- o) 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
- p) 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 organizational 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) Qualified Health Plans identified in Attachment 1 are offered in accordance with the terms and conditions of the Agreement and in compliance with the Affordable Care Act and the California Affordable Care Act and implementing regulations, and with applicable Federal and State laws, rules and regulations as may be amended from time to time as required under applicable laws, rules and regulations or as otherwise authorized under this Agreement;
- d) Notify the Exchange of any material concerns identified by Contractor or by a regulatory agency that may impact Contractor's performance under this Agreement;
- e) Participate in 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.

1.6 Transition between Exchange and Other Coverage

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

1.7 Coordination with Other Programs

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

The Contractor shall cooperate with the Exchange and DHCS to implement coverage or subsidy programs to complement existing programs that are administered by DHCS. Such programs may provide State and/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 and/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;
- 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 and/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; 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, Section 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, Section 12990, set forth in CCR Chapter 5 of Division 4 of Title 2, including, 2 CCR Section 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 Section 8350, et seq.).
- c) Child Support Compliance Act. Contractor shall fully comply with all applicable State and Federal laws relating to child and family support enforcement, including, but not limited to, disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of Part 5 of Division 9 of the Family Code.
- d) Domestic Partners. Contractor shall fully comply with Public Contract Code Section 10295.3 with regard to benefits for domestic partners.
- e) Environmental. Contractor shall comply with environmental laws, rules and regulations applicable to its operations, including, those relating to certifies compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30, commencing with Section 42460 of the Public Resources Code, relating to hazardous and solid waste.
- f) Other Laws. Contractor shall comply with any and all other State and Federal laws, rules and regulations applicable to this Agreement, to the operation of the Exchange, and Contractor's provision of Services under this Agreement.

1.15 Contractor's Representations and Warranties

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

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

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

Power and Authority. Contractor represents and warrants that: (i) it has the power and authority to enter into this Agreement and to carry out its obligations hereunder; (ii) the execution of this

Agreement has been duly authorized and executed by Contractor and no other internal proceeding on the part of Contractor is necessary to authorize this Agreement; and (iii) to the best of its knowledge, Contractor has completed, obtained, and performed all registrations, filings, approvals, authorizations, consents, or examinations required by any Health Insurance Regulators and other government or governmental authority for its acts contemplated by this Agreement.

1.16 Fraud, Waste and Abuse; Ethical Conduct

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

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

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

1.17 Current Enrollee Notification

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

ARTICLE 2 -- ELIGIBILITY AND ENROLLMENT

2.1 Eligibility and Enrollment Responsibilities

2.1.1 Exchange Responsibilities

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

2.1.2 Contractor Responsibilities

- a) Contractor shall comply with all Federal and State eligibility and enrollment laws and regulations, including, but not limited to, the Affordable Care Act § 1411 et seq. (42 U.S.C. § 18081 et seq.), Government Code § 100503, and 10 CCR § 6400 et seq.
- b) Contractor shall comply with the Exchange eligibility and enrollment determinations made through CalHEERS for Enrollees, including any determinations that result from an applicant's appeal of an Exchange determination. Contractor shall implement appeals decisions within ten (10) business days of receiving all necessary data elements from the Exchange required to implement the appeals decision. In the event that an enrollee requires immediate care, the QHP Issuer will work closely with the Exchange to implement the appeals decision as soon as reasonably possible. Contractor shall accept all Enrollees assigned by the Exchange except as

otherwise authorized by policies and procedures of the Exchange or upon the approval of the Exchange.

- c) Contractor shall review and compare the Exchange enrollment reconciliation file, distributed monthly, against the Contractor's membership enrollment and financial databases. Contractor shall prepare a comparison extract in accordance with the file validations and resolution timelines, as mutually agreed upon in the reconciliation process guide.
- d) Contractor shall provide a supplemental file for those members who are missing from the Exchange enrollment reconciliation file in accordance with the defined list of fields and technical requirements established by the Exchange. Contractor shall provide this file within two weeks of the receipt of the monthly reconciliation file.
- e) Contractor shall rely upon the accuracy of current eligibility and enrollment information furnished by the Exchange during the term of this Agreement; provided, however, that Contractor shall: (i) reconcile premium payment information with enrollment and eligibility information received from the Exchange on a monthly basis. Contractor shall only accept changes to eligibility information submitted by Employers or Enrollees when the Exchange notifies or confirms such change to Contractor.

2.1.3 Collection Practices

Contractor shall maintain fair and reasonable collection practices that comply with applicable laws, rules and regulations. Contractor shall monitor the collection activities and provide the Exchange with reasonable documentation to facilitate the Exchange's monitoring, tracking or reporting with respect to Contractor's collection efforts including, policies, and procedures and copy of any form of delinquency or termination warning or notice sent to an Enrollee or Employer.

2.2 Individual Exchange

2.2.1 Enrollment and Enrollment Periods

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

Contractor shall provide monthly special enrollment periods for American Indians or Alaska natives enrolled through the Exchange.

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/or as otherwise established by Contractor in accordance with applicable laws, rules and regulations.

The Exchange shall require payment of one hundred percent (100%) of the entire first month premium to be received by the Contractor by the Contractor's due date. 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 and/or receive funds above the premium amounts except with respect to cost-sharing amounts or to the extent that such payment (i) is expressly authorized under the QHPs, such as out-of-network services that comply with the notice requirements set forth at Section 3.4.3, or (ii) relates to a charge for non-sufficient funds or transaction fees initiated by Enrollee at rates that are reasonable and customary for such transactions. Contractor shall not pursue collections of any said fees from the Exchange. Contractor shall not pursue collection of any delinquent premiums from the Exchange for an Enrollee enrolled in the Individual Exchange who is responsible for directly paying his or her premium to Contractor.

Premium charged to individuals includes the assessment of the participation fee (see Sections 5.1.3 and 5.2.2 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.

The Exchange will notify Contractor within five (5) business days of any individual Enrollee termination.

2.2.5 Notice to Provider Regarding Enrollee's Grace Period Status

- a) In the event of nonpayment of premium by an individual Exchange Enrollee receiving advance payments of the premium tax credit, Contractor shall provide notice to its network providers within 15 days of the start of the second month of the three month grace period. This notice shall inform the network provider of the enrollee's suspension of coverage during the second and third months of the Enrollee's grace period, and shall include any other information required by State and Federal law. This notice obligation only applies to network providers who have submitted claims to the QHP Issuer within the previous two months, any provider who is an assigned Primary Care Provider for that Enrollee, and providers who have an outstanding prior authorization to provide services to the APTC Enrollee.
- b) Notwithstanding (a) above, this notice obligation does not relieve the QHP Issuer from compliance with existing state laws governing claims payment.

2.2.6 Agents in the Individual Exchange

- a) Compensation. The provisions of this Section apply to agents who sell Contractor's QHPs through the Individual Exchange.
- b) Compensation Methodology. 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 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 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 for the Contractor's review. If the Contractor approves the delegation, Contractor shall make the change in their system and follow Contractor's normal administrative procedures, including notifying the current agent as appropriate. If the Contractor denies the delegation request, Contractor shall notify the individual, the agent and the Exchange within ten (10) business days of such denial.
- g) Change to Agent of Record. The Exchange shall notify agents to send consumer Agent of Record Change Request to the applicable Contractor. If the Contractor approves the change, Contractor shall make the change in their system and follow Contractor's normal administrative procedures, including notifying the current agent as appropriate. If the Contractor denies the change request, Contractor shall notify the consumer and the Agent. Contractor shall notify the Exchange of any Agent of Record changes in a standard format developed by the Exchange via e-mail within five (5) business days and provide the Exchange and the agent the following: enrollee name, Exchange case number, former agent name and

license number, new agent name, license number and contact information and the effective date of the change. The Exchange shall process changes to Agent of Record within five (5) business days from receipt of the change from Contractor.

2.3 Covered California for Small Business Exchange

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

2.3.1 Covered California for Small Business Enrollment Periods

Contractor agrees to allow Employers and Employees to purchase coverage in Covered California for Small Business at any point during the year (“rolling enrollment period”) and as a result of specified triggering events during Special Enrollment Periods. Contractor shall accept changes to enrollment received from the Exchange other than during the Employer’s Open Enrollment period for qualifying events as required under State and Federal laws, rules and regulations. Contractor agrees to accept new Employers, Employees and eligible dependents who enroll during these periods in Covered California for Small Business.

2.3.2 Covered California for Small Business Coverage Effective Dates

- a) Upon verification of eligibility and selection of Contractor’s QHP, the Exchange shall: (i) process enrollment of Employees into Contractor’s QHPs, (ii) establish effective dates of Employee coverage, and (iii) transmit enrollment information for Employees to Contractor and Contractor shall notify Employee of the effective date of coverage.
- b) Contractor shall coordinate and cooperate with Exchange to the extent necessary during the Exchange’s enrollment process following the Exchange’s acceptance of the single employer and single employee application forms. Contractor shall provide Services as may be required to support the Exchange during the enrollment process conducted by the Exchange in accordance with the Exchange’s responsibilities under State and Federal laws, rules and regulations. Such Services shall include support of the Exchange’s performance of the following activities that must occur before the effective date of coverage: (i) determination of

Employer eligibility, (ii) selection of Contractor's QHPs coverage levels by Employers and Employees, and (iii) verification of Employee's eligibility.

- c) Covered California for Small Business coverage shall commence on the first (1st) day of a month or such other date as may be established by the Exchange under its enrollment timeline and processes in accordance with State and Federal laws, rules and regulations. The specific terms and conditions relating to commencement of coverage, including cancellation or postponement of the effective date of coverage in the event of nonpayment or partial payment of an initial premium will be determined in accordance with applicable laws, rules and regulations.
- d) Contractor shall provide Covered California for Small Business with all information necessary to send the renewal notifications to Covered California small businesses, including information needed to satisfy any applicable language accessibility requirements.

2.3.3 Covered California for Small Business Premiums

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

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

Premium charged in Covered California for Small Business includes the assessment of the participation fee (\$18.60 per member per month), agent and general agent commissions (see Section 5.1.3 and 5.2.2 Participation Fee).

2.3.4 Covered California for Small Business Terminations of Coverage

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

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

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

2.3.5 Covered California for Small Business Minimum Participation Rates

Contractor shall comply with minimum participation rates for Employers participating in Covered California for Small Business that shall require the following: (i) participation of a specified percentage of Employer's eligible employees in the Exchange, (ii) Employer's contribution in an amount equal to a specified percentage of the Employees premium and (iii) compliance with applicable laws, rules and regulations. Participation rates shall be established by the Exchange in consultation with Health Insurance Issuers and may be modified by the Exchange no more frequently than annually based on consideration of various factors, including, prevailing market standards and changes in applicable laws, rules and regulations.

2.3.6 Agents in the Covered California for Small Business Exchange

- a) The provisions of this Section apply to agents who sell Contractor's QHPs through Covered California for Small Business.
- b) Agent Commissions. The Exchange's intent is to pay market level broker and general agent commissions. In order to facilitate the Exchange's ability to administer enrollment in Covered California for Small Business based on efforts that are consistent for non-Exchange products

and to achieve consistency in compensation arrangement for products sold inside and outside the Exchange: (i) the Exchange shall enter into arrangements with agents to sell Contractor's QHPs through Covered California for Small Business, (ii) the Exchange will be responsible for payment of agents, (iii) the Exchange will provide Enrollee specific and agent-specific information to Contractor regarding commissions paid, and (iv) Contractor will reimburse the Exchange for the Exchange's payment of a standard agent commission through the Exchange's offset of agent commissions owing to the Exchange from the Covered California for Small Business premiums collected by the Exchange, as such offset shall be performed in accordance with the offset procedures set forth at Section 5.1.3 and 5.2.2.

- c) General agents. The commission rate payable to a general agent by the Exchange shall be established by the Exchange based on its evaluation of market data, including pricing information submitted in connection with its rate bids and/or pursuant to other policies that shall be established by the Exchange from time to time. The Exchange will contract with multiple general agents to represent the Covered California for Small Business. Contractor agrees to amend any of its agreements with such agents to include a standard general agent override commission for authorized general agents to assure that payments made to agents are consistent with the rate set forth in the agreement between the Exchange and such agent.
- d) Incentive Compensation Program. In order to enhance consistency in sales efforts for products offered inside and outside of the Exchange, Contractor shall consider information provided by the Exchange regarding sales commissions in order to credit the agent's sale of QHPs through Covered California for Small Business to the agent's sale of Contractor's policies outside the Exchange for purposes of determining agent's aggregate sales that shall be used by Contractor to determine incentive or other compensation payable by Contractor to agent. Contractor shall provide information as may reasonably be required by the Exchange from time to time to monitor Contractor's compliance with the requirements set forth in this section.
- e) Agent Appointments. Agents enrolling Employers in Covered California for Small Business do not need to be appointed by each individual health plan that participates in Covered California for Small Business. As long as the agent is licensed by the California Department of Insurance and certified by Covered California, the agent may enroll employers in Covered California for Small Business. The Exchange's appointment standards are intended to encourage all qualified agents who sell for Covered California for Small Business to maintain or receive issuer appointments; provided, however that not all qualified agents are required to receive an issuer appointment in order to sell QHPs through Covered California for Small Business. Contractor shall not take any action that may restrict agents certified by the Exchange from becoming appointed by all Health Insurance Issuers that elect to market products through an agent.
- f) Agent Conduct. The Exchange shall implement policies, procedures, training, monitoring and other processes to assure that agents who sell Contractor's QHPs through Covered California

for Small Business will fairly and objectively represent all Health Insurance Issuers and all products offered on the Exchange that market through agents in order to present health plan options in an unbiased manner and that minimizes steerage..

- g) Training. Agents shall receive training and certification in order to promote the offer of the broad array of potential products available to potential enrollees.

2.4 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) A standard interface through which Contractor may electronically accept from the Exchange the initial binder payment (via ACH or EFT) to effectuate coverage and accept subsequent premium payment in Covered California for Small Business;
- e) Complete documentation and reasonable testing timelines for interfaces with the Exchange's eligibility and enrollment system;
- f) Eligibility and enrollment training for Contractor's staff and for licensed agents and brokers;
- g) 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;
- h) Joint marketing activities of the Exchange, Contractor and other Health Insurance Issuers designed to drive awareness and enrollment in the Exchange;

- i) Confidential treatment of all Contractor marketing plans and materials consistent with Section 1.4.1;
- j) The Exchange's annual marketing plans, including Open Enrollment Period (OEP), Special Enrollment Period (SEP) retention and renewal efforts; and
- k) 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 and small group marketplaces and inform agents that a prospective Enrollee's health status is irrelevant to advice provided with respect to health plan selection other than informing individuals about their estimated out-of-pocket costs;
- c) Provide education and awareness regarding eligibility for Federal tax credits, plan offerings and benefits available through the Exchange in connection with any applicable outreach to Contractor's existing members, as mutually agreed;
- d) Cooperate with the Exchange to develop and implement an Enrollee retention plan;
- e) Submit to the Exchange a marketing plan at least thirty (30) days prior to Open Enrollment that details the anticipated budget, objectives, strategy, creative messaging and ad placement by medium promoting acquisition activities. Marketing plans for Retention and Renewal efforts should be submitted to the Exchange within thirty (30) days after Open Enrollment begins
- f) Submit to the Exchange annual actualized spend amounts for: (1) OEP within thirty (30) days after OEP closes, and (2) SEP for the calendar year, thirty (30) days after the calendar year ends, and (3) for retention and renewal, thirty (30) days after OEP begins. The Exchange shall treat as confidential consistent with Section 1.4.1; and
- g) Have successfully tested interfaces with the Exchange's eligibility and enrollment system, or be prepared to complete successful interface tests by dates established by the Exchange.

2.5 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 Style Guide available to Contractor online and notify Contractor when updates are made.
- b) Cobranded Marketing Materials. Contractor must submit all cobranded marketing materials for review and approval to Covered California prior to release. Contractor shall allow at least ten (10) business days from the date of the request for Covered California to review any materials submitted.
- c) Enrollee Materials. Upon request, Contractor shall provide the Exchange with at least one (1) copy, unless otherwise specified, of any information Contractor intends to send or make available to all the Exchange Enrollees, including, but not limited to, Evidence of Coverage 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 Web Site. During each year of this Agreement which carries over into a subsequent Contract Year, Contractor shall make the Evidence of Coverage booklet for the next benefit year available on Contractor's website no later than the first day of the Open Enrollment Period provided that Contractor has received any revisions in the material that is to be included in the Evidence of Coverage from the Exchange and the applicable Regulator in sufficient time to allow for posting on the first day of Open Enrollment. The Evidence of Coverage booklet for the then-current benefit year shall remain on Contractor's web site through December 31 of the then-current benefit year.
- 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”). Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for this purpose.

3.1.2 Certification

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

3.1.3 Accreditation

- a) Contractor agrees to maintain a current accreditation throughout the term of the Agreement from one of the following accrediting bodies: (i) Utilization Review Accreditation Commission (URAC); (ii) National Committee on Quality Assurance (NCQA); (iii) Accreditation Association for Ambulatory Health Care (AAAHC) Contractor shall authorize the accrediting agency to provide information and data to the Exchange relating to Contractor's accreditation, including the most recent accreditation survey and other data and information maintained by accrediting agency as required under 45 C.F.R. § 156.275.
- b) Contractor shall be currently accredited and maintain its NCQA, URAC or AAAHC health plan accreditation throughout the term of the Agreement. Contractor shall notify the Exchange of the date of any accreditation review scheduled during the term of this Agreement and the results of such review. Upon completion of any health plan accreditation review conducted during the term of this Agreement, Contractor shall provide the Exchange with a copy of the Assessment Report within forty-five (45) days of report receipt.
- c) If Contractor receives a rating of less than "accredited" in any category, loses an accreditation, or fails to maintain a current and up to date accreditation, Contractor shall notify the Exchange within ten (10) business days of such rating(s) change and shall be required to provide the Exchange with all corrective action(s). 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.

- 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.

3.2 Benefit Standards

3.2.1 Essential Health Benefits

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

3.2.2 Standard Benefit Designs

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

3.2.3 Offerings Outside of the Exchange

- a) Contractor acknowledges and agrees that as required under State and Federal law QHPs and substantially similar plans offered by Contractor outside the Exchange must be offered at the same 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 and small businesses in the Exchange to individuals and small businesses seeking coverage outside the Exchange consistent with California law.
- c) For purposes of this Section, “product” does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Department of Health Care Services (DHCS) and health care service plans for Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of

the Welfare and Institutions Code between the DHCS and health care service plans for enrolled Medi-Cal beneficiaries.

3.2.4 Pediatric Dental Benefits

When Contractor elects to embed and offer Pediatric Dental Essential Health Benefit services either directly or through a subcontract with a dental plan issuer authorized to provide Specialized Health Care Services to Enrollees under applicable laws, rules and regulations pursuant to: (i) a certificate of authority issued by the CDI under § 699 et seq. of the California Insurance Code, and/or (ii) a license issued by the DMHC pursuant to the Knox-Keene Health Care Service Plan Act of 1975 § 1340 et seq. of the California Health and Safety Code. Contractor shall require its dental plan subcontractor to comply with all applicable provisions of this Agreement, including, but not limited to, standard benefit designs for the embedded pediatric dental benefit, as well as any network adequacy standards applicable to dental provider networks and any pediatric dental quality measures as determined by the Exchange.

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

3.2.5 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. 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 Internet Web site 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 dedicated pharmacy 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: (i) participation by Employers in Covered California for Small Business, including those requirements related to the Employer's principal place of business or primary worksite in the Service Area, or (ii) participation of Qualified Individuals in the Individual Exchange, including requirements related to residency in the Contractor's service area.

Contractor shall notify the Exchange if it becomes aware that an Employer or individual Enrollee enrolled in a QHP of Contractor no longer meets the requirements for eligibility, based on place of business, primary worksite or residence. The Exchange will evaluate, or cause CalHEERS to evaluate, such information to determine Enrollee's continuing enrollment in the Contractor's Service Area under the Exchange's policies which shall be established in accordance with applicable laws, rules and regulations. Contractor and its subcontractors will have no duty to investigate representations made by Employers regarding eligibility; provided, however, that Contractor shall notify the Exchange in the event that it becomes aware that such representation may not be accurate.

3.3.2 Network 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 (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, 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 essential community providers ("ECP") available to provide reasonable and timely access to Covered Services for low-income populations in each geographic region where Contractor's QHPs provide services to Enrollees. Contractor shall comply with other laws, rules and regulations relating to arrangements with ECPs, as applicable, including, those rules set forth at 45 C.F.R. § 156.235.
- b) Sufficient geographic distribution. The Exchange shall determine whether Contractor meets the requirement of a sufficient geographic distribution of ECPs in its reasonable discretion, in accordance with the conditions set forth in the Application, and based on a consideration of various factors, including: (i) the nature, type and distribution of Contractor's ECP contracting arrangements in each geographic rating region in which Contractor's QHPs provides Covered Services to Enrollees, (ii) the balance of hospital and non-hospital ECPs in each geographic rating region, (iii) the inclusion in Contractor's provider contracting network of at least 15% of entities in each applicable geographic rating region that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B) ("340B Entity"), (iv) the inclusion of at least one ECP hospital in each region, (v) the inclusion of Federally Qualified Health Centers, and county hospitals, and (vi) other factors as mutually agreed upon by the Exchange and the Contractor regarding Contractor's ability to serve the low income population.
- c) Low-income populations shall be defined for purposes of the ECP requirements as families living at or below 200% of Federal Poverty Level. ECPs shall consist of participating entities in the following programs: (i) 340B Entity (ii) California Disproportionate Share Hospital Program, per the Final DSH Eligibility List FY (CA DHCS 2012-13), (iii) Federally

designated 638 Tribal Health Programs and Title V Urban Indian Health Programs, (iv) Community Clinic or health centers licensed as either a “community clinic” or “free clinic”, by the State under Health and Safety Code section 1204(a), or is a community clinic or free clinic exempt from licensure under Health and Safety Code Section 1206, and (v) Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program. Covered California will post a non-exhaustive essential community provider list annually.

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

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

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

3.3.4 Special Rules Governing American Indians and Alaskan Natives

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

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

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

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

3.3.5 Network Stability

- a) Contractor shall implement policies and practices designed (i) to reduce the potential for disruptions in Contractor's provider networks, and (ii) to minimize the amount of uncertainty, disruption, and inconvenience of Enrollees in the execution of the transition of care as required under State laws, rules and regulations in connection with any such disruption. Contractor agrees to maintain adequate records, reasonably satisfactory to the Exchange, documenting its policies and its compliance with these requirements by Contractor and Participating Providers.
- b) Block Transfers. If Contractor experiences a termination of a Provider Group(s) or hospital(s) that constitutes a block transfer as defined in Health and Safety Code § 1373.65 and Title 28, C.C.R. § 1300.67.1.3, Contractor shall provide the Exchange with copies of the written notices the Contractor proposes to send to affected Enrollees, in compliance with the notice requirements of Health and Safety Code § 1373.65, prior to mailing the notices to Enrollees.
- c) Network Disruptions. If Contractor experiences provider network disruptions or other similar circumstances that make it necessary for Enrollees to change QHPs or Participating Providers, Contractor agrees to provide prior notice to the Exchange and Health Insurance Regulator, in accordance with advance notice, meeting, and other requirements set forth in applicable laws, rules and regulations, including Insurance Code § 10199.1 and Health and Safety Code § 1367.23 and § 1366.1.
- d) Enrollee transfers. In the event of a change in Participating Providers or QHPs related to network disruption, block transfers or other similar circumstances, Contractor shall, and shall require Participating Providers to, cooperate with the Exchange in planning for the orderly transfer of Enrollees as necessary and as required under applicable laws, rules, and regulations including, those relating to continuity of care set forth at Health and Safety Code § 1373.95 and Insurance Code § 10133.55.

3.4 Participating Providers

3.4.1 Provider Contracts

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

- x. Enrollment and eligibility determinations and collection practices (Article 2);
- xi. Appeals and grievances (Section 3.6.2);
- xii. Enrollee and marketing materials (Section 2.5);
- xiii. Disclosure of information required by the Exchange, including, financial and clinical (Section 1.13; Quality, Network Management and Delivery System Standards (Article 4) and other data, books and records (Article 10));
- xiv. Nondiscrimination (Section 1.11);
- xv. Conflict of interest and integrity (Section 1.12);
- xvi. Other laws (Section 1.14);
- xvii. Quality, Network Management and Delivery System Standards to the extent applicable to Participating Providers (Article 4), including, disclosure of contracting arrangements with Participating Providers as required pursuant to Attachment 7;
- xviii. Performance Measures, to the extent applicable to Participating Providers (Article 6);
- xix. Continuity of care, coordination and cooperation upon termination of Agreement and transition of Enrollees (Section 3.35 and Article 7);
- xx. Security and privacy requirements, including compliance with HIPAA (Article 9); and
- xxi. Maintenance of books and records (Article 10).

3.4.2 Provider Credentialing

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

3.4.3 Enrollee costs; Disclosure

Contractor shall, and shall require Participating Providers to, comply with applicable laws, rules and regulations governing liability of Enrollees for 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 and/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 their provider manual. Participating Providers may rely on Contractor's provider directory in fulfilling their obligation under this provision.

3.4.4 Provider Directory

Contractor shall make its provider directory available to (i) the Exchange electronically for publication online in accordance with guidance from the Exchange, and (ii) in hard copy when potential Enrollees make such request. Contractor shall provide information describing all Participating Providers in its 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. 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 Performance Standard 2.5 in Attachment 14 to this Agreement will not be enforced until testing and implementation on the reporting format is complete.

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

3.5 Premium Rate Setting

3.5.1 Rating Variations

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

Contractor shall comply with rate filing requirements imposed by Health Insurance Regulators, including, those set forth under Insurance Code § 10181 et seq. (if Contractor is an insurer

regulated by CDI) or Health and Safety Code § 1385 et seq. (if Contractor is a licensed HCSP regulated by DMHC) and as applicable, other laws, rules and regulations.

3.5.2 Individual Exchange Rates

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

3.5.3 Covered California for Small Business Exchange Rates

Covered California for Small Business rates for 2016 will be established through an annual bid Application process. If the term of the Agreement is longer than one (1) year, Contractor shall also submit rate information in such form and at such date as shall be established by the Exchange to provide the Exchange with sufficient time for necessary analysis and actuarial certification. The Exchange will permit an update of rates to be offered on the Covered California for Small Business Exchange no more frequently than on a quarterly basis. Updates can only be made on the calendar quarter or such later time as the Exchange and Contractor agree to.

3.5.4 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.

3.5.5 Provider Rates

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

that is treated as confidential information by Health Insurance Regulators pursuant to Insurance Code § 10181.7(b) and/or Health and Safety Code § 1385.07(b).

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

3.6 Customer Service Standards

3.6.1 Basic Customer Service Requirements

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

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.

3.6.2 Enrollee Appeals and Grievances

- a) Internal Grievances and Appeals. Contractor shall maintain an internal review process to resolve Enrollee's written or oral expression of dissatisfaction regarding the Contractor and Participating Providers, including appeals of claim and benefit determinations, and complaints relating to the scope of Covered Services required to be covered under the 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) Independent Medical Review. Contractor shall comply with State and Federal laws, rules and regulations relating to the external independent medical review process available to Enrollees

for Covered Services. Contractor's external medical review process shall be conducted in accordance with the requirements set forth at Insurance Code Section 10169 et seq. and Health and Safety Code Section 1374.30 et seq., as applicable.

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

3.6.4 Customer Service Call Center

- a) During Open Enrollment Period, Contractor's call center hours shall be Monday through Friday eight o'clock (8:00) a.m. to eight o'clock (8:00) p.m. and Saturday eight o'clock (8:00) a.m.) to six o'clock (6:00) p.m. (Pacific Standard Time), except on holidays observed by the Exchange. During non-Open Enrollment Periods, the Contractor shall maintain call center hours Monday through Friday eight o'clock (8:00) a.m. to six o'clock (6:00) p.m. and Saturday eight o'clock (8:00) a.m. to five o'clock (5:00) p.m. (Pacific Standard Time), however, Contractor may adjust Saturday hours as required by customer demand. Contractor shall inform the Exchange of its standard call center hours and any changes to the call center hours during non-Open-Enrollment Periods.
- b) Contractor's call center shall be staffed at levels reasonably necessary to handle call volume and achieve compliance with Performance Measurement Standards set forth in Article 6. Contractor shall staff the Call Center with highly trained individuals to provide detailed benefit information, answer Enrollee questions about 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 Measurement 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 Measurement Standards and sufficient to facilitate a live transfer (from the Exchange to Contractor) of customers who call the Exchange with issues or complaints that need to be addressed by Contractor. The Exchange shall maintain staff resources sufficient to facilitate a live transfer (from Contractor to the Exchange) of customers who call Contractor with issues or complaints that need to be addressed by the Exchange.
- 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 yearly.

3.6.7 Notices

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

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 Qualified Health Plan information.

3.6.9 Enrollee Materials: Basic Requirements

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

- b) Enrollee materials shall be available in English, Spanish and other languages as required by applicable laws, rules and regulations. Contractor shall comply with Federal and State laws, rules and regulations regarding language access. To the extent possible, Enrollee materials shall be written in plain language, as that term is defined in applicable laws, rules and regulations. Plan materials that require Exchange notification before usage are those that communicate specific eligibility and enrollment and other key information to Enrollees. Such materials may include, but are not limited to:
- i. Welcome letters;
 - ii. Enrollee ID card with the same product name as used in the Covered CA and issuer websites;
 - iii. Billing notices and statements;
 - iv. Notices of actions to be taken by Plan that may impact coverage or benefit letters;
 - v. Termination Grievance process materials;
 - vi. Drug formulary information;
 - vii. Uniform Summary of Benefits and Coverage; and
 - viii. Other materials required by the Exchange.

3.6.10 New Enrollee Enrollment Packets

- a) Contractor shall mail or provide online enrollment packets to all new Individual Exchange Enrollees in individual Exchange QHPs within ten (10) business days of receiving complete and accurate enrollment information from the Exchange and the binder payment; and within ten (10) business days of receipt of complete and accurate enrollment information for Covered California for Small Business QHP Enrollees. Contractor may deliver Enrollee materials pursuant to other methods that are consistent with: (1) Contractor's submission of materials to enrollees of its other plans; (2) the needs of Enrollees; (3) the consent of the Enrollee; and (4) with applicable laws, rules and regulations. Contractor shall report to the Exchange monthly, in a format mutually agreed upon by the Exchange and Contractor, on the number and accuracy rate of identification cards that were sent to new Enrollees and Contractor's compliance with the Performance Measurement Standards set forth in this Agreement. The enrollment packet shall include, at the minimum, the following:
- i. Welcome letter;
 - ii. Enrollee ID card, in a form approved by the Exchange;
 - iii. If Enrollee ID card is not included in the enrollment packet, Contractor must send a notice to the Enrollee that states the ID card will be sent separately; when the Enrollee should

expect to receive it, and provide the information necessary for the enrollee to receive services and for providers to file claims;

- iv. Summary of Benefits and Coverage;
 - v. Pharmacy benefit information;
 - vi. Nurse advice line information; and
 - vii. Other materials required by the Exchange.
- b) Contractor shall maintain access to enrollment packet materials; Summary of Benefits and Coverage (“SBC”); claim forms and other Plan-related documents in both English and Spanish and any other languages required by State and Federal laws, rules and regulations to the extent required to timely meet all requirements of this Agreement for timely mailing and delivery of Plan materials to Enrollees. Contractor shall be responsible for printing, storing and stocking, as applicable, all materials.

3.6.11 Summary of Benefits and Coverage

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

3.6.12 Electronic Listing of Participating Providers

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

3.6.13 Access to Medical Services Pending ID Card Receipt

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

3.6.14 Explanation of Benefits

Contractor shall send each Enrollee, by mail, an Explanation of Benefits (EOB) to Enrollees in Plans that issue EOBs or similar documents as required by Federal and State laws, rules and

regulations. The EOB and other documents shall be in a form that is consistent with industry standards.

3.6.15 Secure Plan Website for Enrollees and Providers

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

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

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

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

f) Premiums collected.

3.6.17 Contractor Staff Training about the Exchange

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

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

3.6.18 Customer Service Training Process

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

ARTICLE 4 – QUALITY, NETWORK MANAGEMENT AND DELIVERY SYSTEM STANDARDS

4.1 Exchange Quality Initiatives

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

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

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

4.2 Quality Management Program

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

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

4.3 Utilization Management

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

4.4 Transparency and Quality Reporting

- a) Pursuant to 45 CFR § 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 required no later than March 31st of each year. This includes information relating to claims payment policies and practices, financial disclosures, enrollment, disenrollment, denials, rating practices, cost-sharing, 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 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 3.03 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 2016 are set forth at Attachment 8 (“Monthly Rates - Individual Exchange”). The parties acknowledge and agree that the premium amounts set forth under the Monthly Rates are actuarially determined to assure that premium revenues and cost sharing contributions will provide the total dollar amount necessary to support (i) the provision of Covered Services by Contractor through its 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, the Monthly Rates for each subsequent year of the Agreement will be established no more frequently than annually in accordance with the procedures set forth at and Section 3.5 and Attachment 9 (“Rate Updates - Individual Exchange”).
- c) Collection and Remittance. Contractor understands that Contractor is responsible for collection and the Enrollee is responsible for remittance of the agreed-upon premium rates to Contractor in a timely manner. Contractor understands that individual Enrollees will remit their monthly premium payments directly to Contractor and the Exchange will not aggregate premiums. The failure by an Enrollee to timely pay premiums may result in a termination of coverage pursuant to the terms set forth at Sections 2.2.4 and 2.3.4. Contractor further understands that the premium payment collected by Contractor includes amounts allocated to the Participation Fee due to the Exchange. The Participation Fees shall be billed by the

Exchange to Contractor and payable by Contractor to the Exchange in accordance with the requirements set forth at Section 5.1.3.

5.1.2 Financial Consequences of Non-Payment of Premium

- a) Premium payment rules. Contractor is responsible for enforcement of premium payment rules at its own expense, as outlined in the terms set forth in the Evidence of Coverage regarding the failure by Enrollee to pay the premium in a timely manner as directed by the Enrollee policy agreement and in accordance with applicable laws, rules and regulations. Enforcement by Contractor shall include, but not be limited to, chargebacks, delinquency and termination actions and notices, grace period requirements and partial payment rules. Such enforcement shall be conducted in accordance with requirements in this Agreement consistent with applicable laws, rules and regulations.
- b) Enrollee Terminations. In the event Contractor terminates an Enrollee's coverage in a QHP due to non-payment of premiums, loss of eligibility, fraud or misrepresentation, change in Enrollees selection of QHP, decertification of Contractor's QHP and/or as otherwise authorized under Sections 2.2.4 and 2.3.4, Contractor must include the Health Insurance Regulator-approved 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 2.3.4 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 collected by Contractor by spreading the cost across the premiums charged to Contractor's entire individual risk pool (both inside and outside the Exchange) for the Individual Exchange Participation Fees. No rate charged to an Enrollee can have a higher per member per month fee to cover this overall Participation Fee than is charged to all other enrollees of the respective risk pool.
- c) The Participation Fee payable to the Exchange during each month of this Agreement shall be equal to a per member per month ("PMPM") rate of \$13.95 multiplied by the number of

Enrollees in Contractor's QHPs for such month. The Participation Fee will be assessed by the Exchange and payable monthly by Contractor based on enrollment in Contractor's QHPs sold through the Individual Exchange for 2016.

- d) Participation Fee invoices will be issued by the Exchange prospectively to Contractor on the 15th of the month for the coming month. Contractor's Participation Fee obligation will be determined and billed by evaluating Contractor's then-current QHP confirmed enrollment and may be subject to adjustment to reflect changes in enrollment that may have occurred in prior months (including additions, terminations and cancellations of enrollment). However, Contractor may reconcile the invoice and remit payment only for those members who are enrolled in a QHP with Contractor in accordance with Billing Discrepancy Reporting requirement in Attachment 13. Participation Fee payments will be due on the 1st of the month the Participation Fee covers. For Participation Fees received after the 15th of the month in which the Participation Fee is due, the Exchange will charge, and Contractor shall owe, a 1% per month late fee on the unpaid balance as of that date.
- e) In the event that Contractor disputes the amount of Participation Fees billed or deducted by the Exchange, Contractor shall submit a written notice of such dispute to the Exchange within thirty (30) days following receipt of such bill or deduction by the Exchange. Contractor's notice will document the nature of the discrepancies, including, reconciliation of any differences identified by Contractor in enrollment or premiums collected. The Exchange will respond to Contractor within forty-five (45) days of receipt of the notice by either (i) paying the amount claimed by Contractor or (ii) providing a detailed explanation for the denial of the refund. If the Contractor still disputes the findings of the Exchange, Contractor may pursue additional remedies in accordance with Section 12.1.
- f) Subject to the provisions of Section 10.5, Contractor agrees to a periodic audit or other examination by the Exchange or its designee regarding the computation and payment of Participation Fees. In the case of material non-compliance with Participation Fee payments, Contractor shall implement any necessary corrective action. The Exchange may perform follow up audits or examinations more frequently than annually to monitor Contractor's implementation of such corrective actions.
- g) Contractor acknowledges that the Exchange is required under Government Code §100520(c) to maintain a prudent reserve as determined by the Exchange.

5.2 Covered California for Small Business Exchange

5.2.1 Rates and Payments

- a) Schedule of Rates. The rates for the Covered California for Small Business plan year 2016 are set forth in Attachment 10 ("Monthly Rates - Covered California for Small Business"). The parties acknowledge and agree that the premium rates for Covered California for Small

Business are actuarially determined to assure that premium revenues and cost sharing contributions will provide the total dollar amount necessary to support (i) the provision of Covered Services by Contractor through its QHPs, (ii) administrative expenses and reasonable reserves by Contractor to meet the requirements outlined in this Agreement and in accordance with applicable laws, rules and regulations, and (iii) the Contractor's payment of the Participation Fee to the Exchange. The Participation Fee payable with respect to Enrollees in Covered California for Small Business includes a fee specified by the Exchange as necessary to support payment of agent and general agent commissions, (set at \$18.60 per member per month for 2016). Contractor acknowledges and agrees that any Participation Fees due to the Exchange from Contractor shall be withheld by the Exchange before passing through any premium payments received by the Exchange from Employers and Employees to Contractor in accordance with paragraph (d) of this Section 5.2.1.

- b) Updates. The Monthly Rates shall be established in accordance with the procedures set forth at Section 3.5 and in Attachment 11 ("Rate Updates - Covered California for Small Business"). The Exchange may authorize an update of rates no more frequently than on a quarterly basis in the Covered California for Small Business in accordance with requirements and update schedules to be determined by the Exchange.
- c) Rate Determinations. Rates will be determined by the Exchange in accordance with applicable laws, rules and regulations. Rates for Employers and all covered Employees will be determined by the ZIP Code of the Employer's primary business address. Rates for an Employer and all covered Employees will be determined and frozen at initial enrollment, or upon renewal, for twelve (12) months, until the next group renewal. Rates for all Employees including new Employees or Employees with qualifying events during the Employer plan year will be determined by the prevailing rates at group enrollment.
- d) Collection and Remittance. The Exchange agrees to perform collection and aggregation of monthly premiums with respect to Contractor's QHPs in the Small Business Exchange and will remit said premiums, net of (i) Participation Fees payable to the Exchange and (ii) the fee associated with agent commissions paid by the Exchange pursuant to Section 2.3.6.
- e) The Exchange's collection of premiums and remittance of net amounts to Contractor as described in this Section shall be made on a monthly basis.
- f) Grace Period. Contractor acknowledges and agrees that applicable laws, rules and regulations, including, the Knox-Keene Act and Insurance Code, set a grace period with respect to the delinquent payment of premiums for the small group market. Contractor agrees to comply with the requirements set forth at Section 2.3.2 and required under applicable laws, rules and regulations with respect to these grace periods.

5.2.2 Covered California for Small Business Participation Fees

- a) Contractor understands and agrees that (i) under the Affordable Care Act and the California Affordable Care Act, the Exchange may generate funds through a participation fee (“Participation Fees”) on Contractor’s 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 collected by Contractor by spreading the cost across the premiums charged to Contractor’s entire small employer risk pool (both inside and outside the Exchange) for Covered California for Small Business Participation Fees. No rate charged to an Enrollee can have a higher per member per month fee to cover this overall Participation Fee than is charged to all other enrollees of the respective risk pool.
- c) With respect to Covered California for Small Business, Contractor acknowledges that (i) the Exchange is responsible for collecting premiums from Employers and Employees, and (ii) the Exchange will remit applicable Employer and Employee premiums collected by the Exchange to Contractor, net of (1) Participation Fees computed in accordance with the Participation Methodology - Covered California for Small Business, and (2) agent commissions determined in accordance with the terms set forth at Section 2.3.6. The Exchange shall transfer funds to Contractor on a monthly basis or such other intervals as mutually agreed upon by the Exchange and Contractor and shall establish a process to resolve any disagreements on premium amounts due in a timely manner and prior to transfer of funds to Contractor as required under this Section.
- d) In the event that Contractor disputes the amount of Participation Fees billed or deducted by the Exchange, Contractor shall submit a written notice of such dispute to the Exchange within thirty (30) days following receipt of such bill or deduction by the Exchange. Contractor’s notice will document the nature of the discrepancies, including reconciliation of any differences identified by Contractor in enrollment or premiums collected. The Exchange will respond to Contractor within forty-five (45) days of receipt of the notice by either (i) paying the amount claimed by Contractor or (ii) providing a detailed explanation for the denial of the refund. If the Contractor still disputes the findings of the Exchange, Contractor may pursue additional remedies in accordance with Section 12.1.
- e) Subject to the provisions of Section 10.5, Contractor agrees to a periodic audit or other examination by the Exchange or its designee regarding the computation and payment of Participation Fees. In the case of material non-compliance with Participation Fee payments, Contractor shall implement any necessary corrective action and follow up audits or examinations may be performed by the Exchange more frequently than annually to monitor Contractor’s implementation of such corrective actions.
- f) Contractor acknowledges that the Exchange is required under Government Code § 100520(c) to maintain a prudent reserve as determined by the Exchange.

ARTICLE 6 – PERFORMANCE MEASURES

6.1 Standards

Contractor shall comply with the performance measurement standards set forth in Attachment 14 (“Performance Measurement 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 25% 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 Measurement 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 failed, delayed, and/or other performance that does not meet the Performance Measurement Standards, the amounts to be determined in accordance with the Performance Measurement Standards set forth at Attachment 14.

The assessment of fees relating to the failure to meet Performance Measurement Standards shall be subject to the following: (1) be determined in accordance with the amounts and other terms set forth in the Performance Measurement 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 shall commence on the date on which Contractor's QHPs are certified and the Agreement is executed by all parties ("Agreement Effective Date"), and expire on [December 31, 2016] ("Expiration Date"), unless terminated earlier or extended in accordance with the provisions 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 and/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 and/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

The Exchange shall have all rights afforded by law in case of Contractor default, including, but not limited to: Decertification of Contractor's QHPs and termination of this Agreement.

- a) Recovery of damages to the Exchange caused by Contractor delay or non-performance;
- b) Imposing sanctions under the Performance Measures;
- c) Specific performance of particular covenants made by Contractor hereunder; and
- d) Initiating an action or proceeding for damages, declaratory or injunctive relief.

All remedies of the Exchange under this Agreement for Contractor default are cumulative to the extent permitted by law.

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 during any Contract Year regarding Contractor's election to not seek recertification of Contractor's QHP as of the expiration of the Agreement ("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 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, Employers and Employees in Covered California for Small Business and other stakeholders regarding the transition of Enrollees to another QHP.

- c) Individual Exchange. The following provisions shall apply to the Individual Exchange.
 - i. During the thirty (30) day period following the Exchange's receipt of the Non-Recertification Election, Contractor shall (i) be removed from the enrollment and eligibility assignment process, and (ii) no longer receive assignment of new Enrollees;
 - ii. Contractor will provide coverage for Enrollees assigned to Contractor as of the date of the Non-Recertification Election if coverage commences within the sixty (60) day period following the Notice of Non-Recertification. Contractor shall provide coverage for such

Enrollees until the earlier of (i) the end of the Contract Year, or (ii) the Enrollee's transition to another QHP during the Special Enrollment Period; and

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

d) Covered California for Small Business. The following provisions shall apply to the Covered California for Small Business Exchange:

i. In the event that Contractor continues to offer small group coverage in the State following the Notice of Non-Recertification Election, Contractor shall comply with applicable laws, rules and regulations relating to the discontinuation of a benefit package, including those set forth at Section 1365 of the Health and Safety Code and Section 10713 of the Insurance Code.

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

1. In the event that an Employer's plan year, as determined in accordance with 45 C.F.R. § 155.725, expires between the July 1 effective date of the Non-Recertification Election and the expiration of the Contract Year on December 31, Contractor shall provide coverage to Employers and Employees until the termination of the Agreement that shall be effective upon the expiration of the Employer's first plan year that commences after the Non-Recertification Election.
2. In the event that an Employer's plan year terminates between January 1 and the July 1 effective date of the Notice of Non-Recertification, Contractor shall provide coverage until the termination of the Agreement effective upon the expiration of Employer's first plan year that commences prior to the July 1 effective date of the Notice of Non-Recertification.
3. In the event that an Employer's plan year expires more than ninety (90) days following the Notice of Non-Recertification Election, the Exchange shall notify Employers and Employees in a format approved by the Exchange that Contractor's QHP will not be available upon the next renewal anniversary date.

ii. Contractor shall comply with other requirements of the Exchange relating to the continuation and transition of coverage following Contractor's Non-Recertification Election, including, without limitation, those relating to protocols and timing for the removal of Contractor from the listing of QHPs to be selected by Employers and Employees, the commencement of coverage for new Employers and Employees, and termination and transition of coverage.

7.4 Decertification

Notwithstanding any other language set forth in this Section 7.4, the Agreement shall expire on the Expiration Date set forth in Section 7.1 in the event that the Exchange elects to decertify Contractor's 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 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 7.4 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 and/or otherwise required under Section 7.6, following the termination of this Agreement. Such cooperation shall include, without limitation, 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 and Employers in accordance with a timeline to be established by the Exchange.
 - iii. In order to assure the proper transition of Services provided prior to, and subsequent to, termination, Contractor will forward to any new QHP the electronic and direct paper claims that are received by Contractor but which relate to Services provided by new contractor. Any such information shall be subject to compliance with applicable laws, rules and regulations and shall be sent at such time periods and in the manner requested by the Exchange for a period of up to three (3) months following the termination date.
 - iv. Contractor shall provide customer service to support the processing of claims for Covered Services rendered on or before the termination date for a period of two (2) months or such other longer period reasonably requested by the Exchange at a cost to be mutually agreed upon per Enrollee.
 - v. If so instructed by the Exchange in the termination notice, Contractor shall promptly discontinue the provision of Services requested by the Exchange to be discontinued as of the date requested by the Exchange.
 - vi. Contractor will perform reasonable and necessary acts requested by the Exchange and as required under applicable laws, rules, regulations, and consistent with industry standards to facilitate transfer of Covered Services herewith to a succeeding Contractor. Contractor shall comply with requirements reasonably imposed by the Exchange relating to (i) the discontinuation of new enrollment or re-enrollment in Contractor's QHP, (ii) the transfer of Enrollee coverages to another QHP prior to the commencement date, (iii) the expiration

of existing quotes, and (iv) such other protocols that may reasonably be established by the Exchange.

- vii. Contractor will reasonably cooperate with the Exchange and any successor QHP Issuer in good faith with respect to taking such actions that are reasonably determined to be the best interest of the QHP Issuer, Enrollees, and Employers.
- f) Contractor shall cooperate with the Exchange's conduct of an accounting of amounts paid or payable and Enrollees enrolled during the month in which termination is effective in order to assure an appropriate determination of premiums earned by and payable to Contractor for Services rendered prior to the date of termination, which shall be accomplished as follows:
 - 1) Mid-Month Termination: For a termination of this Agreement that occurs during the middle of any month, the premium for that month shall be apportioned on a pro rata basis. Contractor shall be entitled to premiums from Enrollees for the period of time prior to the date of termination and Enrollees shall be entitled to a refund of the balance of the month.
 - 2) Responsibility to Complete Contractual Obligations: Contractor is responsible for completing submission and corrections to Encounter Data for 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 and 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, without limitation: (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/or (iii) communicating with affected Enrollees in cooperation with the Exchange and/or the succeeding contractor, each as shall be reasonably requested by the Exchange.
- b) In the event of the termination or expiration of the Agreement requires the transfer of some or all Enrollees into any other health plan, the terms of coverage under Contractor's QHP shall not be carried over to the replacement QHP but rather the transferred Enrollees shall be

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

- c) Notwithstanding the foregoing, the coverage of Enrollee under Contractor's QHP may be extended to the extent that an Enrollee qualifies for an extension of benefits including, those to effect the continuity of care required due to hospitalization or disability pursuant to Health and Safety Code section 1399.62. For purposes of this Agreement, "disability" means that the Enrollee has been certified as being totally disabled by the Enrollee's treating physician, and the certification is approved by Contractor. Such certification must be submitted for approval within thirty (30) days from the date coverage is terminated. Recertification of Enrollee's disability status must be furnished by the treating Provider not less frequently than at sixty (60) calendar day intervals during the period that the extension of benefits is in effect. The extension of benefits shall be solely in connection with the condition causing total disability. This extension, which is contingent upon payment of the applicable premiums, shall be provided for the shortest of the following periods:
- i. Until total disability ceases;
 - ii. For a maximum period of twelve (12) months after the date of termination, subject to plan maximums;
 - iii. Until the Enrollee's enrollment in a replacement plan; or
 - iv. Recertification.

ARTICLE 8 – INSURANCE AND INDEMNIFICATION

8.1 Contractor Insurance

8.1.1 Required Coverage

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

Contractor's obligations under this Agreement. The minimum acceptable limits shall be as indicated below:

- i. Commercial general liability or equivalent self-insurance covering the risks of bodily injury (including death), property damage and personal injury, including coverage for contractual liability, with a limit of not less than \$1 million per occurrence/\$2 million general aggregate;
- ii. Comprehensive business automobile liability (owned, hired, or non-owned vehicles used by Contractor in connection with performance of its obligations under this Agreement) covering the risks of bodily injury (including death) and property damage, including coverage for contractual liability, with a limit of not less than \$1 million per accident;
- iii. Employers liability insurance covering the risks of Contractor's employees and employees' bodily injury by accident or disease with limits of not less than \$1 million per accident for bodily injury by accident and \$1 million per employee for bodily injury by disease and \$1 million disease policy limit;
- iv. Umbrella policy providing excess limits over the primary general liability, automobile liability and employer's liability policies in an amount not less than \$10 million per occurrence and in the aggregate;
- v. Crime coverage at such levels consistent with industry standards and reasonably determined by Contractor to cover occurrences falling in the following categories: computer and funds transfer fraud; forgery; money and securities; and employee theft; and
- vi. Professional liability or errors and omissions with coverage of not less than \$1 million per claim/\$2 million general aggregate.

8.1.2 Workers' Compensation

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

8.1.3 Subcontractor Coverage

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

8.1.4 Continuation of Required Coverage

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

8.1.5 Premium Payments and Disclosure

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

8.2 Indemnification

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

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

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

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

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

ARTICLE 9 – PRIVACY AND SECURITY

9.1 Privacy and Security Requirements for Personally Identifiable Data

- a) HIPAA Requirements. Contractor agrees to comply with applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), including the Administrative Simplification Provisions of HIPAA, as codified at 42 U.S.C. § 1320d et seq., the Health Information Technology for Economic and Clinical Health Act of 2009 (“HITECH”), and any current and future regulations promulgated under HITECH or HIPAA, all as amended from time to time and collectively referred to herein as the “HIPAA Requirements”. Contractor agrees not to use or further disclose any Protected Health Information, other than as permitted or required by the HIPAA Requirements and the terms of this Agreement.
- b) Exchange Requirements. With respect to Contractor Exchange Functions, Contractor agrees to comply with following privacy and security requirements and standards applicable to Personally Identifiable Information which have been established and implemented by the Exchange in accordance with the requirements of 45 C.F.R. Part 155(a) (collectively, “the Exchange Requirements”):
 - i. Uses and Disclosures. Pursuant to the terms of this Agreement, Contractor may receive from the Exchange Protected Health Information and/or Personally Identifiable Information in connection with Contractor Exchange Functions that is protected under applicable Federal and State laws and regulations. Contractor shall not use or disclose such Protected Health Information or Personally Identifiable Information obtained in connection with Contractor Exchange Functions other than as is expressly permitted under the Exchange Requirements and only to the extent necessary to perform the functions called for within this Agreement.
 - ii. Fair Information Practices. Contractor shall implement reasonable and appropriate fair information practices to ensure:
 - 1. Individual Access. Contractor shall provide access to, and permit inspection and copying of Protected Health Information and Personally Identifiable Information in

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

2. Amendment. Contractor shall provide an individual with the right to request an amendment of inaccurate Protected Health Information and Personally Identifiable Information. Contractor shall respond to such individual within sixty (60) days of such a request either by making the correction and informing the individual of such correction or notifying the individual in writing that the request was denied, which notice shall provide an explanation for the denial and explain that the individual may submit a statement of disagreement with the denial.
3. Openness and Transparency. Contractor shall make available to individuals applicable policies, procedures, and technologies that directly affect such individuals and/or their Protected Health Information and Personally Identifiable Information.
4. Choice. Contractor shall provide individuals with a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their Protected Health Information and Personally Identifiable Information.
5. Limitations. Contractor represents and warrants that all Protected Health Information and Personally Identifiable Information shall be collected, used, and/or disclosed under this Agreement only to the extent necessary to accomplish a specified purpose under the terms of this Agreement or as permitted by the Exchange Requirements and never to discriminate inappropriately.
6. Data Integrity. Contractor shall implement policies and procedures reasonably intended to ensure that Protected Health Information and Personally Identifiable Information in its possession is complete, accurate, and current, to the extent necessary for the Contractor's intended purposes, and has not been altered or destroyed in an unauthorized manner.
7. Safeguards. Contractor shall have in place administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Protected Health Information and Personally Identifiable Information that it creates, receives, maintains or transmits pursuant to the Agreement and to prevent the use or disclosure of Protected Health Information and/or Personally

Identifiable Information other than as provided for in this Agreement, or as required by law. In furtherance of compliance with such requirements, Contractor shall:

- a. Encrypt all Protected Health Information and/or Personally Identifiable Information that is in motion or at rest, including but not limited to data on portable media devices, using commercially reasonable means, consistent with applicable Federal and State laws, regulations and agency guidance, including but not limited to the U.S. Department of Health and Human Services Guidance Specifying the Technologies and Methodologies That Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements or issued by the National Institute for Standards and Technology (“NIST”) concerning the protection of identifiable data such as Protected Health Information and/or Personally Identifiable Information. Data centers shall be encrypted or shall otherwise comply with industry data security best practices.
- b. Implement a contingency plan for responding to emergencies and/or disruptions to business that in any way affect the use, access, disclosure or other handling of Protected Health Information and/or Personally Identifiable Information;
- c. Maintain and exercise a plan to respond to internal and external security threats and violations;
- d. Maintain an incident response plan;
- e. Maintain technology policies and procedures that provide reasonable safeguards for the protection of Protected Health Information and Personally Identifiable Information stored, maintained or accessed on hardware and software utilized by Contractor and its subcontractors and agents;
- f. Mitigate to the extent practicable, any harmful effect that is known to Contractor of any Security Incident related to Protected Health Information and/or Personally Identifiable Information or of any use or disclosure of Protected Health Information and/or Personally Identifiable Information by Contractor or its subcontractors or agents in violation of the requirements of this Agreement or applicable privacy and security laws and regulations and agency guidance;
- g. Destroy Protected Health Information and Personally Identifiable Information in a manner consistent with applicable State and Federal laws, regulations, and agency guidance on the destruction of Protected Health Information and Personally Identifiable Information; and
- h. Comply with all applicable Exchange policies within Section 9.2. Protection of Information Assets, including, but not limited to, executing non-disclosure

agreements and other documents required by such policies. Contractor shall also require any subcontractors and agents to comply with all such Exchange policies.

- c) California Requirements. With respect to all provisions of information under this Agreement, Contractor agrees to comply with all applicable California state health information privacy and security laws applicable to Personally Identifiable Information, including but not limited to the confidentiality of the Medical Information Act, the California Insurance Information and Privacy Protection Act, and the Information Practices Act, all collectively referred to as “California Requirements.”
- d) Interpretation. Notwithstanding any other provisions in this section, to the extent a conflict arises between the permissibility of a use or disclosure of Protected Health Information or Personally Identifiable Information under the HIPAA Requirements, the Exchange Requirements, or California Requirements with respect to Contractor Exchange Functions, the applicable requirements imposing the more stringent privacy and security standards to such uses and disclosures shall apply. In addition, any ambiguity in this Agreement regarding the privacy and security of Protected Health Information and/or Personally Identifiable Information shall be resolved to permit the Exchange and Contractor to comply with the most stringent of the applicable privacy and security laws or regulations.
- e) Breach Notification.
 - i. Contractor shall report to the Exchange: (i) any use or disclosure of Protected Health Information and/or Personally Identifiable Information not permitted by this Agreement; (ii) any Security Incident involving Protected Health Information and/or Personally Identifiable Information created or received in connection with Contractor Exchange Functions; and/or (iii) any breach as defined in the HIPAA Requirements or California Requirements – in connection with Protected Health Information and/or Personally Identifiable Information created or received in connection with Contractor Exchange Functions (each of which shall be referred to herein as a “Breach”).
 - ii. Contractor shall, without unreasonable delay, but no later than within three (3) days after Contractor’s discovery of a Breach, report such Breach to the Exchange. In addition, Contractor shall, without unreasonable delay, but no later than within five (5) days after Contractor’s discovery of a successful Security Incident not involving Protected Health Information and/or Personally Identifiable Information, report such successful Security Incident not involving Protected Health Information and/or Personally Identifiable Information to the Exchange. Any such report will be made on a form made available to Contractor, or by such other reasonable means of reporting as may be communicated to Contractor by the Exchange.
 - iii. Contractor shall cooperate with the Exchange in investigating the Breach and/or successful Security Incident not involving Protected Health Information and/or Personally Identifiable Information and in meeting the Exchange’s obligations, if any, under

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

- iv. To the extent possible, Contractor's initial report shall include: (a) the names of the individual(s) whose Protected Health Information and/or Personally Identifiable Information has been, or is reasonably believed by Contractor to have been accessed, acquired, used or disclosed or in the event of a successful Security Incident not involving Protected Health Information and/or Personally Identifiable Information, provide such information regarding the nature of the information system intrusion and any systems potentially compromised; (b) a brief description of what happened including the date of the incident and the date of the discovery of the incident, if known; (c) a description of the types of Protected Health Information and/or Personally Identifiable Information that were involved in the incident, as applicable; (d) a brief description of what Contractor is doing or will be doing to investigate, to mitigate harm to the individual(s) and to its information systems, and to protect against recurrences; and (e) any other information that the Exchange determines it needs to include in notifications to the individual(s) or relevant regulatory authorities under applicable privacy and security requirements.
- v. After conducting its investigation, and within fifteen (15) days, unless an extension is granted by the Exchange, Contractor shall file a complete report with the information listed above, if available. Contractor shall make all reasonable efforts to obtain the information listed above and shall provide an explanation if any information cannot be obtained. Contractor and the Exchange will cooperate in developing content for any public statements.
- vi. Contractor also shall, on at least a quarterly basis, report to the Exchange the occurrence and nature of attempted but Unsuccessful Security Incidents (as defined herein). "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Contractor's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Protected Health Information and/or Personally Identifiable Information.

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

- i. Subcontractors and Agents. Contractor shall enter into an agreement with any agent or subcontractor that will have access to Protected Health Information and/or Personally Identifiable Information that is received from, or created or received by, Contractor on behalf of the Exchange or in connection with this Agreement, or any of its contracting Plans

pursuant to which such agent or subcontractor agrees to be bound by the same or more stringent restrictions, terms and conditions as those that apply to Contractor pursuant to this Agreement with respect to such Protected Health Information and Personally Identifiable Information.

- ii. Exchange Operations. Unless otherwise agreed to by the Contractor and the Exchange, Contractor shall provide de-identified patient medical and pharmaceutical information needed by the Exchange to effectively oversee and administer the Plans. As used in this Subsection (f), the term “de-identified” shall have the meaning set forth in 45 C.F.R. § 164.514.
- iii. Records and Audit. Contractor agrees to make its internal practices, books and records relating to the use and disclosure of Protected Health Information and/or Personally Identifiable Information received from the Exchange, or created or received by Contractor on behalf of the Exchange or in connection with this Agreement available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Contractor’s and/or the Exchange’s compliance with HIPAA Requirements. In addition, Contractor shall provide the Exchange with information concerning its safeguards described throughout this Section and/or other information security practices as they pertain to the protection of Protected Health Information and Personally Identifiable Information, as the Exchange may from time to time request. Failure of Contractor to complete or to respond to the Exchange’s request for information within the reasonable timeframe specified by the Exchange shall constitute a material breach of this Agreement. In the event of a Breach or Security Incident related to Protected Health Information and/or Personally Identifiable Information or any use or disclosure of Protected Health Information and/or Personally Identifiable Information by Contractor in violation of the requirements of this Agreement, the Exchange will be permitted access to Contractor’s facilities in order to review policies, procedures and controls relating solely to compliance with the terms of this Agreement.
- iv. Electronic Transactions Rule. In conducting any electronic transaction that is subject to the Electronic Transactions Rule on behalf of any Plan, Contractor agrees to comply with all applicable requirements of the Electronic Transactions Rule set forth in 45 C.F.R. Part 162. Contractor agrees to require that any agent, including a subcontractor, of Contractor that conducts standard transactions with Protected Health Information and/or Personally Identifiable Information of the Plan comply with all applicable requirements of the Electronic Transactions Rule.
- v. Minimum Necessary. Contractor agrees to request and use only the minimum necessary type and amount of Protected Health Information required to perform its services and will comply with any regulations promulgated under the HIPAA Requirements and agency guidance concerning the minimum necessary standard pertaining to Protected Health

Information. Contractor will collect, use and disclose Personally Identifiable Information only to the extent necessary to accomplish a specified purpose under this Agreement.

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

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

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

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

- j) Contract Breach. Without limiting the rights of the parties pursuant to this Agreement, if Contractor breaches its obligations under this Section, the Exchange may, at its option: (a) exercise any of its rights of access and inspection under this Agreement; (b) require Contractor to submit to a plan of monitoring and reporting, as the Exchange may determine necessary to maintain compliance with this Agreement and such plan shall be made part of this Agreement; or (c) notwithstanding any other provisions of this Agreement, after giving Contractor opportunity to cure the breach, terminate this Agreement. If Contractor materially breaches its obligations under this Section, the Exchange may terminate this Agreement, with or without opportunity to cure the breach. The Exchange's remedies under this Section and any other

part of this Agreement or provision of law shall be cumulative, and the exercise of any remedy shall not preclude the exercise of any other.

9.2 Protection of Information Assets.

- a) The following terms shall apply as defined below:
- i. “Information Assets” means any information, including Confidential Information, necessary to the operation of either party that is created, stored, transmitted, processed or managed on any hardware, software, network components, or any printed form or is communicated orally. “Information Assets” does not include information that has been transferred from the Disclosing Party to the Receiving Party under applicable laws, regulations and agency guidance, and that is being maintained and used by the Receiving Party solely for purposes that are not Contractor Exchange Functions.
 - ii. “Confidential Information” includes, but is not limited, to any information (whether oral, written, visual or fixed in any tangible medium of expression), relating to either party’s services, operations, systems, programs, inventions, techniques, suppliers, customers and prospective customers (excluding the Exchange), cost and pricing data, trade secrets, know-how, processes, plans, reports, designs and any other information of or relating to the business or either party, including Contractor’s programs, but does not include information that (a) is described in the Evidence of Coverage booklets; (b) was known to the Receiving Party before it was disclosed to the Receiving Party by the Disclosing Party, (c) was or becomes available to the Receiving Party from a source other than the Disclosing Party, provided such fact is evidenced in writing and the source is not bound by a confidentiality obligation regarding such information to Disclosing Party, or (d) is developed by either party independently of the other party’s Confidential Information, provided that such fact can be adequately documented.
 - iii. “Disclosing Party” means the party who sends Information Assets that it owns to the other party for the purposes outlined in this Agreement.
 - iv. “Receiving Party” means the party who receives Information Assets owned by the other.
- b) The Receiving Party shall hold all Information Assets of the Disclosing Party in confidence and will not use any of the Disclosing Party’s Information Assets for any purpose, except as set forth in this Agreement, or as otherwise required by law, regulation or compulsory process.
- c) The Receiving Party must take all reasonable and necessary steps to prevent the unauthorized disclosure, modification or destruction of the Disclosing Party’s Information Assets. The Receiving Party must, at a minimum, use the same degree of care to protect the Disclosing Party’s Information Assets that it uses to protect its own Information Assets.

- d) The Receiving Party agrees not to disclose the Disclosing Party's Information Assets to anyone, except to employees or third parties who require access to the Information Assets pursuant to this Agreement, but only where such third parties have signed agreements regarding the Information Assets containing terms that are equivalent to, or stricter than, the terms of this Section, or as otherwise required by law.
- e) In the event the Receiving Party is requested to disclose the Disclosing Party's Information Assets pursuant to a request under the California Public Records Act (PRA), a summons, subpoena or in connection with any litigation, or to comply with any law, regulation, ruling or government or public agency request, the Receiving Party shall, to the extent it may do so lawfully, give the Disclosing Party five (5) business days notice of such requested disclosure and afford the Disclosing Party the opportunity to review the request before Receiving Party discloses the Information Assets. The Disclosing Party shall, in accordance with applicable law, have the right to take such action as it reasonably believes may be necessary to protect the Information Assets, and such action shall not be restricted by the dispute resolution process of this Agreement. If such request is pursuant to the PRA, the Exchange shall give Contractor five (5) business days notice to permit Contractor to consult with the Exchange prior to disclosure of any Confidential Information. This subdivision shall not apply to restrict disclosure of any information to the State or in connection with a dispute between the Exchange and Contractor or any audit or review conducted pursuant to this Agreement.
- f) The Receiving Party shall notify the Disclosing Party in writing of any unauthorized disclosure, modification or destruction of the Disclosing Party's Information Assets by the Receiving Party, its officers, directors, employees, contractors, agents or third parties. The Receiving Party shall make this notification promptly upon becoming aware of such disclosure, modification or destruction, but in any event, not later than four (4) days after becoming aware of the unauthorized disclosure, modification or destruction. After such notification, the Receiving Party agrees to cooperate reasonably, at the Receiving Party's expense, with the Disclosing Party to remedy or limit the unauthorized disclosure, modification or destruction and/or its effects.
- g) The Receiving Party understands and agrees the Disclosing Party may suffer immediate, irreparable harm in the event the Receiving Party fails to comply with any of its obligations under this Section, that monetary damages will be inadequate to compensate the Disclosing Party for such breach and that the Disclosing Party shall have the right to enforce this section by injunctive or other equitable remedies. The provisions of this Section shall survive the expiration or termination, for any reason, of this Agreement.
- h) To the extent that information subject to this Section on Protection of Information Assets is also subject to HIPAA Requirements, the Exchange Requirements or California Requirements in Section 9.1(b) and (c), such information shall be governed by the provisions of Section 9.1. In the event of a conflict or inconsistency between the requirements of the various applicable sections and attachments of this Agreement, including Section 9.1 and this Section 9.2,

Contractor shall comply with the provisions that provide the greatest protection against access, use or disclosure.

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

ARTICLE 10 – RECORDKEEPING

10.1 Clinical Records

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

10.2 Financial Records

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

this Agreement shall include, without limitation, those certain items identified in Attachment 13 (“Required Reports”).

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

10.6 Notice

Contractor shall promptly notify the Exchange in writing of any inquiry, audit, investigation, litigation, claim, examination, or other proceeding involving Contractor, or any Contractor personnel, Participating Provider or other authorized subcontractor, that is threatened or

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

10.7 Confidentiality

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

10.8 Tax Reporting

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

10.9 Electronic Commerce

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

ARTICLE 11 – INTELLECTUAL PROPERTY

11.1 Warranties

- a) Contractor represents, warrants and covenants to the best of its knowledge that:
- i. It has secured and will secure all rights and licenses necessary for its performance of this Agreement, including but not limited to consents, waivers, releases from all authors of or owners of any copyright interests in music or performances used, individuals, and talent (radio, television, and motion picture talent), owners of any interest in and to real estate site, locations, property, or props that may be used or shown.
 - ii. To the best of the Contractor's knowledge, neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary or contractual right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.
 - iii. Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute false or misleading advertising or a libel or slander against any person or entity, misuse of social media, or violate privacy rights.
 - 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

In any agreement 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 Code of Federal Regulations part 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 raw materials and information developed for the purposes of producing those final products. Works do not include articles submitted to peer review or reference journals or independent research projects.

11.5 Survival

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

ARTICLE 12 – SPECIAL TERMS AND CONDITIONS

12.1 Dispute Resolution

- a) If any dispute arising out of or in connection with this Agreement is not resolved within thirty (30) days, or such other reasonable period of time determined by Contractor and the Exchange staff normally responsible for the administration of this Agreement, the parties shall attempt to resolve the dispute through the submission of the matter for executive level involvement. The executive officer of each party or his or her designated representative shall meet and confer to attempt to resolve the dispute. If the parties agree, a neutral third party mediator may be engaged to assist in dispute resolution at either the line employee level or the executive level, or both. If after expending reasonable efforts at executive level resolution of the dispute, no resolution can be reached within thirty (30) days or such other reasonable period determined by Contractor and the Exchange, then either party may seek its rights and remedies in a court of competent jurisdiction or otherwise available under this Agreement or applicable laws, rules and regulations.
- b) Each party shall document in writing the nature of each dispute and the actions taken to resolve any disputes utilizing this dispute resolution procedure. Each party shall act in good faith to resolve such disputes. Neither party may seek its rights and remedies in court

respecting any such notice of termination for default without first following the dispute resolution process stated in this section.

- c) The Exchange and Contractor agree that the existence of a dispute notwithstanding, they will continue without delay to carry out all their responsibilities under this Agreement which are not affected by the dispute.
- d) Either party may request an expedited resolution process if such party determines that irreparable harm will be caused by following the timelines set forth in Section 12.1(a). If the other party does not consent to such expedited process, the requesting party will hire, at its sole cost and expense, an independent mediator to determine whether such an expedited process is necessary to avoid or reduce irreparable harm. In the event that the mediator determines that irreparable harm may result from delays required under the thirty (30) day period required under Section 12.1(a), the parties will engage in an expedited process that will require the parties to resolve the dispute within five (5) business days or such other period as mutually agreed upon by the parties.
- e) This section shall survive the termination or expiration of this Agreement.

12.2 Attorneys' Fees

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

12.3 Notices

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

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

Attention: Anne Price
1601 Exposition Blvd.
Sacramento, CA 95815
Telephone No. (916) 228-8660 FAX No. (916) _____
Email: Anne.Price@covered.ca.gov

For Contractor:

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

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

12.4 Amendments

- a) By the Exchange. In the event that any law or regulation is enacted or any decision, opinion, interpretive policy or guidance of a court or governmental agency is issued (any of the foregoing, a “Change in Law”) that the Exchange determines, based on its consultation with legal counsel, other regulators or other state-based or Federal health benefit exchanges: (i) affects or may affect the legality of this Agreement or any provision hereof or cause this Agreement or any provision hereof to prevent or hinder compliance with laws, rules or regulations, or (ii) adversely affects or may adversely affect the operations of the Exchange or the ability of the Exchange or Contractor to perform its respective obligations hereunder or receive the benefits intended hereunder, the Exchange may, by written notice to Contractor, amend this Agreement to comply with or otherwise address the Change in Law in a manner reasonably determined by the Exchange to carry out the original intent of the parties to the extent practical in light of such Change in Law. Such amendment shall become effective upon sixty (60) days’ notice, or such lesser period as required for compliance or consistency with the Change in Law or to avoid the adverse effect of the Change in Law. If Contractor objects to such amendment, it must notify the Exchange in writing within twenty (20) days of receipt of notice from the Exchange. If the parties are unable to agree on an amendment within thirty (30) days thereafter, the Exchange may terminate this Agreement.
- b) Other Amendments. Except as provided in Section 12.4(a), this Agreement may be amended only by mutual consent of the parties. Except as provided herein, no alteration or variation of the terms of this Agreement shall be valid unless made in writing and signed by the parties hereto, and no oral understanding or agreement not incorporated herein shall be binding on any of the parties hereto.

12.5 Time is of the Essence

Time is of the essence in this Agreement.

12.6 Publicity

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

12.7 Force Majeure

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

12.8 Further Assurances

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

12.9 Binding Effect

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

12.10 Titles/Section Headings

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

12.11 Severability

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

12.12 Entire Agreement/Incorporated Documents/Order of Precedence

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

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

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.

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 New Entrant Certification Application or QHP Issuer Recertification Application for Plan Year 2016.

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

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

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

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

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

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

CCR – The California Code of Regulations.

CDI – The California Department of Insurance.

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

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

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

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

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

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

DHCS – The California Department of Health Care Services.

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

DMHC – The California Department of Managed Health Care.

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

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

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

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

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

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

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

Enrollee – Enrollee means each and every individual or an Employee 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 or Employee’s family, as defined in 26 U.S.C. § 36B (d)(1).

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

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

Health Care Professional – An individual with current and appropriate licensure, certification, or accreditation in a medical or behavioral health profession, including without limitation, medical doctors

(including psychiatrists), dentists, osteopathic physicians, psychologists, registered nurses, nurse practitioners, licensed practical nurses, certified medical assistants, licensed physician assistants, mental health professionals, chemical dependency counselors, clinical laboratory professionals, allied health care professionals, pharmacists, social workers, physical therapists, occupational therapists, and others to provide Covered Services.

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

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

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

Health Insurance Regulators – CDI and DMHC, as applicable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Premium – The dollar amount payable by the Enrollee, Employer, or Employee 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 Provider (PCP) – The following types of health care providers or organizations are considered Primary Care Providers: a California licensed doctor of medicine or osteopathy who is a general or family practitioner, internist, obstetrician-gynecologist, nurse practitioner, physicians’ assistant, or Health Center and who has a contract with the Contractor to assume the primary responsibility for providing initial and primary medical care to enrollees.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attachment 1 – Contractor’s Qualified Health Plan List

Attachment 2 – 2016 Standard Benefit Plan Designs

2016 Standard Benefit Plan Designs

May 21, 2015

Final OAL-approved



Summary of Benefits and Coverage

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

		Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator		88.5%	89.5%
Plan design includes a deductible?		No	No
Integrated Individual deductible		\$0	\$0
Integrated Family deductible		\$0	\$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Individual Out-of-pocket maximum		\$4,000	\$4,000
Family Out-of-pocket maximum		\$8,000	\$8,000
HSA plan: Self-only coverage deductible		N/A	N/A
HSA family plan: Individual deductible		N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$20		\$20	
	Other practitioner office visit	\$20		\$20	
	Specialist visit	\$40		\$40	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$20		\$20	
	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs)	10%		\$150	
Drugs to treat illness or condition	Tier 1	\$5		\$5	
	Tier 2	\$15		\$15	
	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		\$250	
	Physician/surgeon fees	10%		\$40	
	Outpatient visit	10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	10%		No charge	
	Emergency medical transportation	\$150		\$150	
Hospital stay	Urgent care	\$40		\$40	
	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%		\$40	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$20		\$20	
	Mental/Behavioral health other outpatient items and services	\$20		\$20	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%		\$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee	10%		\$40	
	Substance Use disorder outpatient office visits	\$20		\$20	
	Substance Use disorder other outpatient items and services	\$20		\$20	
	Substance Use inpatient facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpatient physician/surgeon fee	10%		\$40	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	\$250 per day up to 5 days	
		Professional	10%		\$40
Help recovering or other special health needs	Home health care	10%		\$20	
	Outpatient Rehabilitation services	\$20		\$20	
	Outpatient Habilitation services	\$20		\$20	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	20%		\$25	
Child Dental Major Services	Root Canal- Molar			\$300	
	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or Erupted	50%		\$65	
	Extraction- Complete Bony			\$160	
	Porcelain with Metal Crown			\$300	
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

2016 Standard Benefit Plan Designs

10.0 EHB

Date: May 21, 2015

Summary of Benefits and Coverage

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

		Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator		80.2%	81.0%
Plan design includes a deductible?		No	No
Integrated Individual deductible		\$0	\$0
Integrated Family deductible		\$0	\$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Individual Out-of-pocket maximum		\$6,200	\$6,200
Family Out-of-pocket maximum		\$12,400	\$12,400
HSA plan: Self-only coverage deductible		N/A	N/A
HSA family plan: Individual deductible		N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
	Other practitioner office visit	\$35		\$35	
	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$50		\$50	
	Imaging (CT/PET scans, MRIs)	20%		\$250	
Drugs to treat illness or condition	Tier 1	\$15		\$15	
	Tier 2	\$50		\$50	
	Tier 3	\$70		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		\$600	
	Physician/surgeon fees	20%		\$55	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250		\$250	
	Emergency room physician fee (waived if admitted)	20%		No charge	
	Emergency medical transportation	\$250		\$250	
	Urgent care	\$60		\$60	
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%		\$55	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$35		\$35	
	Mental/Behavioral health other outpatient items and services	\$35		\$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee	20%		\$55	
	Substance Use disorder outpatient office visits	\$35		\$35	
	Substance Use disorder other outpatient items and services	\$35		\$35	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpatient physician/surgeon fee	20%		\$55	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	20%		\$600 per day up to 5 days	
Help recovering or other special health needs	Home health care	20%		\$30	
	Outpatient Rehabilitation services	\$35		\$35	
	Outpatient Habilitation services	\$35		\$35	
	Skilled nursing care	20%		\$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	20%		\$25	
Child Dental Major Services	Root Canal- Molar			\$300	
	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or Erupted	50%		\$65	
	Extraction- Complete Bony			\$160	
Child Orthodontics	Porcelain with Metal Crown			\$300	
	Medically necessary orthodontics	50%		\$1,000	

2016 Standard Benefit Plan Designs
10.0 EHB
Date: May 21, 2015

Summary of Benefits and Coverage

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

		Individual	
		Silver Plan	
Actuarial Value - AV Calculator		70.4%	
Plan design includes a deductible?		Yes, Medical/Pharmacy	
Integrated Individual deductible		N/A	
Integrated Family deductible		N/A	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$2,250 / \$250 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$4,500 / \$500 / \$0	
Individual Out-of-pocket maximum		\$6,250	
Family Out-of-pocket maximum		\$12,500	
HSA plan: Self-only coverage deductible		N/A	
HSA family plan: Individual deductible		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$45	
	Other practitioner office visit	\$45	
	Specialist visit	\$70	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	\$35	
	X-rays and Diagnostic Imaging	\$65	
	Imaging (CT/PET scans, MRIs)	\$250	
Drugs to treat illness or condition	Tier 1	\$15	
	Tier 2	\$50	Pharmacy deductible
	Tier 3	\$70	Pharmacy deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
	Outpatient visit	20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250	X
	Emergency room physician fee (waived if admitted)	\$50	X
	Emergency medical transportation	\$250	X
	Urgent care	\$90	
Hospital stay	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$45	
	Mental/Behavioral health other outpatient items and services	\$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X
	Substance Use disorder outpatient office visits	\$45	
	Substance Use disorder other outpatient items and services	\$45	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X
	Substance use disorder inpatient physician/surgeon fee	20%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services	Hospital Professional	20% 20%
Help recovering or other special health needs	Home health care	\$45	
	Outpatient Rehabilitation services	\$45	
	Outpatient Habilitation services	\$45	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
Child eye care	Hospice service	No charge	
	Eye exam	No charge	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
	Preventive - X-ray		
	Sealants per Tooth		
Child Dental Basic Services	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Major Services	Amalgam Fill - 1 Surface	20%	
	Root Canal- Molar		
	Gingivectomy per Quad		
	Extraction- Single Tooth Exposed Root or Erupted		
Child Orthodontics	Extraction- Complete Bony	50%	
	Porcelain with Metal Crown		
	Medically necessary orthodontics	50%	

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

		SHOP Silver Coinsurance Plan		SHOP Silver Copay Plan	
Actuarial Value - AV Calculator		71.6%		71.3%	
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy	
Integrated individual deductible		N/A		N/A	
Integrated Family deductible		N/A		N/A	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$1,500 / \$250 / \$0		\$1,500 / \$250 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$3,000 / \$500 / \$0		\$3,000 / \$500 / \$0	
Individual Out-of-pocket maximum		\$6,500		\$6,500	
Family Out-of-pocket maximum		\$13,000		\$13,000	
HSA plan: Self-only coverage deductible		N/A		N/A	
HSA family plan: Individual deductible		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$45		\$45	
	Other practitioner office visit	\$45		\$45	
	Specialist visit	\$70		\$70	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
Drugs to treat illness or condition	Tier 1	\$15		\$15	
	Tier 2	\$55	Pharmacy deductible	\$55	Pharmacy deductible
	Tier 3	\$75	Pharmacy deductible	\$75	Pharmacy deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250	X	\$250	X
	Emergency room physician fee (waived if admitted)	\$50	X	\$50	X
	Emergency medical transportation	\$250	X	\$250	X
	Urgent care	\$90		\$90	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%	X	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$45		\$45	
	Mental/Behavioral health other outpatient items and services	\$45		\$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	20%	X
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X	20%	X
	Substance Use disorder outpatient office visits	\$45		\$45	
	Substance Use disorder other outpatient items and services	\$45		\$45	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	20%	X
	Substance use disorder inpatient physician/surgeon fee	20%	X	20%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	Hospital Professional	20% X	20% 20%	X X
Help recovering or other special health needs	Home health care	20%		\$45	
	Outpatient Rehabilitation services	\$45		\$45	
	Outpatient Habilitation services	\$45		\$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental Diagnostic and Preventive	Preventive - Cleaning	No charge		No charge	
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		\$25	
Child Dental Major Services	Root Canal- Molar	50%		\$300	
	Gingivectomy per Quad		\$150		
	Extraction- Single Tooth Exposed Root or Erupted		\$65		
	Extraction- Complete Bony		\$160		
	Porcelain with Metal Crown		\$300		
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

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

		SHOP Silver HSA Plan		
Actuarial Value - AV Calculator		70.5%		
Plan design includes a deductible?		Yes, integrated		
Integrated Individual deductible		\$2,000 integrated		
Integrated Family deductible		\$4,000 integrated		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Individual Out-of-pocket maximum		\$6,250		
Family Out-of-pocket maximum		\$12,500		
HSA plan: Self-only coverage deductible		\$2,000		
HSA family plan: Individual deductible		\$2,600		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	20%	X	
	Other practitioner office visit	20%	X	
	Specialist visit	20%	X	
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	20%	X	
	X-rays and Diagnostic Imaging	20%	X	
	Imaging (CT/PET scans, MRIs)	20%	X	
Drugs to treat illness or condition	Tier 1	20%	X	
	Tier 2	20%	X	
	Tier 3	20%	X	
	Tier 4	20%	X	
Outpatient services	Surgery facility fee (e.g., ASC)	20%	X	
	Physician/surgeon fees	20%	X	
	Outpatient visit	20%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	20%	X	
	Emergency room physician fee (waived if admitted)	20%	X	
	Emergency medical transportation	20%	X	
	Urgent care	20%	X	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	20%	X	
	Mental/Behavioral health other outpatient items and services	20%	X	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X	
	Substance Use disorder outpatient office visits	20%	X	
	Substance Use disorder other outpatient items and services	20%	X	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician/surgeon fee	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care	20%	X	
	Outpatient Rehabilitation services	20%	X	
	Outpatient Habilitation services	20%	X	
	Skilled nursing care	20%	X	
	Durable medical equipment	20%	X	
Child eye care	Hospice service	0%	X	
	Eye exam	No charge		
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
	Preventive - Cleaning			
	Preventive - X-ray	No charge		
	Sealants per Tooth			
Child Dental Basic Services	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Major Services	Amalgam Fill - 1 Surface	20%		
	Root Canal- Molar			
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or Erupted	50%		
	Extraction- Complete Bony			
Child Orthodontics	Porcelain with Metal Crown			
	Medically necessary orthodontics	50%		

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

		Silver Plan 100%-150% FPL		Silver Plan 150%-200% FPL		
Actuarial Value - AV Calculator		93.8%		86.8%		
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy		
Integrated Individual deductible		N/A		N/A		
Integrated Family deductible		N/A		N/A		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$75 / \$0 / \$0		\$550 / \$50 / \$0		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$150 / \$0 / \$0		\$1,100 / \$100 / \$0		
Individual Out-of-pocket maximum		\$2,250		\$2,250		
Family Out-of-pocket maximum		\$4,500		\$4,500		
HSA plan: Self-only coverage deductible		N/A		N/A		
HSA family plan: Individual deductible		N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$5		\$15		
	Other practitioner office visit	\$5		\$15		
	Specialist visit	\$8		\$25		
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests	\$8		\$15		
	X-rays and Diagnostic Imaging	\$8		\$25		
	Imaging (CT/PET scans, MRIs)	\$50		\$100		
Drugs to treat illness or condition	Tier 1	\$3		\$5		
	Tier 2	\$10		\$20	Pharmacy deductible	
	Tier 3	\$15		\$35	Pharmacy deductible	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		15%		
	Physician/surgeon fees	10%		15%		
	Outpatient visit	10%		15%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$30	X	\$75	X	
	Emergency room physician fee (waived if admitted)	\$25	X	\$40	X	
	Emergency medical transportation	\$30	X	\$75	X	
	Urgent care	\$6		\$30		
Hospital stay	Facility fee (e.g. hospital room)	10%	X	15%	X	
	Physician/surgeon fee	10%	X	15%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$5		\$15		
	Mental/Behavioral health other outpatient items and services	\$5		\$15		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%	X	15%	X	
	Mental/Behavioral health inpatient physician/surgeon fee	10%	X	15%	X	
	Substance Use disorder outpatient office visits	\$5		\$15		
	Substance Use disorder other outpatient items and services	\$5		\$15		
	Substance Use inpatient facility fee (e.g. hospital room)	10%	X	15%	X	
	Substance use disorder inpatient physician/surgeon fee	10%	X	15%	X	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	10%	X	15%	X
		Professional	10%	X	15%	X
Help recovering or other special health needs	Home health care	\$3		\$15		
	Outpatient Rehabilitation services	\$5		\$15		
	Outpatient Habilitation services	\$5		\$15		
	Skilled nursing care	10%	X	15%	X	
	Durable medical equipment	10%		15%		
Child eye care	Hospice service	No charge		No charge		
	Eye exam	No charge		No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	No charge		
	Child Dental Diagnostic and Preventive	Oral Exam				
		Preventive - Cleaning				
		Preventive - X-ray	No charge		No charge	
		Sealants per Tooth				
Topical Fluoride Application						
Child Dental Basic Services	Space Maintainers - Fixed					
	Amalgam Fill - 1 Surface	20%		20%		
Child Dental Major Services	Root Canal- Molar					
	Gingivectomy per Quad					
	Extraction- Single Tooth Exposed Root or Erupted	50%		50%		
	Extraction- Complete Bony					
Child Orthodontics	Porcelain with Metal Crown					
	Medically necessary orthodontics	50%		50%		

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

		Silver Plan 200%-250% FPL		
Actuarial Value - AV Calculator		72.8%		
Plan design includes a deductible?		Yes, Medical/Pharmacy		
Integrated Individual deductible		N/A		
Integrated Family deductible		N/A		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$1,900 / \$250 / \$0		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$3,800 / \$500 / \$0		
Individual Out-of-pocket maximum		\$5,450		
Family Out-of-pocket maximum		\$10,900		
HSA plan: Self-only coverage deductible		N/A		
HSA family plan: Individual deductible		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$40		
	Other practitioner office visit	\$40		
	Specialist visit	\$55		
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	\$35		
	X-rays and Diagnostic Imaging	\$50		
	Imaging (CT/PET scans, MRIs)	\$250		
Drugs to treat illness or condition	Tier 1	\$15		
	Tier 2	\$45	Pharmacy deductible	
	Tier 3	\$70	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		
	Physician/surgeon fees	20%		
	Outpatient visit	20%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250	X	
	Emergency room physician fee (waived if admitted)	\$50	X	
	Emergency medical transportation	\$250	X	
	Urgent care	\$80		
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$40		
	Mental/Behavioral health other outpatient items and services	\$40		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X	
	Substance Use disorder outpatient office visits	\$40		
	Substance Use disorder other outpatient items and services	\$40		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician/surgeon fee	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care	\$40		
	Outpatient Rehabilitation services	\$40		
	Outpatient Habilitation services	\$40		
	Skilled nursing care	20%	X	
	Durable medical equipment	20%		
Child eye care	Hospice service	No charge		
	Eye exam	No charge		
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
	Preventive - Cleaning			
	Preventive - X-ray	No charge		
	Sealants per Tooth			
Child Dental Basic Services	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Major Services	Amalgam Fill - 1 Surface	20%		
	Root Canal- Molar			
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or Erupted	50%		
Child Orthodontics	Extraction- Complete Bony			
	Porcelain with Metal Crown			

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

		Bronze Plan	Bronze HSA Plan		
Actuarial Value - AV Calculator		61.9%	61.1%		
Plan design includes a deductible?		Yes, Medical/Pharmacy	Yes, integrated		
Integrated Individual deductible		N/A	\$4,500 integrated		
Integrated Family deductible		N/A	\$9,000 integrated		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$6,000 / \$500 / \$0	N/A		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$12,000 / \$1,000 / \$0	N/A		
Individual Out-of-pocket maximum		\$6,500	\$6,500		
Family Out-of-pocket maximum		\$13,000	\$13,000		
HSA plan: Self-only coverage deductible		N/A	\$4,500		
HSA family plan: Individual deductible		N/A	\$4,500		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$70	After 1st three non-preventive visits	40%	X
	Other practitioner office visit	\$70	After 1st three non-preventive visits	40%	X
	Specialist visit	\$90	After 1st three non-preventive visits	40%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$40		40%	X
	X-rays and Diagnostic Imaging	100%	X	40%	X
	Imaging (CT/PET scans, MRIs)	100%	X	40%	X
Drugs to treat illness or condition	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	X
	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	X
	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	X
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	X
Outpatient services	Surgery facility fee (e.g., ASC)	100%	X	40%	X
	Physician/surgeon fees	100%	X	40%	X
	Outpatient visit	100%	X	40%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	100%	X	40%	X
	Emergency room physician fee (waived if admitted)	100%	X	40%	X
	Emergency medical transportation	100%	X	40%	X
	Urgent care	\$120	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)	100%	X	40%	X
	Physician/surgeon fee	100%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$70	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health other outpatient items and services	\$70	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	X	40%	X
	Mental/Behavioral health inpatient physician/surgeon fee	100%	X	40%	X
	Substance Use disorder outpatient office visits	\$70	After 1st three non-preventive visits	40%	X
	Substance Use disorder other outpatient items and services	\$70	After 1st three non-preventive visits	40%	X
	Substance Use inpatient facility fee (e.g. hospital room)	100%	X	40%	X
	Substance use disorder inpatient physician/surgeon fee	100%	X	40%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services				
Help recovering or other special health needs	Home health care	100%	X	40%	X
	Outpatient Rehabilitation services	\$70		40%	X
	Outpatient Habilitation services	\$70		40%	X
	Skilled nursing care	100%	X	40%	X
	Durable medical equipment	100%	X	40%	X
	Hospice service	No charge		0%	X
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray	No charge		No charge	
	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	20%		20%	
Child Dental Major Services	Root Canal- Molar				
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted	50%		50%	
	Extraction- Complete Bony				
Child Orthodontics	Porcelain with Metal Crown				
	Medically necessary orthodontics	50%		50%	

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

		Catastrophic Plan		
Actuarial Value - AV Calculator				
Plan design includes a deductible?		Yes, integrated		
Integrated Individual deductible		\$6,850 integrated		
Integrated Family deductible		\$13,700 integrated		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Individual Out-of-pocket maximum		\$6,850		
Family Out-of-pocket maximum		\$13,700		
HSA plan: Self-only coverage deductible		N/A		
HSA family plan: Individual deductible		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-preventive visits	
	Other practitioner office visit	0%	After 1st three non-preventive visits	
	Specialist visit	0%	X	
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	0%	X	
	X-rays and Diagnostic Imaging	0%	X	
	Imaging (CT/PET scans, MRIs)	0%	X	
Drugs to treat illness or condition	Tier 1	0%	X	
	Tier 2	0%	X	
	Tier 3	0%	X	
	Tier 4	0%	X	
Outpatient services	Surgery facility fee (e.g., ASC)	0%	X	
	Physician/surgeon fees	0%	X	
	Outpatient visit	0%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	0%	X	
	Emergency room physician fee (waived if admitted)	0%	X	
	Emergency medical transportation	0%	X	
	Urgent care	0%	After 1st three non-preventive visits	
Hospital stay	Facility fee (e.g. hospital room)	0%	X	
	Physician/surgeon fee	0%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	0%	After 1st three non-preventive visits	
	Mental/Behavioral health other outpatient items and services	0%	After 1st three non-preventive visits	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	X	
	Mental/Behavioral health inpatient physician/surgeon fee	0%	X	
	Substance Use disorder outpatient office visits	0%	After 1st three non-preventive visits	
	Substance Use disorder other outpatient items and services	0%	After 1st three non-preventive visits	
	Substance Use inpatient facility fee (e.g. hospital room)	0%	X	
	Substance use disorder inpatient physician/surgeon fee	0%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care	0%	X	
	Outpatient Rehabilitation services	0%	X	
	Outpatient Habilitation services	0%	X	
	Skilled nursing care	0%	X	
	Durable medical equipment	0%	X	
Child eye care	Hospice service	0%	X	
	Eye exam	No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X	
	Oral Exam			
	Preventive - Cleaning	No charge		
	Preventive - X-ray			
	Sealants per Tooth			
Child Dental Diagnostic and Preventive	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface	0%	X	
	Root Canal- Molar		X	
Child Dental Major Services	Gingivectomy per Quad		X	
	Extraction- Single Tooth Exposed Root or Erupted	0%	X	
	Extraction- Complete Bony		X	
	Porcelain with Metal Crown		X	
Child Orthodontics	Medically necessary orthodontics	0%	X	



Summary of Benefits and Coverage

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

		Platinum Coinsurance Plan	Platinum Copay Plan		
Actuarial Value - AV Calculator		88.5%	89.5%		
Plan design includes a deductible?		No	No		
Integrated individual deductible		\$0	\$0		
Integrated Family deductible		\$0	\$0		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0		
Individual Out-of-pocket maximum		\$4,000	\$4,000		
Family Out-of-pocket maximum		\$8,000	\$8,000		
HSA plan: Self-only coverage deductible		N/A	N/A		
HSA family plan: Individual deductible		N/A	N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$20		\$20	
	Other practitioner office visit	\$20		\$20	
	Specialist visit	\$40		\$40	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$20		\$20	
	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs)	10%		\$150	
Drugs to treat illness or condition	Tier 1	\$5		\$5	
	Tier 2	\$15		\$15	
	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		\$250	
	Physician/surgeon fees	10%		\$40	
	Outpatient visit	10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	10%		No charge	
	Emergency medical transportation	\$150		\$150	
Hospital stay	Urgent care	\$40		\$40	
	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%		\$40	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$20		\$20	
	Mental/Behavioral health other outpatient items and services	\$20		\$20	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%		\$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee	10%		\$40	
	Substance Use disorder outpatient office visits	\$20		\$20	
	Substance Use disorder other outpatient items and services	\$20		\$20	
	Substance Use inpatient facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpatient physician/surgeon fee	10%		\$40	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	\$250 per day up to 5 days	
		Professional	10%	\$40	
Help recovering or other special health needs	Home health care	10%		\$20	
	Outpatient Rehabilitation services	\$20		\$20	
	Outpatient Habilitation services	\$20		\$20	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray	Not Covered		Not Covered	
	Sealants per Tooth				
Child Dental Basic Services	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Major Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
	Root Canal- Molar			Not Covered	
	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
	Extraction- Complete Bony			Not Covered	
Child Orthodontics	Porcelain with Metal Crown			Not Covered	
	Medically necessary orthodontics	Not Covered		Not Covered	

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

		Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator		80.2%	81.0%
Plan design includes a deductible?		No	No
Integrated Individual deductible		\$0	\$0
Integrated Family deductible		\$0	\$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Individual Out-of-pocket maximum		\$6,200	\$6,200
Family Out-of-pocket maximum		\$12,400	\$12,400
HSA plan: Self-only coverage deductible		N/A	N/A
HSA family plan: Individual deductible		N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
	Other practitioner office visit	\$35		\$35	
	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$50		\$50	
	Imaging (CT/PET scans, MRIs)	20%		\$250	
Drugs to treat illness or condition	Tier 1	\$15		\$15	
	Tier 2	\$50		\$50	
	Tier 3	\$70		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		\$600	
	Physician/surgeon fees	20%		\$55	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250		\$250	
	Emergency room physician fee (waived if admitted)	20%		No charge	
	Emergency medical transportation	\$250		\$250	
Hospital stay	Urgent care	\$60		\$60	
	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
Mental health, behavioral health, or substance abuse needs	Physician/surgeon fee	20%		\$55	
	Mental/Behavioral health outpatient office visits	\$35		\$35	
	Mental/Behavioral health other outpatient items and services	\$35		\$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee	20%		\$55	
	Substance Use disorder outpatient office visits	\$35		\$35	
	Substance Use disorder other outpatient items and services	\$35		\$35	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
Pregnancy	Substance use disorder inpatient physician/surgeon fee	20%		\$55	
	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	Hospital 20% Professional 20%		\$600 per day up to 5 days \$55	
Help recovering or other special health needs	Home health care	20%		\$30	
	Outpatient Rehabilitation services	\$35		\$35	
	Outpatient Habilitation services	\$35		\$35	
	Skilled nursing care	20%		\$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray	Not Covered		Not Covered	
	Sealants per Tooth				
Child Dental Basic Services	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Major Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
	Root Canal- Molar			Not Covered	
	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
	Extraction- Complete Bony			Not Covered	
Child Orthodontics	Porcelain with Metal Crown			Not Covered	
	Medically necessary orthodontics	Not Covered		Not Covered	

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

		Individual	
		Silver Plan	
Actuarial Value - AV Calculator		70.4%	
Plan design includes a deductible?		Yes, Medical/Pharmacy	
Integrated Individual deductible		N/A	
Integrated Family deductible		N/A	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$2,250 / \$250 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$4,500 / \$500 / \$0	
Individual Out-of-pocket maximum		\$6,250	
Family Out-of-pocket maximum		\$12,500	
HSA plan: Self-only coverage deductible		N/A	
HSA family plan: Individual deductible		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$45	
	Other practitioner office visit	\$45	
	Specialist visit	\$70	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	\$35	
	X-rays and Diagnostic Imaging	\$65	
	Imaging (CT/PET scans, MRIs)	\$250	
Drugs to treat illness or condition	Tier 1	\$15	
	Tier 2	\$50	Pharmacy deductible
	Tier 3	\$70	Pharmacy deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
	Outpatient visit	20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250	X
	Emergency room physician fee (waived if admitted)	\$50	X
	Emergency medical transportation	\$250	X
	Urgent care	\$90	
Hospital stay	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$45	
	Mental/Behavioral health other outpatient items and services	\$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X
	Substance Use disorder outpatient office visits	\$45	
	Substance Use disorder other outpatient items and services	\$45	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X
	Substance use disorder inpatient physician/surgeon fee	20%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services	Hospital	20% X
		Professional	20% X
Help recovering or other special health needs	Home health care	\$45	
	Outpatient Rehabilitation services	\$45	
	Outpatient Habilitation services	\$45	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
Child eye care	Hospice service	No charge	
	Eye exam	No charge	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
	Preventive - X-ray		
	Sealants per Tooth		
Child Dental Basic Services	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Major Services	Amalgam Fill - 1 Surface	Not Covered	
	Root Canal- Molar		
	Gingivectomy per Quad		
	Extraction- Single Tooth Exposed Root or Erupted		
Child Orthodontics	Extraction- Complete Bony	Not Covered	
	Porcelain with Metal Crown		
	Medically necessary orthodontics	Not Covered	

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

		SHOP Silver Coinsurance Plan		SHOP Silver Copay Plan		
Actuarial Value - AV Calculator		71.6%		71.3%		
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy		
Integrated Individual deductible		N/A		N/A		
Integrated Family deductible		N/A		N/A		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$1,500 / \$250 / \$0		\$1,500 / \$250 / \$0		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$3,000 / \$500 / \$0		\$3,000 / \$500 / \$0		
Individual Out-of-pocket maximum		\$6,500		\$6,500		
Family Out-of-pocket maximum		\$13,000		\$13,000		
HSA plan: Self-only coverage deductible		N/A		N/A		
HSA family plan: Individual deductible		N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$45		\$45		
	Other practitioner office visit	\$45		\$45		
	Specialist visit	\$70		\$70		
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests	\$35		\$35		
	X-rays and Diagnostic Imaging	\$65		\$65		
	Imaging (CT/PET scans, MRIs)	20%	X	\$250		
Drugs to treat illness or condition	Tier 1	\$15		\$15		
	Tier 2	\$55	Pharmacy deductible	\$55	Pharmacy deductible	
	Tier 3	\$75	Pharmacy deductible	\$75	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		20%		
	Physician/surgeon fees	20%		20%		
	Outpatient visit	20%		20%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250	X	\$250	X	
	Emergency room physician fee (waived if admitted)	\$50	X	\$50	X	
	Emergency medical transportation	\$250	X	\$250	X	
	Urgent care	\$90		\$90		
Hospital stay	Facility fee (e.g. hospital room)	20%	X	20%	X	
	Physician/surgeon fee	20%	X	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$45		\$45		
	Mental/Behavioral health other outpatient items and services	\$45		\$45		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	20%	X	
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X	20%	X	
	Substance Use disorder outpatient office visits	\$45		\$45		
	Substance Use disorder other outpatient items and services	\$45		\$45		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	20%	X	
	Substance use disorder inpatient physician/surgeon fee	20%	X	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%	X	20%	X
Help recovering or other special health needs	Home health care	20%		\$45		
	Outpatient Rehabilitation services	\$45		\$45		
	Outpatient Habilitation services	\$45		\$45		
	Skilled nursing care	20%	X	20%	X	
	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
Child Dental Diagnostic and Preventive	Oral Exam					
	Preventive - Cleaning					
	Preventive - X-ray	Not Covered		Not Covered		
	Sealants per Tooth					
	Topical Fluoride Application					
Child Dental Basic Services	Space Maintainers - Fixed					
	Amalgam Fill - 1 Surface	Not Covered		Not Covered		
Child Dental Major Services	Root Canal- Molar			Not Covered		
	Gingivectomy per Quad			Not Covered		
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered		
	Extraction- Complete Bony			Not Covered		
Child Orthodontics	Porcelain with Metal Crown			Not Covered		
	Medically necessary orthodontics	Not Covered		Not Covered		

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Summary of Benefits and Coverage

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

		SHOP Silver HSA Plan		
Actuarial Value - AV Calculator		70.5%		
Plan design includes a deductible?		Yes, integrated		
Integrated Individual deductible		\$2,000 integrated		
Integrated Family deductible		\$4,000 integrated		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Individual Out-of-pocket maximum		\$6,250		
Family Out-of-pocket maximum		\$12,500		
HSA plan: Self-only coverage deductible		\$2,000		
HSA family plan: Individual deductible		\$2,600		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	20%	X	
	Other practitioner office visit	20%	X	
	Specialist visit	20%	X	
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	20%	X	
	X-rays and Diagnostic Imaging	20%	X	
	Imaging (CT/PET scans, MRIs)	20%	X	
Drugs to treat illness or condition	Tier 1	20%	X	
	Tier 2	20%	X	
	Tier 3	20%	X	
	Tier 4	20%	X	
Outpatient services	Surgery facility fee (e.g., ASC)	20%	X	
	Physician/surgeon fees	20%	X	
	Outpatient visit	20%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	20%	X	
	Emergency room physician fee (waived if admitted)	20%	X	
	Emergency medical transportation	20%	X	
	Urgent care	20%	X	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	20%	X	
	Mental/Behavioral health other outpatient items and services	20%	X	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X	
	Substance Use disorder outpatient office visits	20%	X	
	Substance Use disorder other outpatient items and services	20%	X	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician/surgeon fee	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care	20%	X	
	Outpatient Rehabilitation services	20%	X	
	Outpatient Habilitation services	20%	X	
	Skilled nursing care	20%	X	
	Durable medical equipment	20%	X	
	Hospice service	0%	X	
Child eye care	Eye exam	No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
Child Dental Diagnostic and Preventive	Oral Exam			
	Preventive - Cleaning			
	Preventive - X-ray	Not Covered		
	Sealants per Tooth			
	Topical Fluoride Application			
Child Dental Basic Services	Space Maintainers - Fixed			
	Amalgam Fill - 1 Surface	Not Covered		
Child Dental Major Services	Root Canal- Molar			
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		
	Extraction- Complete Bony			
Child Orthodontics	Porcelain with Metal Crown			
	Medically necessary orthodontics	Not Covered		

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

Actuarial Value - AV Calculator		Silver Plan 100%-150% FPL	Silver Plan 150%-200% FPL
Plan design includes a deductible?		Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible		N/A	N/A
Integrated Family deductible		N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$75 / \$0 / \$0	\$550 / \$50 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$150 / \$0 / \$0	\$1,100 / \$100 / \$0
Individual Out-of-pocket maximum		\$2,250	\$2,250
Family Out-of-pocket maximum		\$4,500	\$4,500
HSA plan: Self-only coverage deductible		N/A	N/A
HSA family plan: Individual deductible		N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$5		\$15		
	Other practitioner office visit	\$5		\$15		
	Specialist visit	\$8		\$25		
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests	\$8		\$15		
	X-rays and Diagnostic Imaging	\$8		\$25		
	Imaging (CT/PET scans, MRIs)	\$50		\$100		
Drugs to treat illness or condition	Tier 1	\$3		\$5		
	Tier 2	\$10		\$20	Pharmacy deductible	
	Tier 3	\$15		\$35	Pharmacy deductible	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		15%		
	Physician/surgeon fees	10%		15%		
	Outpatient visit	10%		15%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$30	X	\$75	X	
	Emergency room physician fee (waived if admitted)	\$25	X	\$40	X	
	Emergency medical transportation	\$30	X	\$75	X	
	Urgent care	\$6		\$30		
Hospital stay	Facility fee (e.g. hospital room)	10%	X	15%	X	
	Physician/surgeon fee	10%	X	15%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$5		\$15		
	Mental/Behavioral health other outpatient items and services	\$5		\$15		
	Mental/Behavioral health inpatient facility fee (e.g. hospital room)	10%	X	15%	X	
	Mental/Behavioral health inpatient physician/surgeon fee	10%	X	15%	X	
	Substance Use disorder outpatient office visits	\$5		\$15		
	Substance Use disorder other outpatient items and services	\$5		\$15		
	Substance Use inpatient facility fee (e.g. hospital room)	10%	X	15%	X	
	Substance use disorder inpatient physician/surgeon fee	10%	X	15%	X	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	10%	X	15%	X
		Professional	10%	X	15%	X
Help recovering or other special health needs	Home health care	\$3		\$15		
	Outpatient Rehabilitation services	\$5		\$15		
	Outpatient Habilitation services	\$5		\$15		
	Skilled nursing care	10%	X	15%	X	
	Durable medical equipment	10%		15%		
Child eye care	Hospice service	No charge		No charge		
	Eye exam	No charge		No charge		
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
	Preventive - X-ray	Not Covered		Not Covered		
	Sealants per Tooth					
Child Dental Basic Services	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Major Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered		
	Root Canal- Molar					
	Gingivectomy per Quad	Not Covered		Not Covered		
	Extraction- Single Tooth Exposed Root or Erupted					
Child Orthodontics	Extraction- Complete Bony					
	Porcelain with Metal Crown					
Medically necessary orthodontics	Not Covered		Not Covered			

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

Actuarial Value - AV Calculator		Silver Plan 200%-250% FPL		
Actuarial Value - AV Calculator		72.8%		
Plan design includes a deductible?		Yes, Medical/Pharmacy		
Integrated Individual deductible		N/A		
Integrated Family deductible		N/A		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$1,900 / \$250 / \$0		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$3,800 / \$500 / \$0		
Individual Out-of-pocket maximum		\$5,450		
Family Out-of-pocket maximum		\$10,900		
HSA plan: Self-only coverage deductible		N/A		
HSA family plan: Individual deductible		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$40		
	Other practitioner office visit	\$40		
	Specialist visit	\$55		
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	\$35		
	X-rays and Diagnostic Imaging	\$50		
	Imaging (CT/PET scans, MRIs)	\$250		
Drugs to treat illness or condition	Tier 1	\$15		
	Tier 2	\$45	Pharmacy deductible	
	Tier 3	\$70	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		
	Physician/surgeon fees	20%		
	Outpatient visit	20%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250	X	
	Emergency room physician fee (waived if admitted)	\$50	X	
	Emergency medical transportation	\$250	X	
	Urgent care	\$80		
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$40		
	Mental/Behavioral health other outpatient items and services	\$40		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X	
	Substance Use disorder outpatient office visits	\$40		
	Substance Use disorder other outpatient items and services	\$40		
	Substance use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician/surgeon fee	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care	\$40		
	Outpatient Rehabilitation services	\$40		
	Outpatient Habilitation services	\$40		
	Skilled nursing care	20%	X	
	Durable medical equipment	20%		
Child eye care	Hospice service	No charge		
	Eye exam	No charge		
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
Child Dental Basic Services	Space Maintainers - Fixed			
	Amalgam Fill - 1 Surface	Not Covered		
Child Dental Major Services	Root Canal- Molar			
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or Erupted			
	Extraction- Complete Bony	Not Covered		
Child Orthodontics	Porcelain with Metal Crown			
	Medically necessary orthodontics	Not Covered		

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

		Bronze Plan	Bronze HSA Plan			
Actuarial Value - AV Calculator		61.9%	61.1%			
Plan design includes a deductible?		Yes, Medical/Pharmacy	Yes, integrated			
Integrated Individual deductible		N/A	\$4,500 integrated			
Integrated Family deductible		N/A	\$9,000 integrated			
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$6,000 / \$500 / \$0	N/A			
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$12,000 / \$1000 / \$0	N/A			
Individual Out-of-pocket maximum		\$6,500	\$6,500			
Family Out-of-pocket maximum		\$13,000	\$13,000			
HSA plan: Self-only coverage deductible		N/A	\$4,500			
HSA family plan: Individual deductible		N/A	\$4,500			
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$70	After 1st three non-preventive visits	40%	X	
	Other practitioner office visit	\$70	After 1st three non-preventive visits	40%	X	
	Specialist visit	\$90	After 1st three non-preventive visits	40%	X	
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests	\$40		40%	X	
	X-rays and Diagnostic Imaging	100%	X	40%	X	
	Imaging (CT/PET scans, MRIs)	100%	X	40%	X	
Drugs to treat illness or condition	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	X	
	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	X	
	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	X	
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	X	
Outpatient services	Surgery facility fee (e.g., ASC)	100%	X	40%	X	
	Physician/surgeon fees	100%	X	40%	X	
	Outpatient visit	100%	X	40%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	100%	X	40%	X	
	Emergency room physician fee (waived if admitted)	100%	X	40%	X	
	Emergency medical transportation	100%	X	40%	X	
	Urgent care	\$120	After 1st three non-preventive visits	40%	X	
Hospital stay	Facility fee (e.g. hospital room)	100%	X	40%	X	
	Physician/surgeon fee	100%	X	40%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$70	After 1st three non-preventive visits	40%	X	
	Mental/Behavioral health other outpatient items and services	\$70	After 1st three non-preventive visits	40%	X	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	X	40%	X	
	Mental/Behavioral health inpatient physician/surgeon fee	100%	X	40%	X	
	Substance Use disorder outpatient office visits	\$70	After 1st three non-preventive visits	40%	X	
	Substance Use disorder other outpatient items and services	\$70	After 1st three non-preventive visits	40%	X	
	Substance Use inpatient facility fee (e.g. hospital room)	100%	X	40%	X	
	Substance use disorder inpatient physician/surgeon fee	100%	X	40%	X	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	100%	X	40%	X
		Professional	100%	X	40%	X
Help recovering or other special health needs	Home health care	100%	X	40%	X	
	Outpatient Rehabilitation services	\$70		40%	X	
	Outpatient Habilitation services	\$70		40%	X	
	Skilled nursing care	100%	X	40%	X	
	Durable medical equipment	100%	X	40%	X	
	Hospice service	No charge		0%	X	
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
Child Dental Diagnostic and Preventive	Oral Exam					
	Preventive - Cleaning	Not Covered		Not Covered		
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
Space Maintainers - Fixed						
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered		
Child Dental Major Services	Root Canal- Molar	Not Covered		Not Covered		
	Gingivectomy per Quad					
	Extraction- Single Tooth Exposed Root or Erupted					
	Extraction- Complete Bony					
Child Orthodontics	Porcelain with Metal Crown					
	Medically necessary orthodontics	Not Covered		Not Covered		

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Summary of Benefits and Coverage

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

Actuarial Value - AV Calculator		Catastrophic Plan	
Plan design includes a deductible?		Yes, integrated	
Integrated Individual deductible		\$6,850 integrated	
Integrated Family deductible		\$13,700 integrated	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	
Individual Out-of-pocket maximum		\$6,850	
Family Out-of-pocket maximum		\$13,700	
HSA plan: Self-only coverage deductible		N/A	
HSA family plan: Individual deductible		N/A	

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

Endnotes to 2016 Standard Benefit Plan Designs

Notes:

- 1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider but are approved as in-network by the carrier.
- 2) For covered out of network services in a PPO plan, these Standard Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs linked to HSA plans, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the carrier pays all costs for covered services for all family members.
- 5) For HDHPs linked to HSAs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or \$2600 for Plan Year 2016. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) For the Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits, which may include urgent care visits or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$200 per month per state law.
- 9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
- 10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost-share.
- 11) As applicable, for the child dental portion of the benefit design, a carrier may choose the copay or coinsurance child dental Standard Benefit Plan Design, regardless of whether the carrier selects the copay or the coinsurance design for the non-child dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.

- 12) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Standard Benefit Plan Designs.
- 13) Mental Health/Substance Use Disorder Outpatient Items and Services include post-discharge ancillary care services, such as counseling and other outpatient support services, which may be provided as part of the offsite recovery component of a residential treatment plan.
- 14) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 15) Specialists include physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate (28 CCR § 1300.51(l)(1)).
- 16) The Other Practitioner category includes Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors and other practitioners included in 28 CCR § 1300.67(a)(1).
- 17) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
- 18) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be less than those listed in these standard benefit plan designs if necessary for compliance with MHPAEA.
- 19) Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs or;
	2) Preferred brand name drugs or;
	3) Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or;
	2) Recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.

4	1) Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or;
	2) Self administration requires training, clinical monitoring or;
	3) Drug was manufactured using biotechnology or;
	4) Plan cost (net of rebates) is >\$600.

- 20) Plan formularies must include at least one drug in Tiers 1 or 2 or 3 if all FDA-approved drugs in the same drug class would otherwise qualify for Tier 4 and at least 3 drugs in that class are available as FDA-approved drugs.
- 21) Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.
- 22) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 23) For 2016, a carrier may offer a plan with two in-network facility tiers if the lowest-cost tier network (Tier 1), complies with the cost-sharing requirements in the standard benefit plan design, meets state network adequacy and timeliness standards as applied by the applicable regulator and the carrier demonstrates that the two in-network facility tiers are in the best interest of the consumer as determined by Covered California on a case-by-case basis, based on premium stability, price, quality, choice and value. For non-Qualified Health Plans, the applicable regulator will review.

Attachment 3 – Reserved for future use

Attachment 4 – Service Area Listing

Attachment 5 – Reserved for future use

Attachment 6 – Reserved for future use

Attachment 7 – Quality, Network Management and Delivery System Standards

Quality, Network Management and Delivery System Standards

Preamble

PROMOTING HIGHER QUALITY AND BETTER VALUE

The mission of Covered California (the “Exchange”) is to increase the number of insured Californians, improve health care quality and access to care, promote better health, lower costs, and reduce health disparities through an innovative and competitive marketplace that empowers consumers to choose the health plan and providers that offer the best value. The Exchange’s “Triple Aim” framework seeks to improve the patient care experience including quality and satisfaction, improve the health of the population, and reduce the per capita cost of Covered Services. The Exchange and Contractor recognize that promoting better quality and value will be contingent upon smooth implementation and large enrollment in the Exchange.

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

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

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

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

- (a) The Exchange shall facilitate ongoing discussions with the Contractor and other stakeholders through the Exchange's Plan Management and Delivery System Reform Advisory Group and through other forums as may be appropriate to work with Contractors to assess the elements of this Section and their impact, and ways to improve upon them on:
 - i. Enrollees and other consumers;
 - ii. Providers in terms of burden, changes in payment and rewarding the triple aim of improving care, promoting better health and lowering costs; and
 - iii. Contractors in terms of the burden of reporting, participating in quality or delivery system efforts.
- (b) The Contractor agrees to participate in Exchange advisory and planning processes, including but not limited to participating in the Plan Management and Delivery System Reform Advisory Group.

1.02 Participation in Collaborative Quality Initiatives. Contractor shall participate in one or more established statewide and national collaborative initiatives for quality improvement. Specific collaborative initiatives may include, but are not limited to:

- (a) Leapfrog
- (b) California Maternal Data Center (sponsored by the California Maternal Quality Care Collaborative (CMQCC))
- (c) California Joint Replacement Registry developed by the California Healthcare Foundation (CHCF), California Orthopaedic Association (COA) and Pacific Business Group on Health (PBGH)
- (d) NCDR® (National Cardiovascular Data Registry that currently includes seven specific registry programs)
- (e) Society of Thoracic Surgeons National Database for the collection of general thoracic surgery clinical data
- (f) National Neurosurgery Quality and Outcomes Database (N2QOD)
- (g) Integrated Healthcare Association's (IHA) Pay for Performance Program

- (h) IHA Payment Bundling demonstration
- (i) Centers for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement initiative (BPCI)
- (j) CMMI Comprehensive Primary Care initiative (CPC)
- (k) CMMI Shared Savings Program (including Pioneer, Advanced Payment and other models)
- (l) Contractor-sponsored accountable care programs
- (m) California Perinatal Quality Care Collaborative
- (n) California Quality Collaborative

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

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

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

- (a) Contractor to complete select components of the Covered California eValue8 Request for Information (RFI) Submission specific to reducing health disparities and assuring health equity, which describes its programs to address health equity and health disparities;
- (b) Participating in Exchange workgroups and forums to share strategies and tactics that are particularly effective;
- (c) Describing to the Exchange how, if at all, it collects and uses the data elements described in 1.03(d) that follows regarding Exchange's Enrollees to: (1) understand how health care is being differently delivered to different populations and (2) to support targeted clinical or preventive services; and

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

- iv. Race
- v. Ethnicity
- vi. Gender
- vii. Primary language
- viii. Disability status
- ix. Sexual orientation
- x. Gender identity

Article 2. RESERVED FOR FUTURE USE

Article 3. Provision and Use of Data and Information for Quality of Care

3.01 HEDIS and CAHPS Reporting. For Measurement Year 2014 and thereafter Contractor shall collect and report to the Exchange, for each QHP Issuer Product Type, its Quality Rating System HEDIS, CAHPS and other performance data (numerators, denominators, and rates). Contractor shall provide such data to the Exchange each year regardless of extent to which CMS uses the data for public reporting or other purposes.

For Measurement Year 2014 and thereafter, if requested, Contractor shall submit to the Exchange HEDIS and CAHPS scores to include the measure numerator, denominator and rate for the required measures set that is reported to NCQA Quality Compass and/or DHCS, per each Product Type for which it collects data in California. The timeline for Contractor's HEDIS and CAHPS quality data submission shall be consistent with the timeline for submitting data to the NCQA Quality Compass and/or DHCS. The Exchange reserves the right to use the Contractor-reported measures scores to construct Contractor summary quality ratings that the Exchange may use for such purposes as supporting consumer choice and the Exchange's plan oversight management.

3.02 Hospital Quality Oversight. Contractor agrees to develop and implement oversight programs (if not already in place by January 1, 2015) targeting the following areas related to hospital-based services, as outlined by the Center for Medicare and Medicaid Services (CMS) Hospital Compare Program, including:

- (a) Deaths and readmissions;
- (b) Serious complications related to specific conditions;
- (c) Hospital acquired conditions; and
- (d) Healthcare associated infections.

These oversight programs should be consistent with Medicare performance areas whenever possible and should reflect the overall performance of the hospital. Contractor agrees to provide/submit regular reporting of program(s) results from Contractor. Standard reporting requirements, including format, frequency and other technical specifications will be mutually agreed upon between the Exchange and Contractor.

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

- a) Disclosures to Enterprise Analytics Solution Vendor.

Covered California has entered into a contract with an Enterprise Analytics Solution Vendor ("EAS Vendor") to support its oversight and management of the health exchange. EAS Vendor has provided Contractor with a written list of data elements ("EAS Dataset") and a data submission template that defines the data elements and format for transmitting the data. Contractor shall provide EAS Vendor with

the data identified in the EAS Dataset, on a monthly basis, which is attached as Appendix 1 to this Attachment 7. The parties may modify the data fields in Appendix 1 to Attachment 7 upon mutual agreement of the parties, and without a formal amendment to this Agreement.

Contractor shall submit data in accordance with the following schedule:

- No later than 2/26/2016 – Submission of three (3) months of production-quality test enrollment and medical/RX claims data (and capitation data if applicable)
- No later than 4/27/2016 – Submission of historical production enrollment and medical/Rx claims data (and capitation data if applicable) for January 2014 through March 2016
- No later than 6/27/2016 – Submission of historical production enrollment and medical/Rx claims data (and capitation data if applicable) for April 2016 through May 2016
- No later than 10/21/2016 – Submission of production enrollment and medical/Rx claims data (and capitation data if applicable) for June 2016 through September 2016

Beginning no sooner than December 1, 2016, Contractor shall submit data updates monthly based on a schedule to be developed in cooperation with EAS Vendor. Contractor, EAS Vendor, and Covered California may adjust the data submission schedule outlined above via mutual agreement.

To enable the submission of the EAS Dataset to EAS Vendor, Contractor has to execute a Business Associate Agreement (“BAA”), and any other agreements that Contractor determines are required for the submission of the EAS Dataset to EAS Vendor, by February 15, 2016. Contractor’s obligation to provide any data to EAS Vendor is contingent on a BAA being executed and in force at the time information is to be provided to EAS Vendor. Covered California may, upon request to Contractor, review such BAA and any other agreements between Contractor and EAS Vendor related to the submission of the EAS Dataset.

b) Disclosures to Covered California.

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

c) EAS Vendor Designation

Truven Health Analytics (“Truven”) is Covered California’s current EAS Vendor. In the event that Covered California terminates its contract with Truven during the term of this Agreement, Covered California shall provide notice to Contractor pursuant to section 12.3 of the Agreement. Any such termination of the agreement with Truven shall excuse any performance of Contractor under this section 3.03 effective on the date of termination of the agreement with Truven until a replacement EAS Vendor is designated.

d) Covered California is a Health Oversight Agency

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

3.04 eValue8 Submission. For measurement year 2016, Contractor shall respond to those eValue8 questions identified and required by the Exchange in the Covered California eValue8 Health Plan Request for Information due with the annual certification application.

Such information will be used by the Exchange to evaluate Contractor's performance under the terms of the Quality, Network Management and Delivery System Standards and/or in connection with the evaluation regarding any extension of the Agreement and/or the recertification process. The timing, nature and extent of such disclosures will be established by the Exchange based on its evaluation of various quality-related factors. Contractor's response shall include information relating to all of Contractor's then-current California-based business and Contractor shall disclose any information that reflects California-based information that is provided by Contractor due to Contractor's inability to report on all Exchange-specific business. If applicable, Contractor shall report data separately for HMO/POS, PPO and EPO product lines.

3.05 Determining Enrollee Health Status and Use of Health Assessments. Contractor shall demonstrate the capacity and systems to collect, maintain and use individual information about Exchange Plan Enrollees' health status and behaviors in order to promote better health and to better manage Enrollees' health conditions.

To the extent the Contractor uses or relies upon Health Assessments to determine health status, Contractor shall offer, upon initial enrollment and on a regular basis thereafter, a Health Assessment to all Plan Enrollees over the age of 18, including those Plan Enrollees that have previously completed such an assessment. If a Health Assessment tool is used, Contractor should select a tool that adequately evaluates Plan Enrollees current health status and provides a mechanism to conduct ongoing monitoring for future intervention(s).

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

Contractor shall report to the Exchange its process to monitor and track Plan Enrollees' health status, which may include its process for identifying individuals who show a decline in health status, and referral of such Plan Enrollees to Contractor care management and chronic condition program(s) as defined in Section 5.04, for the necessary intervention. Contractor shall annually report to the Exchange the number of Plan Enrollees who are identified through their selected mechanism and the results of their referral to receive additional services.

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

Article 4. Preventive Health and Wellness

4.01 Health and Wellness Services. Contractor is required to encourage and monitor the extent to which Exchange Plan Enrollees obtain preventive health and wellness services within the Enrollee's first year of enrollment. Contractor shall submit information annually to the Exchange related to Plan Enrollees' access to preventive health and wellness services. Such information should be coordinated with existing national measures, whenever possible, including HEDIS. Specifically, Contractor shall assess and discuss the participation by Plan Enrollees in:

- (a) necessary preventive services appropriate for each enrollee;
- (b) tobacco cessation intervention, inclusive of evidenced based counseling and appropriate pharmacotherapy, if applicable; and
- (c) obesity management, if applicable.

4.02 Community Health and Wellness Promotion. The Exchange and Contractor recognize that promoting better health for Plan Enrollees also requires engagement and promotion of community-wide initiatives that foster better health, healthier environments and the promotion of healthy behaviors across the community. Contractor shall report annually in a mutually agreed upon form the initiatives, programs and/or projects that it supports that promote wellness and better community health that specifically reach beyond the Contractors' Enrollees. Such programs may include, but are not limited to, partnerships with local or state public health departments (e.g. Let's Get Healthy California) and voluntary health organizations which operate preventive and other health programs.

Contractor shall develop and provide a report regarding its participation in community health and wellness promotion. Report information should be coordinated with existing national measures (e.g. Healthy People 2020), whenever possible.

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

- (a) Documentation of health and wellness communication process to Exchange Enrollees and appropriate Participating Providers - that takes into account the cultural and linguistic diversity of Exchange enrollees;
- (b) Documentation of process to ensure network adequacy required by State or Federal laws, rules and regulations - given the focus on prevention and wellness and the impact it may have on network capacity; and
- (c) Documentation of a process to incorporate Enrollees health and wellness information into Contractor's data and information specific to each individual Enrollee. This Enrollee's data is Contractor's most complete information on each Enrollee and is distinct from the Enrollee's medical record maintained by the providers.

Article 5. Access, Coordination, and At-Risk Enrollee Support

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

5.01 Encouraging Consumers' Access to Appropriate Care. Contractor is encouraged to assist Exchange Enrollees in selecting a Primary Care Provider (PCP), Federally Qualified Health Center (FQHC) or a Patient-Centered Medical Home (PCMH) within sixty (60) days of enrollment. In the event the Enrollee does not select a PCP, FQHC or a PCMH, Contractor may auto-assign the enrollee to a PCP, FQHC or a PCMH and the assignment shall be communicated to the Plan Enrollee. Nothing in this section shall be construed to prohibit Contractor from assigning an Enrollee to a PCP, FQHC or a PCMH prior to the expiration of the sixty (60) day self-selection period. In the event of an auto-assignment, Contractor shall use commercially reasonable efforts to make assignment to a participating provider consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, and will consider geographic accessibility and existing family member assignment or prior provider assignment.

5.02 Promoting Development and Use of Care Models. In addition to fostering appropriate linkage of enrollees with primary care providers, Contractor is encouraged to actively promote the development and use of care models that promote access, care coordination and early identification of at risk enrollees. Such models may include, but are not limited to:

- (a) Accountable Care Organizations (ACO);
- (b) Patient Centered Medical Homes (PCMH);
- (c) The use of a patient-centered, team-based approach to care delivery and member engagement;
- (d) A focus on additional primary care recruitment, use of Advanced Practice Clinicians (e.g. Nurse Practitioner, Certified Nurse Midwife and Physician Assistant) and development of new primary care and specialty clinics;
- (e) A focus on expanding primary care access through payment systems and strategies;
- (f) The use of an intensive outpatient care programs ("Ambulatory ICU") for enrollees with complex chronic conditions;
- (g) The use of qualified health professionals, including community health workers, to deliver coordinated patient education and health maintenance support, with a proven approach for improving care for high-risk and vulnerable populations;
- (h) Support of physician and patient engagement in shared decision-making;
- (i) Providing patient access to their health information;
- (j) Promoting team care;

- (k) The use of telemedicine; and
- (l) Promoting the use of remote patient monitoring.

Contractor shall report annually, in a format to be mutually agreed upon between Contractor and Exchange, on: (1) the number and percentage of Exchange Plan Enrollees who have selected or been assigned to a Primary Care Provider, as described in Section 5.01; (2) the involvement of Exchange Plan Enrollees in the models described in Section 5.02 or such other models as the Contractor identifies as promoting better access, coordination and care for at risk enrollees; and (3) the results of such involvement, including clinical, patient experience and costs impacts. In the event that the reporting requirements identified herein include Protected Health Information, Contractor shall provide the Exchange only with de-identified Protected Health Information as defined in 45 C.F.R. Section 164.514. All information provided to the Exchange in this section shall be treated by the Exchange as confidential information.

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

5.03 Supporting At-Risk Enrollees Requiring Transition. Contractor shall have an evaluation and transition plan in place for the Enrollees of the Exchange with existing health coverage including, but not limited to, those members transferring from Major Risk Medical Insurance Program, Pre-Existing Condition Insurance Plan, AIDS Drug Assistance Program, or other individuals under active care for complex conditions and who require therapeutic provider and formulary transitions. It is the intention of the Exchange to work with Contractors and State partners to facilitate early identification of at-risk patients where possible.

In a manner that is consistent with California law the evaluation and transition plan will include the following:

- (a) Identification of in-network providers with appropriate clinical expertise or any alternative therapies including specific drugs when transitioning care;
- (b) Clear process(es) to communicate Enrollee's continued treatment using a specific therapy, specific drug or a specific provider when no equivalent is available in-network;
- (c) Where possible, advance notification and understanding of out-of-network provider status for treating and prescribing physicians; and
- (d) A process to allow incoming Enrollees access to Contractor's formulary information prior to enrollment.

It is not the intention of the Exchange to require that Contractor's transition plans for At-Risk Enrollees impose any obligations on contractor which are not otherwise required under applicable State Law or by other provisions of this Agreement

5.04 Identification and Services for At-Risk Enrollees. Contractor agrees to identify and proactively manage the Plan Enrollees with existing and newly diagnosed chronic conditions and who are most likely to benefit from well-coordinated care ("At-Risk Enrollees"). Contractor will target at-risk enrollees, typically with one or more conditions, including, but not limited to, diabetes, asthma, heart disease or hypertension. As described in Section 3.06, Contractor shall determine the health status of its

new enrollees including identification of those with chronic conditions or other significant health needs. For Enrollees transitioning from state and federal programs such as the Major Risk Medical Insurance Program or Pre Existing Condition Insurance Plan, Contractor shall provide the Exchange with a documented process, care management plan and strategy for targeting these specific Enrollees. Such documentation may include the following:

- a) Methods to identify and target At-Risk Enrollees;
- b) Description of Contractor's predictive analytic capabilities to assist in identifying At Risk Plan Enrollees who would benefit from early, proactive intervention;
- c) Communication plan for known At-Risk Enrollees to receive information prior to provider visit, including the provision of culturally and linguistically appropriate communication;
- d) Process to update At-Risk Enrollee medical history in the Contractor maintained Plan Enrollee health profile;
- e) Mechanisms to evaluate access within provider network, on an ongoing basis, to ensure that an adequate network is in place to support a proactive intervention and care management program for At-Risk Enrollees;
- f) Care and network strategies that focus on supporting a proactive approach to at-risk Plan Enrollee intervention and care management. Contractor agrees to provide the Exchange with a documented plan and include "tools" and strategies to supplement and/or expand care management and provider network capabilities, including an expansion and/or reconfiguration of specialties or health care professionals to meet clinical needs of At Risk Enrollees;
- g) Strategies or "tools" not otherwise described in Section 5.02 may include but are not limited to the following:
 - i. Enrollment of At-Risk Enrollees in care, case and disease management program(s); and
 - ii. At Risk Plan Enrollee's access to Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMH), Ambulatory ICUs or other delivery models designed to focus on individual chronic condition management and focused intervention.

Article 6. Patient-Centered Information and Communication

6.01 Provider Cost and Quality. Contractor shall provide the Exchange with its plan, measures and process to provide Plan Enrollees with current cost and quality information for network providers, including at the individual physician and hospital level, using the most current nationally recognized or endorsed measures, including National Quality Forum (NQF), in accordance with the principles of the Patient Charter for Physician Performance Measurement. At a minimum, Contractor shall document its plans to make available to Plan Enrollees information provided for public use, as it becomes available, that reflects the CMS Hospital Compare Program and CMS Physician Quality Reporting System, or Health Resources and Services Administration (HRSA) Uniform Data System as appropriate. Contractor shall report how it is or intends to make provider specific cost and quality information available by region, and the processes by which it updates the information. Information delivered through Contractor's Provider performance programs should be meaningful to Plan Enrollees and reflect a diverse array of Provider clinical attributes and activities, including, but not be limited to: provider background; quality performance; patient experience; volume; efficiency; price of services; and should be integrated and accessible through one forum providing Plan enrollees with a comprehensive view.

6.02 Enrollee Cost Transparency. The Exchange and Contractor acknowledge and agree that information relating to the cost of procedures and services is important to enrollees, the Exchange, the Contractor and providers. The Exchange also understands that Contractor negotiates Agreements with providers, including physicians, hospitals, physician groups and other clinical providers, which may or may not result in varied provider reimbursement levels for identical services and or procedures. In the event that Contractor's provider contracts do result in different provider reimbursement levels that have an impact on Plan Enrollee out of pocket costs within a specific region, as defined by paid claims for like CPT, ICD9/10 and DRG based services: (1) Contractor agrees to provide the Exchange with its plan, measures and process to assist Plan Enrollees identify total cost and out-of-pocket cost information for the highest frequency and highest cost service(s) and or procedure(s); (2) when available, this pricing information shall be prominently displayed and made available to both Plan Enrollees and contracted Contractor providers if provided; and (3) this information shall be updated on at least an annual basis; provided however, if there is a contractual change that would change enrollee out-of-pocket costs by more than 10%, information must be updated within 30 days of the effective date of the new contract.

6.03 Enrollee Benefit Information. Contractor shall provide Plan Enrollees with current information regarding annual out-of-pocket costs, status of deductible and total Covered Services received to date.

6.04 Enrollee Shared Decision-Making. Contractor shall demonstrate effective engagement of enrollees with information, decision support, and strategies to optimize self-care and make the best choices about their treatment, with materials from sources such as Consumer Reports, developed as part of the American Board of Internal Medicine ("ABIM") Foundation campaign, "Choosing Wisely" or structured shared decision-making programs.

Contractor shall also provide specific information to the Exchange regarding the number of Plan Enrollees who have accessed consumer information and/or have participated in a shared decision-making process prior to reaching an agreement on a treatment plan. For example, Contractor may adopt shared-decision-making practices for preference-sensitive conditions, including but not limited to breast cancer, prostate cancer, and knee and hip replacements, that feature patient-decision-making aids in addition to physician opinions and present trade-offs regarding quality or length of life. Contractor shall report the percentage of Enrollees with identified health conditions above who received information that allowed the Enrollee to share in the decision-making process prior to agreeing to a treatment plan. Contractor shall report annually to the Exchange documenting participation in these programs and their results, including

clinical, patient experience and costs impacts and to the extent collected provide the results to the Exchange.

Article 7. Promoting Higher Value Care

7.01 Reward-based Consumer Incentive Programs. Contractor may, to the extent permitted by law, maintain or develop a Reward-based Consumer Incentive Program to promote evidence-based, optimal care for Plan Enrollees with identified chronic conditions. To the extent Contractor implements such a program for Plan Enrollees and to the extent such information is known, Contractor shall report participation rates and outcomes results, including clinical, patient experience and cost impacts, to the Exchange.

7.02 Value Based Reimbursement Inventory and Performance. Contractor will provide an inventory of all current value based provider reimbursement methodologies within the geographic regions served by the Exchange. Value based reimbursement methodologies will include those payments to hospitals and physicians that are linked to quality metrics, performance, costs and/or value measures. Integrated care models that receive such value based reimbursements may be included, but are not limited to, those referenced in Section 5.02.

This inventory must include:

- a) The percentage of total valued based reimbursement to providers, by provider and provider type.
- b) The total number of Contractor Plan Enrollees accessing participating providers reimbursed under value based payment methodologies.
- c) The percentage of total Contractor Network Providers participating in value based provider payment programs.
- d) An evaluation of the overall performance of Contractor network providers, by geographic region, participating in value based provider payment programs.

Contractor and the Exchange shall reach an annual agreement on the targeted percentage of providers to be reimbursed under value based provider reimbursement methodologies.

7.03 Value Based Reimbursement and Adherence to Clinical Guidelines. If not already in place, by January 1, 2016, Contractor agrees to develop and/or implement alternative reimbursement methodologies to promote adherence to clinical guidelines. Methodologies will target the highest frequency conditions and procedures as mutually agreed upon by the Exchange and Contractor.

When considering the implementation of value based reimbursement programs, Contractor shall demonstrate and design approaches to payment that reduce waste and inappropriate care, while not diminishing quality.

7.04 Value-Pricing Programs. Contractor agrees to provide the Exchange with the details of any value-pricing programs for procedures or in service areas that have the potential to improve care and generate savings for the Exchange enrollees. Contractor agrees to share the results with the Exchange of programs that may focus on high cost regions or those with the greatest cost variation(s). These programs may include but are not limited to payment bundling pilots for specific procedures where wide cost variations exist.

7.05 Payment Reform and Data Submission.

- a) Contractor will provide information to the Exchange noted in all areas of this Article 7 understanding that the Exchange will provide such information to the Catalyst for Payment Reform's (CPR) National Scorecard on Payment Reform and National Compendium on Payment Reform.
- b) The CPR National Scorecard will provide a view of progress on payment reform at the national level and then at the market level as the methodology and data collection mechanisms allow.
- c) The CPR National Compendium will be an up-to-date resource regarding payment reforms being tested in the marketplace and their available results. The Compendium will be publicly available for use by all health care stakeholders working to increase value in the system.

Quality, Network Management and Delivery System Standards

Glossary of Key Terms

Accountable Care Organization (ACO) - A healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. An ACO is intended to provide incentives for participating providers (i.e. clinics, hospitals and physicians) to collectively share financial risk, working towards common goals to 1) reduce medical costs, 2) reduce waste and redundancy, 3) adhere to best care practices (i.e. evidence-based care guidelines, and 4) improve care quality. Care Management and Population Health Management are critical program components that are intended to enable ACOs to achieve favorable financial outcomes as the result of improved care outcomes.

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

Bundled Payments (also known as Global Payment Bundles, episode-of-care payment, or global case rates) - An alternative payment method to reimburse healthcare providers for services that provides a single payment for all physician, hospital and ancillary services that a patient uses in the course of an overall treatment for a specific, defined condition, or care episode. These services may span multiple providers in multiple settings over a period of time, and are reimbursed individually under typical fee-for-service models. The Payment Bundle may cover all inpatient/outpatient costs related to the care episode, including physician services, hospital services, ancillary services, procedures, lab tests, and medical devices/implants. Using Payment Bundles, providers assume financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications, but not the insurance risk (that is, the risk that a patient will acquire that condition, as is the case under capitation).

Care Management - Healthcare services, programs and technologies designed to help individuals with certain long-term conditions better manage their overall care and treatment. Care management typically encompasses Utilization Management (UM), Disease Management (DM) and Case Management (CM). Care Management's primary goal is to prevent the sick from getting sicker, and avoiding acute care events. Care Management is usually considered a subset of Population Health Management.

Complex Conditions - Clinical conditions that are of a complex nature that typically involve ongoing case management support from appropriately trained clinical staff. Frequently, individuals have multiple chronic clinical conditions that complicate management ("polychronic") or may have a complex, infrequent specialty condition that requires specialized expertise for optimal management.

Delivery System Transformation - A set of initiatives taken by purchasers, employers, health plans or providers, together or individually, to drive the creation and preferred use of care delivery models that are designed to deliver higher value aligned with the "triple aim" goals of patient care experience including quality and satisfaction, improve the health of the populations, and reduce the per capita cost of Covered Services. Generally these models require improved care coordination, provider and payer information sharing and programs that identify and manage populations of individuals through care delivery and payment models.

Patient Centered Medical Home - A health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

Population Health Management - A management process that strives to address health needs at all points along the continuum of health and wellbeing, through participation of, engagement with and targeted interventions for the population. The goal of a Population Health Management program is to maintain and/or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions.

Preventive Health and Wellness Services - The provision of specified preventive and wellness services and chronic disease management services, including preventive care, screening and immunizations, set forth under Section 1302 of the Affordable Care Act (42 U.S.C. Section 18022) under the Section 2713 of the Affordable Care Act (42 U.S.C. Section 300gg-13), to the extent that such services are required under the California Affordable Care Act.

Reference Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care based on transparent display of comparative costs for identical services or procedures, typically after each provider has passed a quality assessment screen. In some cases, value pricing will identify the individual enrollees out of pocket costs accounting for plan design and deductible status. While quality is incorporated in the process, typically there is no differentiation based on comparative quality once a threshold performance level is achieved.

Remote Patient Monitoring - A technology or set of technologies to enable monitoring of patients outside of conventional clinical settings (e.g. in the home), which may increase access to care and decrease healthcare delivery costs.

Reward Based Consumer Incentive Program - (aka: Value-Based Insurance Design) individualizes the benefits and claims adjudication to the specific clinical conditions of each high risk member and to reward participation in appropriate disease management & wellness programs. Positive Consumer Incentive programs help align employee incentives with the use of high-value services and medications, offering an opportunity for quality improvement, cost savings and reduction in unnecessary and ineffective care.

Shared Decision Making - The process of making decisions regarding health care diagnosis and treatment that are shared by doctors and patients, informed by the best evidence available and weighted according to the specific characteristics and values of the patient. Shared decision making combines the measurement of patient preferences with evidence-based practice.

Team Care - A plan for patient care that is based on philosophy in which groups of professional and non-professional personnel work together to identify, plan, implement and evaluate comprehensive client-centered care. The key concept is a group that works together toward a common goal, providing qualitative comprehensive care. The team care concept has its roots in team nursing concepts developed in the 1950's.

Telemedicine - Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site. Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Value Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care that provide better value through the identification and transparent display of comparative total cost, out of pocket cost for enrollees and standardized quality performance to allow for informed consumer choice and provider referrals for individual services and bundles of services.

Value Based Reimbursement - Payment models that rewards physicians and providers for taking a broader, more active role in the management of patient health, and provides for a reimbursement rate that reflects results and quality instead of solely for specific visits or procedures.

Appendix 1 to Attachment 7. Enterprise Analytics Solution Dataset

Enrollment Detail Data Elements										
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
1	Enrollment Snapshot Month	1	10	10	Date	First day of eligibility snapshot month	MM/DD/CCYY format			Enrollee-Specific
2	Date of Birth	11	20	10	Date	Birth date of the person	MM/DD/CCYY format			Enrollee-Specific
3	Date of Death	21	30	10	Date	The Date of Death of the enrollee	MM/DD/CCYY format			Enrollee-Specific
4	Subscriber SSN	31	39	9	Char	The policy holder SSN				Policy Holder-Specific
5	CC Subscriber ID	40	59	20	Char	The Covered California subscriber Identifier				Policy Holder-Specific
6	Enrollee / Member SSN	60	68	9	Char	The SSN of the individual enrollee.				Enrollee-Specific
7	CC Member ID	69	88	20	Char	The Covered California member Identifier				Enrollee-Specific
8	Plan Member ID	89	108	20	Char	The enrollee Identifier as identified by the issuer				Enrollee-Specific
9	Policy ID	109	128	20	Char	Identifier of the individual policy for the enrollee				Policy-Holder Specific

Enrollment Detail Data Elements										
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
10	Enrollee First Name	129	188	60	Char	The enrollee's first name.	If name is longer than 60 bytes, please truncate remaining bytes.			Enrollee-Specific
11	Enrollee Last Name	189	248	60	Char	The enrollee's last name.	If name is longer than 60 bytes, please truncate remaining bytes.			Enrollee-Specific
12	Enrollee Middle Initial	249	249	1	Char	The enrollee's middle initial				Enrollee-Specific
13	Enrollment End Reason Code	250	253	4	Char	The reason for termination of enrollment. Please include death as one of the reasons for termination.	Reason codes will be identified in the Data Dictionary.		Yes	Enrollee-Specific
14	Address 1	254	303	50	Char	The street address for the residence of the enrollee, for the most recent month of enrollment.				Enrollee-Specific
15	Address 2	304	333	30	Char	The second part of the street address if needed for the residence of the person, for the most recent month of enrollment.				Enrollee-Specific
16	City	334	363	30	Char	The city of the residence for the person				Enrollee-Specific

Enrollment Detail Data Elements										
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
17	State Code	364	365	2	Char	The state code of the residence of the person				Enrollee-Specific
18	ZIP Code (5 digit)	366	370	5	Char	The 5 digit ZIP Code of the residence of the member at the time of the eligibility month.				Enrollee-Specific
19	ZIP Code plus 4 (last 4)	371	374	4	Char	The last 4 digits of the ZIP Code of the residence of the member at the time of the eligibility month.	If only 5-digit ZIP Code is available, blank fill this field.			Enrollee-Specific
20	County Code	375	379	5	Char	The state/county FIPS code for the enrollee address of residence.				Enrollee-Specific
21	Gender Code	380	380	1	Char	Gender of the person.	M or F			Enrollee-Specific
22	Relationship Code	381	385	5	Char	Code with values that specify the relationship of the enrollee to the policy-holder.	Relationship code values will be identified in the Data Dictionary.		Yes	Enrollee-Specific
23	Race 1 Code	386	386	1	Char	Code specifying the race or ethnicity of the person.	Race code values will be identified in the Data Dictionary.		Yes	Enrollee-Specific

Enrollment Detail Data Elements										
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
24	Race 2 Code	387	387	1	Char	Code specifying the race or ethnicity of the enrollee.	Race code values will be identified in the Data Dictionary.		Yes	Enrollee-Specific
25	Race 3 Code	388	388	1	Char	Code specifying the race or ethnicity of the person.	Race code values will be identified in the Data Dictionary.		Yes	Enrollee-Specific
26	Ethnicity 1 Code	389	394	6	Char	Code specifying the ethnicity of the enrollee	Ethnicity code values will be identified in the Data Dictionary.		Yes	Enrollee-Specific
27	Ethnicity 2 Code	395	400	6	Char	Code specifying the ethnicity of the enrollee	Ethnicity code values will be identified in the Data Dictionary.		Yes	Enrollee-Specific
28	Ethnicity 3 Code	401	406	6	Char	Code specifying the ethnicity of the enrollee	Ethnicity code values will be identified in the Data Dictionary.		Yes	Enrollee-Specific
29	Language Written Code	407	410	4	Char	Code for the preferred written language of the enrollee	Values will be identified in the Data Dictionary.		Yes	Enrollee-Specific
30	Language Spoken Code	411	414	4	Char	Code for the preferred spoken language of the enrollee	Values will be identified in the Data Dictionary.		Yes	Enrollee-Specific
31	Coverage Start Date	415	424	10	Date	The effective date of the current coverage	MM/DD/CCYY format			Enrollee-Specific
32	Coverage End Date	425	434	10	Date	The end date of the coverage	MM/DD/CCYY format			Enrollee-Specific

Enrollment Detail Data Elements										
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
33	Coverage Indicator Dental	435	435	1	Char	Indicator of Dental Coverage	Standard values: Y = Have coverage, N = Do not have coverage Children Only Hard code to "N"			Enrollee-Specific
34	Coverage Indicator Drug	436	436	1	Char	Indicator of Drug Coverage	Standard values: Y = Have coverage, N = Do not have coverage All Hard code to "Y"			Enrollee-Specific
35	Coverage Indicator Hearing	437	437	1	Char	Indicator of Hearing Coverage	Standard values: Y = Have coverage, N = Do not have coverage All Hard code to "Y"			Enrollee-Specific
36	Coverage Indicator Medical	438	438	1	Char	Indicator of Medical Coverage	Standard values: Y = Have coverage, N = Do not have coverage All Hard code to "Y"			Enrollee-Specific
37	Coverage Indicator MHSA	439	439	1	Char	Indicator of MHSA Coverage	Standard values: Y = Have coverage, N = Do not have coverage All Hard code to "Y"			Enrollee-Specific
38	Coverage Indicator Vision	440	440	1	Char	Indicator of Vision Coverage	Standard values: Y = Have coverage, N = Do not have coverage Children Only Hard code to "N"			Enrollee-Specific

Enrollment Detail Data Elements										
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
39	PCP Type Code	441	444	4	Char	A code indicating the Primary Care Physician's specialty or type ex. General Practice, Family Practice, OB/GYN	PCP Type code values will be identified in the Data Dictionary. Field is not available, EAS Vendor to impute PCP		Yes	Enrollee-Specific
40	PCP Provider ID	445	457	13	Char	The provider identifier of the Primary Care Physician.	The NPI number for the provider is preferred. Field is not available, EAS Vendor will impute.			Enrollee-Specific
41	Gross Premium	458	467	10	Num	The total value of the monthly premium paid for medical benefits.	<p>Format 9(8)v99 (2 – digit, implied decimal)</p> <p>This field should contain total premium amounts paid by the government for fully-insured plans and not premium equivalents. It should not be the net amount (minus policy-holder contribution) as this will be calculated within the EAS Vendor tool.</p> <p>It should be populated only on records for those policyholders / contract holders enrolled in fully-insured medical plans. On all other records this field should be zero filled.</p>			Policy Holder / Contract Holder Only

Enrollment Detail Data Elements										
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
42	Net Premium	468	477	10	Num	The monthly amount contributed by the policy-holder for medical benefits	Format 9(8)v99 (2-digit, implied decimal). Only recorded on policy-holder record (zero-filled on non-policy-holder records).			Policy Holder / Contract Holder Only
43	Subsidy Amount	478	487	10	Num	The government paid monthly premium for medical benefits	Format 9(8)v99 (2-digit, implied decimal). Only recorded on policy-holder record (zero-filled on non-policy holder records).			Policy Holder / Contract Holder Only
44	Product Type / Medical Plan Type	488	491	4	Char	The type of product in which the enrollee is enrolled. Examples include PPO, HMO, POS, etc.	Indemnity, HMO, PPO, FFS, POS, HDHP, CDHP, etc.		Yes	Enrollee-Specific
45	Medical Fully Insured Indicator	492	492	1	Char	An indicator of fully insured medical coverage for the member or employee.	Y = Yes N = No Hard code to "Y"			Enrollee-Specific
46	Drug Fully Insured Indicator	493	493	1	Char	An indicator of fully insured drug coverage for the member or employee.	Y = Yes N = No Hard code to "Y"			Enrollee-Specific
47	HIOS Plan Code	494	509	16	Char	The code for HIOS plan				Enrollee-Specific

Enrollment Detail Data Elements										
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
48	Rating Region Code	510	514	5	Char	The code for the geographic region of the person				Enrollee-Specific
49	Policy Structure Code / Coverage Tier Code	515	518	4	Char	The policy structure code/Family Size	Customer-specific values will be identified in the Data Dictionary.		Yes	Policy Holder-Specific
50	Dental Plan Code	519	524	6	Char	The code for the dental plan in which the member is enrolled.	This will currently be blank-filled from the data supplier, EAS Vendor to populate with the same code from Medical. It's desirable to have a plan code explicitly identifying "Opt-outs".		Yes	Enrollee-Specific
51	Dental Policy Structure Code / Coverage Tier Code	525	528	4	Char	The Dental Policy Structure Code (if stand-alone, else blank)	Values will be identified in the Data Dictionary.		Yes	Enrollee-Specific
52	Monthly Policy Holder Dental Contribution	529	538	10	Num	The monthly amount contributed by the policy-holder for dental benefits (if stand-alone, else 0)	Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy-holder records).			Policy Holder / Contract Holder Only

Enrollment Detail Data Elements										
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
53	Monthly Dental Premium	539	548	10	Num	The government paid monthly premium for dental benefits (stand-alone plans)	Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid by the government for fully-insured plans and not premium equivalents. It should not be the net amount (minus policy-holder contrib.) as this will be calculated within the EAS Vendor tool. It should be populated only on policy-holder records for those enrolled in fully-insured medical plans. On all other records this field should be zero filled.			Policy Holder / Contract Holder Only
54	Vision Plan Code	549	554	6	Char	The code for the vision plan in which the member is enrolled.	Vision plan code values will be identified in the Data Dictionary. It's desirable to have a plan code explicitly identifying "Opt-outs". This field will be initially set to blanks.		Yes	Enrollee-Specific
55	Vision Policy Structure Code / Coverage Tier Code	555	558	4	Char	Vision Coverage Tier Code	Values will be identified in the Data Dictionary. This field will be initially set to blanks.		Yes	Enrollee-Specific

Enrollment Detail Data Elements										
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
56	Monthly Policy Holder Vision Contribution	559	568	10	Num	The monthly amount contributed by the policy-holder for their vision benefits	Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on dependent records). This field will be initially set to blanks.			Policy Holder / Contract Holder Only
57	Monthly Vision Premium	569	578	10	Num	The government paid monthly premium for vision benefits if standalone plan else 0	Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid by the government for fully-insured plans and not premium equivalents. It should not be the net amount (minus policy-holder contrib.) as this will be calculated within the EAS Vendor tool. It should be populated only on policy-holder records for those enrolled in fully-insured medical plans. On all other records this field should be zero filled. This field will be initially set to blanks			Policy Holder / Contract Holder Only
58	SHOP Employee Status Code	579	583	5	Char	Customer-specific values of employee status.	Employee Status code values will be identified in the Data Dictionary.	X	Yes	Policy Holder-Specific
59	SHOP Employee Medicare Eligible Indicator	584	584	1	Char	A code indicating whether an employee is Medicare eligible.	Y = Yes N = No	X		Policy Holder-Specific

Enrollment Detail Data Elements										
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
60	SHOP Part-Time / Full-time Indicator	585	585	1	Char	A code indicating whether an employee is full-time or part-time.	P = Part-time F = Full-time	X		Policy Holder-Specific
61	Plan Group Number	586	605	20	Char	The enrollee's group number as identified by the plan		X	Yes	Enrollee-Specific
62	Plan Group Suffix	606	610	5	Char	The enrollee's group suffix as identified by the plan		X	Yes	Enrollee-Specific
63	Industry Classification Code	611	616	6	Char	The standard industry classification code based on the North American Industry Classification System (NAICS).	HPID or SHOP	X		Policy Holder-Specific
64	Filler	617	999	383	Char	Reserved for future use	Fill with blanks			Enrollee-Specific
65	Record Type	1000	1000	1	Char	Record type identifier	Hard Code to "D"			Enrollee-Specific

Enrollment Trailer Data Elements							
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
1	Eligibility Start Date	1	10	10	Date	Eligibility Begin Date	MM/DD/CCYY format – i.e. 09/01/2015 This will represent the 1st day of the month for which data is provided.

Enrollment Trailer Data Elements							
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
2	Eligibility End Date	11	20	10	Date	Eligibility End Date	MM/DD/CCYY format – i.e. 09/30/2015 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Num	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Filler	31	999	969	Char	Reserved for future use	Fill with Blanks
5	Record Type	1000	1000	1	Char	Record Type Identifier	Hard Code 'T'

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
1	Subscriber SSN	1	9	9	Char	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.		The policy holder's Social Security Number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
2	CC Subscriber ID	10	29	20	Char	The subscriber ID as assigned by Covered California		
3	Enrollee/member SSN	30	38	9	Char	Member's Social Security Number		
4	CC Member ID	39	58	20	Char	The member ID as assigned by Covered California		
5	Plan Member ID	59	78	20	Char	The member ID as assigned by the plan		

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
6	Policy ID	79	98	20	Char	The policy number of the policy-holder		
7	Rendering Provider ID	99	111	13	Char	The unique identifier for the provider of service.		
8	Rendering Provider TIN	112	120	9	Char	The federal tax ID of the provider of service.		This must be the federal tax ID in order to use the standard hospital identifier lookup (Standard Facility).
9	Rendering Provider NPI	121	130	10	Char	The National Provider ID number for the provider of service.		
10	Rendering Provider First Name	131	160	30	Char	The description or name corresponding to the servicing Provider ID.		The Provider Name should be specific to the provider and not a group name.
11	Rendering Provider Last Name	161	190	30	Char	The last name corresponding to the servicing Provider ID.		The Provider Name should be specific to the provider and not a group name.
12	Rendering Provider Middle Initial	191	191	1	Char	The middle initial corresponding to the servicing Provider ID.		
13	Rendering Provider Address 1	192	241	50	Char	The current street address1 of the provider of service.		If the provider has multiple addresses, the primary address is preferred.
14	Rendering Provider Address 2	242	271	30	Char	The current street address2 of the provider of service.		If the provider has multiple addresses, the primary address is preferred.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
15	Rendering Provider City	272	301	30	Char	The current city of the provider of service.		
16	Rendering Provider State	302	303	2	Char	The current state of the provider of service.		
17	Rendering Provider County Code	304	308	5	Char	FIPS State/County code of the servicing provider		
18	Rendering Provider ZIP Code	309	313	5	Char	The 5-digit ZIP Code corresponding to the servicing Provider ID		Provider Location ZIP Code
19	Rendering Provider Zip Plus 4 Code	314	317	4	Char	The 4 digit ZIP Code extension code of the servicing provider		
20	Rendering Provider Type Code Claim	318	321	4	Char	Client-specific code for the provider type on the claim record	Yes	Provider Type codes are further defined in the Data Dictionary
21	Referring Provider ID	322	334	13	Char	The ID number of the provider who referred the patient or ordered the test or procedure.		
22	Referring Provider TIN	335	343	9	Char	The federal tax ID of the Referring provider.		
23	Referring Provider NPI	344	353	10	Char	The National Provider ID number for the Referring provider.		

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
24	Referring Provider First Name	354	383	30	Char	The description or name corresponding to the Referring Provider ID.		
25	Referring Provider Last Name	384	413	30	Char	The last name corresponding to the Provider ID.		
26	Referring Provider Middle Initial	414	414	1	Char	The middle initial corresponding to the Referring Provider ID.		
27	Referring Provider ZIP Code	415	419	5	Char	The ZIP Code of the provider who referred the patient or ordered the test or procedure.		
28	Referring Provider Zip Plus 4 Code	420	423	4	Char	The 4 digit ZIP Code extension code of the referring provider		
29	Billing Provider ID	424	436	13	Char	The unique ID number of the Billing provider.		
30	Billing Provider TIN	437	445	9	Char	The federal tax ID of the billing provider.		
31	Billing Provider NPI	446	455	10	Char	The National Provider ID number for the billing provider.		
32	Attending Provider ID	456	468	13	Char	The unique ID number of the attending provider.		

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
33	Attending Provider TIN	469	477	9	Char	The federal tax ID of the attending provider.		
34	Attending Provider NPI	478	487	10	Char	The National Provider ID number for the attending provider.		
35	PCP Provider ID	488	500	13	Char	The unique ID number of the PCP provider.		
36	PCP Provider TIN	501	509	9	Char	The federal tax ID of the PCP provider.		
37	PCP Provider NPI	510	519	10	Char	The National Provider ID number for the PCP provider.		
38	PCP Responsibility Indicator	520	520	1	Char	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.		"Y" or "N"
39	Adjustment Type Code	521	521	1	Char	Client-specific code for the claim adjustment type	Yes	Adjustment Type values will be identified in the Data Dictionary .
40	Allowed Amount	522	531	10	Num	The maximum amount allowed by the plan for payment.		Format 9(8)v99 (2-digit, implied decimal). On facility records, this field must be at the service/detail level as opposed to the header/claim level.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
41	Bill Type Code UB	532	535	4	Char	The UB-04 standard code for the billing type, indicating type of facility, bill classification, and frequency of bill.	See Notes	Bill Type values will be identified in the Data Dictionary only if standard codes are not used.
42	Capitated Service Indicator	536	536	1	Char	An indicator that this service (encounter record) was capitated		Applicable field values are "Y" for Capitated services and "N" for non-cap services.
43	Charge Submitted	537	546	10	Num	The submitted or billed charge amount		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
44	Claim ID	547	596	50	Char	The client-specific identifier of the claim.		
45	Claim Type Code	597	599	3	Char	Client-specific code for the type of claim	Yes	Claim Type Codes will be identified in the Data Dictionary .
46	Coinsurance	600	609	10	Num	The coinsurance paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
47	Copayment	610	619	10	Num	The copayment paid by the subscriber as specified by the plan provision.		

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
48	Date of Birth	620	629	10	Date	Birth date of the person		MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
49	Date of First Service	630	639	10	Date	The date of the first service reported on the claim or authorization record.		MM/DD/CCYY Format
50	Date of Last Service	640	649	10	Date	The date of the last service reported on the claim or authorization record.		MM/DD/CCYY Format
51	Date of Service Facility Detail	650	659	10	Date	The date of service for the facility detail record.		MM/DD/CCYY Format
52	Date Paid	660	669	10	Date	The date the claim or data record was paid.		MM/DD/CCYY format This is the check date.
53	Days Stay	670	675	6	Num	The number of inpatient days for the facility claim.		
54	Deductible	676	685	10	Num	The amount paid by the subscriber through the deductible arrangement of the plan.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
55	Diagnosis Code Principal	686	693	8	Char	The first or principal diagnosis code for a service, claim or lab result. Length expanded from 5 to 8 for future use.		No decimal point.
56	Diagnosis Code 2	694	701	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
57	Diagnosis Code 3	702	709	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
58	Diagnosis Code 4	710	717	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
59	Diagnosis Code 5	718	725	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
60	Diagnosis Code 6	726	733	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
61	Diagnosis Code 7	734	741	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
62	Diagnosis Code 8	742	749	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
63	Diagnosis Code 9	750	757	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
64	Diagnosis Code 10	758	765	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
65	Diagnosis Code 11	766	773	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
66	Diagnosis Code 12	774	781	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
67	Diagnosis Code 13	782	789	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
68	Diagnosis Code 14	790	797	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
69	Diagnosis Code 15	798	805	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
70	Diagnosis Code 16	806	813	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
71	Diagnosis Code 17	814	821	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
72	Diagnosis Code 18	822	829	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
73	Diagnosis Code 19	830	837	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
74	Diagnosis Code 20	838	845	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
75	Diagnosis Code 21	846	853	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
76	Diagnosis Code 22	854	861	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
77	Diagnosis Code 23	862	869	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
78	Diagnosis Code 24	870	877	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
79	Diagnosis Code 25	878	885	8	Char	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
80	Discharge Status Code UB	886	887	2	Num	The UB-04 standard patient status code, indicating disposition at the time of billing.		
81	Discount Amount	888	897	10	Num	The discount amount of the claim, applied to charges for any plan pricing reductions.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
82	Gender Code	898	898	1	Char	Gender of the person.		M or F The member’s gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility
83	Line Number	899	900	2	Num	The detail line number for the service on the claim		
84	Net Payment	901	910	10	Num	The actual check amount for the record		Format 9(8)v99 (2 - digit, implied decimal)
85	Network Paid Indicator	911	911	1	Char	An indicator of whether the claim was paid at in-network or out-of-network level		On facility records, this field must be at the service/detail level as opposed to the header/claim level.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
86	Network Provider Indicator	912	912	1	Char	Indicates if the servicing provider participates in the network to which the patient belongs		"Y" or "N"
87	Place of Service Code	913	914	2	Char	Client-specific code for the place of service.	See Notes	EAS Vendor prefers the CMS place of service values. Place of Service values will be identified in the Data Dictionary only if non-standard values are used.
88	Procedure Code	915	921	7	Char	The procedure code for the service record. Length expanded from 5 to 7 for future use.		CPT/HCPCS codes.
89	Procedure Code UB Surg 1	922	928	7	Char	The primary surgical procedure code (1) on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
90	Procedure Code UB Surg 2	929	935	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
91	Procedure Code UB Surg 3	936	942	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
92	Procedure Code UB Surg 4	943	949	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
93	Procedure Code UB Surg 5	950	956	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
94	Procedure Code UB Surg 6	957	963	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
95	Procedure Code UB Surg 7	964	970	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
96	Procedure Code UB Surg 8	971	977	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
97	Procedure Code UB Surg 9	978	984	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
98	Procedure Code UB Surg 10	985	991	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
99	Procedure Code UB Surg 11	992	998	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
100	Procedure Code UB Surg 12	999	1005	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
101	Procedure Code UB Surg 13	1006	1012	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
102	Procedure Code UB Surg 14	1013	1019	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
103	Procedure Code UB Surg 15	1020	1026	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
104	Procedure Code UB Surg 16	1027	1033	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
105	Procedure Code UB Surg 17	1034	1040	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
106	Procedure Code UB Surg 18	1041	1047	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
107	Procedure Code UB Surg 19	1048	1054	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
108	Procedure Code UB Surg 20	1055	1061	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
109	Procedure Code UB Surg 21	1062	1068	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
110	Procedure Code UB Surg 22	1069	1075	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
111	Procedure Code UB Surg 23	1076	1082	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
112	Procedure Code UB Surg 24	1083	1089	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
113	Procedure Code UB Surg 25	1090	1096	7	Char	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
114	Procedure Modifier Code 1	1097	1098	2	Char	The 2-character code of the first procedure code modifier on the professional claim		
115	Procedure Modifier Code 2	1099	1100	2	Char	The 2-character code of the second procedure code modifier on the professional claim		
116	Procedure Modifier Code 3	1101	1102	2	Char	The 2-character code of the third procedure code modifier on the professional claim		
117	Procedure Modifier Code 4	1103	1104	2	Char	The 2-character code of the fourth procedure code modifier on the professional claim		

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
118	Revenue Code UB	1105	1108	4	Char	The CMS standard revenue code from the facility claim		This field must be at the service/detail level.
119	Third Party Amount	1109	1118	10	Num	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).		Format 9(8)v99 (2 - digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
120	Units of Service	1119	1122	4	Num	Client-specific quantity of services or units		
121	Funding Type Code	1123	1123	1	Char	Specifies whether the claim was paid under a fully or self-funded arrangement		"S" = Self-funded "F" = Fully-funded
122	Account Structure	1124	1143	20	Char	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Yes	Additional fields may be added to the layout if there is more than one component of the account structure.
123	HRA Amount	1144	1153	10	Num	The amount paid from the HRA as a result of this claim.		Format 9(8)v99 (2 - digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
124	HSA Amount	1154	1163	10	Num	The amount paid from the HSA as a result of this claim.		Format 9(8)v99 (2 - digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
125	Present on Admission Principal	1164	1164	1	Char	The principal POA code for the facility claim. Indicates whether the principal diagnosis was present on admission. Standard Values: 1 – Unreported/Not Used N – No, not present at admission U – Unknown W – Clinically Undetermined Y – Yes, present at admission	See Notes	If standard values are not used, define in the Data Dictionary .
126	Present on Admission 02	1165	1165	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
127	Present on Admission 03	1166	1166	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
128	Present on Admission 04	1167	1167	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
129	Present on Admission 05	1168	1168	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
130	Present on Admission 06	1169	1169	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
131	Present on Admission 07	1170	1170	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
132	Present on Admission 08	1171	1171	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
133	Present on Admission 09	1172	1172	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
134	Present on Admission 10	1173	1173	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
135	Present on Admission 11	1174	1174	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
136	Present on Admission 12	1175	1175	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
137	Present on Admission 13	1176	1176	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
138	Present on Admission 14	1177	1177	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
139	Present on Admission 15	1178	1178	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
140	Present on Admission 16	1179	1179	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
141	Present on Admission 17	1180	1180	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
142	Present on Admission 18	1181	1181	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
143	Present on Admission 19	1182	1182	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
144	Present on Admission 20	1183	1183	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
145	Present on Admission 21	1184	1184	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
146	Present on Admission 22	1185	1185	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
147	Present on Admission 23	1186	1186	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
148	Present on Admission 24	1187	1187	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
149	Present on Admission 25	1188	1188	1	Char	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary .
150	DRG MS Payment Code	1189	1191	3	Char	The Diagnosis Related Group (MS-DRG) code under which the claim was paid.		
151	ICD Version	1192	1192	1	Char	The ICD version or qualifier code that identifies either ICD-9 (9) or ICD-10 (0) diagnosis and procedure codes on the facility claim.	See Notes	If 0 and 9 not used, values defined in the Data Dictionary .

Medical Claims / Encounters Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
152	Tax Amount	1193	1202	10	Num	The amount charged by some states per medical claim.		Format 9(8)v99 (2 – digit, implied decimal)
153	Tax Type Code	1203	1203	1	Char	Data Supplier specific code identifying the state and/or type of tax.	Yes	Tax Type Codes will be identified in the Data Dictionary .
154	NDC Number Code	1204	1214	11	Char	The FDA (Food and Drug Administration) registered number for the drug. Please include for any drugs dispensed in the medical setting if available.		Please leave out the dashes.
155	Penalty Amount	1215	1224	10	Num	Penalty amount on the claim		
156	Referral Indicator	1225	1225	1	Char	Indicates if patient was referred		
157	Non-Medicare Paid Amount	1226	1235	10	Num	Third party amount, non-Medicare		
158	Withhold Amount	1236	1245	10	Num	Amount withheld		
159	Filler	1246	1699	454	Char	Reserved for future use		Fill with blanks
160	Record Type	1700	1700	1	Char	Record type identifier		Hard Code to "D"

Medical Claims / Encounters Trailer Data Elements							
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Num	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Num	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	1699	1655	Char	Reserved for future use	Fill with Blanks
6	Record Type	1700	1700	1	Char	Record Type Identifier	Hard Code 'T'

Drug Claims Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
1	Subscriber SSN	1	9	9	Char	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.		The subscriber's Social Security Number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
2	CC Subscriber ID	10	29	20	Char	Unique code assigned by CC to the subscriber		
3	Enrollee/member SSN	30	38	9	Char	Member's Social Security Number		

Drug Claims Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
4	CC_MemberID	39	58	20	Char	The member ID as assigned by Covered California		
5	Plan_MemberID	59	78	20	Char	Unique code assigned by health plan to identify a member		
6	Policy ID	79	98	20	Char	Policy ID assigned by health plan		
7	Claim ID	99	148	50	Char	The client-specific identifier of the claim.		
8	Date of Birth	149	158	10	Date	The birth date of the person.		MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
9	Gender Code	159	159	1	Char	The member's gender code.		"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
10	Adjustment Type Code	160	160	1	Char	Client-specific code for the claim adjustment type	Yes	Adjustment Type values will be identified in the Data Dictionary .
11	Allowed Amount	161	170	10	Num	The maximum amount allowed by the plan for payment.		Format 9(8)v99 (2 - digit, implied decimal)
12	Charge Submitted	171	180	10	Num	The submitted or billed charge amount		Format 9(8)v99 (2 - digit, implied decimal)

Drug Claims Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
13	Claim Type Code	181	183	3	Char	Client-specific code for the type of claim	Yes	Claim Type Codes will be identified in the Data Dictionary .
14	Coinsurance	184	193	10	Num	The coinsurance paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 - digit, implied decimal)
15	Copayment	194	203	10	Num	The copayment paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 - digit, implied decimal)
16	Date of Service	204	213	10	Date	The date of service for the drug claim.		MM/DD/CCYY format
17	Date Paid	214	223	10	Date	The date the claim or data record was paid.		MM/DD/CCYY format This is the check date.
18	Days Supply	224	227	4	Num	The number of days of drug therapy covered by the prescription.		
19	Deductible	228	237	10	Num	The amount paid by the subscriber through the deductible arrangement of the plan.		Format 9(8)v99 (2 - digit, implied decimal)
20	Dispensing Fee	238	247	10	Num	An administrative fee charged by the pharmacy for dispensing the prescription.		Format 9(8)v99 (2 - digit, implied decimal)

Drug Claims Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
21	Formulary Indicator	248	248	1	Char	An indicator that the prescription drug is included in the formulary.		"Y" or "N"
22	Ingredient Cost	249	258	10	Num	The charge or cost associated with the pharmaceutical product.		Format 9(8)v99 (2 - digit, implied decimal)
23	Metric Quantity Dispensed	259	269	11	Num	The number of units dispensed for the prescription drug claim, as defined by the NCPDPD (National Council for Prescription Drug Programs) standard format.		Format 9(8)v99 (3 - digit, implied decimal)
24	NDC Number Code	270	280	11	Char	The FDA (Food and Drug Administration) registered number for the drug, as reported on the prescription drug claims.		Please leave out the dashes.
25	Net Payment	281	290	10	Num	The actual check amount for the record		Format 9(8)v99 (2 - digit, implied decimal)
26	Network Paid Indicator	291	291	1	Char	An indicator of whether the claim was paid at in-network or out-of-network level.		"Y" or "N"

Drug Claims Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
27	Network Provider Indicator	292	292	1	Char	Indicates if the servicing provider participates in the network to which the patient belongs.		"Y" or "N"
28	PCP Responsibility Indicator	293	293	1	Char	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.		"Y" or "N"
29	Pharmacy NPI Number	294	303	10	Char	The National Provider Identifier for the pharmacy.		
30	Pharmacy Provider ID	304	316	13	Char	The identifier for the provider of service.		This should be the NCPDP (National Council for Prescription Drug Programs) number. (Note: The pharmacy NPI is collected in field #28 in this layout.)
31	Pharmacy Address 1	317	366	50	Char	The first line of the address for the pharmacy.		
32	Pharmacy Address 2	367	396	30	Char	The second line of the address for the pharmacy.		
33	Pharmacy County	397	401	5	Char	The FIPS state/county code for the pharmacy.		
34	Pharmacy City	402	431	30	Char	The city for which the pharmacy resides.		

Drug Claims Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
35	Pharmacy State	432	433	2	Char	The state in which the pharmacy resides.		
36	Pharmacy Zip	434	438	5	Char	The ZIP Code of the pharmacy		
37	Pharmacy Zip Plus 4 Code	439	442	4	Char	The zip plus 4 code of the pharmacy		
38	Referring Provider ID	443	455	13	Char	The ID number of the provider who prescribed the drug.		It is preferred that this is the same identifiers used in medical claims.
39	Referring Provider First name	456	485	30	Char	The First Name of the provider who referred the patient or ordered the test or procedure.		
40	Referring Provider Last Name	486	515	30	Char	The Last Name of the provider who referred the patient or ordered the test or procedure.		
41	Referring Provider Middle Initial	516	516	1	Char	The Middle Initial of the provider who referred the patient or ordered the test or procedure.		
42	Referring Provider Address 1	517	566	50	Char	The first line of the Referring provider's address		
43	Referring Provider Address 2	567	596	30	Char	The second line of the Referring provider's address		
44	Referring Provider City	597	626	30	Char	The Referring provider's city		

Drug Claims Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
45	Referring Provider State	627	628	2	Char	The Referring provider's state		
46	Referring Provider ZIP Code	629	633	5	Char	The ZIP Code of the provider who referred the patient or ordered the test or procedure.		
47	Referring Provider Zip Plus 4 Code	634	637	4	Char	The zip plus 4 code of the Referring Provider		
48	Referring Provider NPI	638	647	10	Char	Referring Provider Submitted National Provider Identifier Type 1		
49	Referring Provider DEA number	648	659	12	Char	The DEA Number of the referring provider		
50	Referring Provider TIN	660	668	9	Char	The Tax ID of the referring provider		
51	Rx Dispensed as Written Code	669	669	1	Char	The NCPDP (National Council for Prescription Drug Programs) industry standard code that indicates how the product was dispensed.		
52	Rx Mail or Retail Code	670	670	1	Char	Standard code indicating the purchase place of the prescription.		"M" for Mail, "R" for Retail

Drug Claims Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
53	Rx Payment Tier	671	671	1	Char	Client-specific description for the payment tier of the drug claim.		Data Supplier will help EAS Vendor understand which fields to use in order to set this field for the customer. Examples of Rx Payment Tier are as follows: 1. Generic 2. Brand Formulary 3. Brand Non Formulary 4. Specialty Drug
54	Rx Refill Number	672	675	4	Num	A number indicating the original prescription or the refill number.		This is the refill number, not the number of refills remaining.
55	Tax Amount	676	685	10	Num	The amount of sales tax applied to the cost of the prescription.		Format 9(8)v99 (2 - digit, implied decimal)
56	Third Party Amount	686	695	10	Num	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).		Format 9(8)v99 (2 - digit, implied decimal)
57	Discount Amount	696	705	10	Num	The discount amount of the claim, applied to charges for any plan pricing reductions.		Format 9(8)v99 (2 - digit, implied decimal)

Drug Claims Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
58	Funding Type Code	706	706	1	Char	Specifies whether the claim was paid under a fully or self-funded arrangement		"S" = Self-funded "F" = Fully-funded
59	Account Structure	707	726	20	Char	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Yes	Additional fields may be added to the layout if there is more than one component of the account structure.
60	HRA Amount	727	736	10	Num	The amount paid from the HRA to pay the provider.		Format 9(8)v99 (2 - digit, implied decimal)
61	HSA Amount	737	746	10	Num	The financial amount of the healthcare savings account for consumer-driven health plans		Format 9(8)v99 (2 - digit, implied decimal)
62	Compound Code	747	747	1	Char	Client-specific code for the compound of the drug.	Yes	Compound Codes will be identified in the Data Dictionary . Note that the NCPDP values include: '0' – Not Specified '1' – Not a Compound '2' – Compound

Drug Claims Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
63	Excess Copayment Amount	748	757	10	Num	The amount paid by the patient outside of the flat copayment amount. Examples include when the patient chooses brand name instead of the generic alternative or non-formulary drug instead of the formulary option.		Format 9(8)v99 (2 - digit, implied decimal)
64	Capitation Indicator	758	758	1	Char	Service is/is not capitated (Y/N)		"Y" or "N"
65	NABP Number	759	768	10	Char	National Association of Boards of Pharmacy Number		
66	MAC Price	769	778	10	Num	The maximum acquisition cost price		
67	Penalty Amount	779	788	10	Num	The penalty amount on the claim		
68	Withhold Amount	789	798	10	Num	The amount withheld		
69	Filler	799	1199	401	Char	Reserved for future use		Fill with blanks
70	Record Type	1200	1200	1	Char	Record type identifier		Hard Code to "D"

Drug Claims Trailer Data Elements							
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Num	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Num	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	1199	1155	Char	Reserved for future use	Fill with Blanks
6	Record Type	1200	1200	1	Char	Record Type Identifier	Hard Code 'T'

Capitation Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
1	Subscriber SSN	1	9	9	Char	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.		The subscriber's Social Security Number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
2	CC_SubscriberID	10	29	20	Char	Unique code assigned by CC to the subscriber		
3	Enrollee SSN	30	38	9	Char	Member's Social Security Number		

Capitation Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
4	CC_MemberID	39	58	20	Char	Unique code assigned by CC to the member		
5	Plan_MemberID	59	78	20	Char	Unique code assigned by health plan to identify a member		
6	Policy ID	79	98	20	Char	Policy ID assigned by health plan		
7	Capitation Amount	99	108	10	Num	The pre-paid amount paid to plans or providers under risk-based managed care contracts.		Format 9(7)v99 (2 - digit, implied decimal)
8	Capitation Type Code	109	109	1	Char	This field identifies the type of capitation payment record: <ul style="list-style-type: none"> • 1 – Professional • 2 – Facility • 3 – Mental Health • 4 – Drug • 5 – Dental • 6 – Vision • 7 – Hearing • 8 – Blended 		
9	Date Paid	110	119	10	Date	The date the transaction was paid.		MM/DD/CCYY Format

Capitation Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
10	Date of Service	120	129	10	Date	The date/period of service for the transaction. If the period of service is a month, this can be populated with the first day of that month.		MM/DD/CCYY Format
11	Gender Code	130	130	1	Char	The member's gender code.		"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
12	Date of Birth	131	140	10	Date	The birth date of the person.		MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
13	Adjustment Type Code	141	141	1	Char	Client-specific code for the claim adjustment type.	Yes	Adjustment Type values will be identified in the Data Dictionary .
14	Provider Type Code	142	144	3	Char	This field contains the provider specialty code.	Yes	
15	Provider ID	145	157	13	Char	The unique identifier for the provider. Providers include facilities, physicians, PCPs, pharmacies, and professionals.		This should be the same identifiers used in medical claims.

Capitation Detail Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
16	Provider NPI	158	167	10	Char	The National Provider Identifier for the provider.		
17	Withhold Amount	168	177	10	Num	Withheld Capitation Payment		
18	Filler	178	699	522	Char	Reserved for future use		Fill with blanks
19	Record Type	700	700	1	Char	Record type identifier		Hard Code to "D"

Capitation Trailer Data Elements								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.	
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.	
3	Record Count	21	30	10	Num	Number of Records on File	The count of records provided in the data including the Trailer Record.	
4	Total Net Payments	31	44	14	Num	Total net payments on the file	The sum of net payments provided in the file	
5	Filler	45	699	655	Char	Reserved for future use	Fill with Blanks	
6	Record Type	700	700	1	Char	Record Type Identifier	Hard Code 'T'	

Medical Provider Header Data Elements (for use with individual providers, provider groups, and facilities)						
Field No.	Field Name	Start	End	Length	Type	Note
1	Last_Name	1	9	9	Char	1 st record only
2	First_Name	10	19	10	Char	1 st record only
3	Middle_Name	20	30	11	Char	1 st record only
4	Provider_Type	31	43	13	Char	1 st record only
5	NPI	44	46	3	Char	1 st record only
6	CA_License	47	56	10	Char	1 st record only
7	Non_CA_License	57	70	14	Char	1 st record only
8	Non_CA_License_State	71	90	20	Char	1 st record only
9	Provider_Gender	91	105	15	Char	1 st record only
10	Provider_Language_1	106	124	19	Char	1 st record only
11	Provider_Language_2	125	143	19	Char	1 st record only
12	Provider_Language_3	144	162	19	Char	1 st record only
13	Facility_Language_1	163	181	19	Char	1 st record only
14	Facility_Language_2	182	200	19	Char	1 st record only
15	Facility_Language_3	201	219	19	Char	1 st record only
16	Type_of_Licensure	220	236	17	Char	1 st record only
17	Practice_Address	237	252	16	Char	1 st record only
18	Practice_Address_2	253	270	18	Char	1 st record only
19	Practice_Zip_Code	271	287	17	Char	1 st record only
20	Practice_City	288	300	13	Char	1 st record only
21	Practice_County	301	315	15	Char	1 st record only
22	Practice_Region	316	330	15	Char	1 st record only
23	Practice_State	331	344	14	Char	1 st record only
24	Practice_Phone	345	358	14	Char	1 st record only
25	Provider_Clinic_Name	359	378	20	Char	1 st record only

Medical Provider Header Data Elements (for use with individual providers, provider groups, and facilities)						
Field No.	Field Name	Start	End	Length	Type	Note
26	Provider_Clinic_ID	379	396	18	Char	1 st record only
27	Primary_Specialty	397	413	17	Char	1 st record only
28	Secondary_Specialty	414	432	19	Char	1 st record only
29	Board_Certified	433	447	15	Char	1 st record only
30	Medical_Group/IPA_1	448	466	19	Char	1 st record only
31	Medical_Group/IPA_2	467	485	19	Char	1 st record only
32	Medical_Group/IPA_3	486	504	19	Char	1 st record only
33	Medical_Group/IPA_4	505	523	19	Char	1 st record only
34	Contract_Type	524	536	13	Char	1 st record only
35	Hospital_1	537	546	10	Char	1 st record only
36	Hospital_2	547	556	10	Char	1 st record only
37	Hospital_3	557	566	10	Char	1 st record only
38	Hospital_4	567	576	10	Char	1 st record only
39	Hospital_1_OSHPD_ID	577	595	19	Char	1 st record only
40	Hospital_2_OSHPD_ID	596	614	19	Char	1 st record only
41	Hospital_3_OSHPD_ID	615	633	19	Char	1 st record only
42	Hospital_4_OSHPD_ID	634	652	19	Char	1 st record only
43	Hospitalist_(Hosp_1)	653	672	20	Char	1 st record only
44	Hospitalist_(Hosp_2)	673	692	20	Char	1 st record only
45	Hospitalist_(Hosp_3)	693	712	20	Char	1 st record only
46	Hospitalist_(Hosp_4)	713	732	20	Char	1 st record only
47	NPI_Sup_PCP	733	743	11	Char	1 st record only
48	Sup_PCP_Specialty	744	760	17	Char	1 st record only
49	DEA	761	763	3	Char	1 st record only
50	Facility_Name	764	776	13	Char	1 st record only

Medical Provider Header Data Elements (for use with individual providers, provider groups, and facilities)						
Field No.	Field Name	Start	End	Length	Type	Note
51	Facility_Type	777	789	13	Char	1 st record only
52	Facility_System	790	804	15	Char	1 st record only
53	OSHPD_ID	805	812	8	Char	1 st record only
54	Type_of_Service	813	827	15	Char	1 st record only
55	Tertiary_Care	828	840	13	Char	1 st record only
56	FTIN	841	844	4	Char	1 st record only
57	Last_Update	845	855	11	Char	1 st record only
58	Reserved	856	863	8	Char	1 st record only
59	Current_Assigned_Enrollees	864	889	26	Char	1 st record only
60	PCP_Flag	890	897	8	Char	1 st record only
61	Network_ID	898	907	10	Char	1 st record only
62	Network_Tier_ID	908	922	15	Char	1 st record only
63	Availability	923	934	12	Char	1 st record only
64	Visibility	935	944	10	Char	1 st record only
65	Covered_California_ID	945	965	21	Char	1 st record only
66	ECP_Flag	966	973	8	Char	1 st record only
67	Accepting_New_Patients	974	995	22	Char	1 st record only
68	Snapshot_Date	996	1008	13	Char	1 st record only
69	Issuer_Provider_ID	1009	1026	18	Char	1 st record only
70	Issuer_PCP_ID	1027	1039	13	Char	1 st record only
71	Filler	1040	1306	267	Char	1 st record only
72	Record_Type	1307	1307	1	Char	1 st record only. Hard coded to H

Medical Provider Detail Data Elements (for use with individual providers, provider groups, and facilities)								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Facility Prof. Both	Data Supplier Instructions/Notes
1	Last_Name	1	50	50	Char	Last name of provider.	P	
2	First_Name	51	100	50	Char	First name of provider.	P	
3	Middle_Name	101	150	50	Char	Middle initial of provider.	P	
4	Provider_Type	151	152	2	Char	Indicates type of individual provider.	P	See Appendix B: Provider Lookup Table for acceptable values
5	NPI	153	162	10	Num	National Provider Identification (NPI) number of the individual.	B	Checksum will be validated
6	CA_License	163	177	15	Char	California License number. Applies to all providers and facilities	B	For M.D.s: "A", "G" or "C" followed by sequence of digits with no spaces or leading zeros. For D.O.s : "20" followed by "A", "G" or "C" followed by sequence of digits with no spaces or leading zeros
7	Non_CA_License	178	192	15	Char	License number for non-CA licensed/Out of state providers	B	CA license is a required field for all in state providers. This field to be populated for out of state providers only
8	Non_CA_License_State	193	194	2	Char	License state for non-CA licensed/Out of state providers	B	
9	Provider_Gender	195	195	1	Char	Gender of the Provider	P	M (Male) or F (Female).
10	Provider_Language_1	196	215	20	Char	1st Language spoken by the provider other than English	P	
11	Provider_Language_2	216	235	20	Char	2nd Language spoken by the provider other than English	P	
12	Provider_Language_3	236	255	20	Char	3rd Language spoken by the provider other than English	P	

Medical Provider Detail Data Elements (for use with individual providers, provider groups, and facilities)								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Facility Prof. Both	Data Supplier Instructions/Notes
13	Facility_Language_1	256	275	20	Char	Language spoken by an individual employed at the provider's office or facility but not spoken by the provider other than English.	P	
14	Facility_Language_2	276	295	20	Char	Language spoken by an individual employed at the provider's office or facility but not spoken by the provider other than English.	P	
15	Facility_Language_3	296	315	20	Char	Language spoken by an individual employed at the provider's office or facility but not spoken by the provider other than English.	P	
16	Type_of_Licensure	316	320	5	Char	e.g. MD, DO for physicians. Refer to lookup table for remainder of licensed medical professions in CA	P	Cannot contain special characters (e.g. "." ; "-" etc). See Appendix B: Provider Lookup Table for acceptable values
17	Location_Address	321	355	35	Char	1st line street address for practice or facility location	B	Should be street address only with no secondary suite, office, room etc. no.
18	Location_Address_2	356	365	10	Char	2nd line street address for practice or facility location	B	Suite, office, room, building no. etc. These must be separated from 1st line address
19	Location_Zip_Code	366	370	5	Char	5 digit ZIP Code of practice or facility location	B	

Medical Provider Detail Data Elements (for use with individual providers, provider groups, and facilities)								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Facility Prof. Both	Data Supplier Instructions/Notes
20	Location_City	371	395	25	Char	City of practice or facility location	B	
21	Location_County	396	420	25	Char	County of practice or facility location	B	
22	Location_Region	421	422	2	Num	Rating region of practice or facility location	B	
23	Location_State	423	424	2	Char	State of practice or facility location	B	
24	Location_Phone	425	436	12	Char	Phone number of practice or facility location	B	
25	Provider_Clinic_Name	437	486	50	Char	If individual provider works at a clinic, enter the clinic name.	P	
26	Provider_Clinic_ID	487	502	16	Char	If individual provider works at a clinic, enter the clinic ID	P	Use CCID in case of ECP qualifying clinic, otherwise use NPI
27	Primary_Specialty	503	512	10	Char	Primary specialty of the provider. In case of physicians, this must be highest/latest certification received by the provider. E.g. Neonatologist with a specialty in Pediatrics should be listed as Neonatologist unless it is explicitly known that provider practices primarily as a Pediatrician.	B	Use the National Uniform Claim Committee (NUCC) listing of taxonomy codes http://www.nucc.org/index.php?option=com_content&view=article&id=107&Itemid=132 and return the taxonomy code, not the description as the input value for "Specialty". Primary specialty for physicians refers to the highest level specialty that the provider is licensed for (not self-reported)

Medical Provider Detail Data Elements (for use with individual providers, provider groups, and facilities)								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Facility Prof. Both	Data Supplier Instructions/Notes
28	Secondary_Specialty	513	522	10	Char	Secondary specialty of the provider. Should be populated when provider has secondary/base specialty	B	Use the National Uniform Claim Committee (NUCC) listing of taxonomy codes http://www.nucc.org/index.php?option=com_content&view=article&id=107&Itemid=132 and return the taxonomy code, not the description as the input value for "Specialty".
29	Board_Certified	523	523	1	Char	Board certified, eligible or non-certified indicator	P	Enter Y if provider is board-certified, E if provider is board-eligible, otherwise enter N.
30	Medical_Group/IPA_1	524	573	50	Char	Name of first medical group and/or IPA affiliated with contracted provider (if applicable).	P	
31	Medical_Group/IPA_2	574	623	50	Char	Name of second medical group and/or IPA affiliated with contracted provider (if applicable).	P	
32	Medical_Group/IPA_3	624	673	50	Char	Name of third medical group and/or IPA affiliated with contracted provider (if applicable).	P	
33	Medical_Group/IPA_4	674	723	50	Char	Name of fourth medical group and/or IPA affiliated with contracted provider (if applicable).	P	
34	Contract_Type	724	725	2	Char	Delegated vs. Direct Contract	B	Identifies the type of contract between provider and plan.

Medical Provider Detail Data Elements (for use with individual providers, provider groups, and facilities)								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Facility Prof. Both	Data Supplier Instructions/Notes
35	Hospital_1	726	775	50	Char	Name of the first hospital with which the provider holds admitting privileges	P	Enter the name of each hospital with which the provider holds admitting privileges. If the provider uses a hospitalist to admit to one or more hospitals, please list those hospitals as well and complete the next field, "Hospitalist." List the hospital name exactly as listed on the reference list.
36	Hospital_2	776	825	50	Char	Name of the second hospital with which the provider holds admitting privileges	P	Enter the name of each hospital with which the provider holds admitting privileges. If the provider uses a hospitalist to admit to one or more hospitals, please list those hospitals as well and complete the next field, "Hospitalist." List the hospital name exactly as listed on the reference list.
37	Hospital_3	826	875	50	Char	Name of the third hospital with which the provider holds admitting privileges	P	Enter the name of each hospital with which the provider holds admitting privileges. If the provider uses a hospitalist to admit to one or more hospitals, please list those hospitals as well and complete the next field, "Hospitalist." List the hospital name exactly as listed on the reference list.
38	Hospital_4	876	925	50	Char	Name of the fourth hospital with which the provider holds admitting privileges	P	Enter the name of each hospital with which the provider holds admitting privileges. If the provider uses a hospitalist to admit to one or more hospitals, please list those hospitals as well and complete the next field, "Hospitalist." List the hospital name exactly as listed on the reference list.
39	Hospital_1_OSHPD_ID	926	935	10	Char	OSHPD ID Number for the first hospital with which the provider holds admitting privileges	P	Use OSHPD ID from Covered California Hospital Reference List
40	Hospital_2_OSHPD_ID	936	945	10	Char	OSHPD ID Number for the second hospital with which the provider holds admitting privileges	P	Use OSHPD ID from Covered California Hospital Reference List

Medical Provider Detail Data Elements (for use with individual providers, provider groups, and facilities)								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Facility Prof. Both	Data Supplier Instructions/Notes
41	Hospital_3_OSHPD_ID	946	955	10	Char	OSHPD ID Number for the third hospital with which the provider holds admitting privileges	P	Use OSHPD ID from Covered California Hospital Reference List
42	Hospital_4_OSHPD_ID	956	965	10	Char	OSHPD ID Number for the fourth hospital with which the provider holds admitting privileges		Use OSHPD ID from Covered California Hospital Reference List
43	Hospitalist_(Hosp_1)	966	966	1	Char	Hospitalist Indicator for the first hospital with which the provider holds admitting privileges	P	If the provider is able to admit to the 1st hospital using a hospitalist, enter "Y," if the provider holds the admitting privileges directly with the hospital, enter "N."
44	Hospitalist_(Hosp_2)	967	967	1	Char	Hospitalist Indicator for the second hospital with which the provider holds admitting privileges	P	If the provider is able to admit to the 2nd hospital using a hospitalist, enter "Y," if the provider holds the admitting privileges directly with the hospital, enter "N."
45	Hospitalist_(Hosp_3)	968	968	1	Char	Hospitalist Indicator for the third hospital with which the provider holds admitting privileges	P	If the provider is able to admit to the 3rd hospital using a hospitalist, enter "Y," if the provider holds the admitting privileges directly with the hospital, enter "N."
46	Hospitalist_(Hosp_4)	969	969	1	Char	Hospitalist Indicator for the fourth hospital with which the provider holds admitting privileges	P	If the provider is able to admit to the 4th hospital using a hospitalist, enter "Y," if the provider holds the admitting privileges directly with the hospital, enter "N."
47	NPI_Sup_PCP	970	979	10	Char	National Provider Identification (NPI) number of the Supervising provider in case of PCP extenders	P	

Medical Provider Detail Data Elements (for use with individual providers, provider groups, and facilities)								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Facility Prof. Both	Data Supplier Instructions/Notes
48	Sup_PCP_Specialty	980	989	10	Char	Supervising Providers primary specialty.	P	Use the National Uniform Claim Committee (NUCC) listing of taxonomy codes http://www.nucc.org/index.php?option=com_content&view=article&id=107&Itemid=132 and return the taxonomy code, not the description as the input value for "Specialty"
49	DEA	990	1001	12	Char	Provider DEA Number	P	
50	Facility_Name	1002	1051	50	Char	Legal name of facility utilized by the Plan. In case of hospitals name exactly as listed Covered California reference list.	F	
51	Facility_Type	1052	1052	1	Char	Type of Facility: Hospital = H, Clinic = C, Other Contracted Provider Facility = O	F	See Appendix C: Facility Lookup Table for acceptable values
52	Facility_System	1053	1102	50	Char	Health system of facility		
53	OSHPD_ID	1103	1112	10	Char	OSHPD ID in case of hospitals as per Covered California reference list	F	Use OSHPD ID from Covered California Hospital Reference List
54	Type_of_Service	1113	1117	5	Char	Type of Service as defined by the Facility Type	F	See Appendix C: Facility Lookup Table for acceptable values If Facility is identified as a Hospital, the appropriate values are derived from Hospitals Lookup table If Facility is identified as a Clinic, the appropriate values are derived from Clinics Lookup table If Facility is identified as an Other Contracted Provider, the appropriate values are derived from Other Contracted Provider Lookup table
55	Tertiary_Care	1118	1118	1	Char	Tertiary Care Indicator	F	Enter "Y" if the facility provides tertiary care, enter "N" if the facility does not provide tertiary care (e.g. burn unit, organ transplantation, etc.)

Medical Provider Detail Data Elements (for use with individual providers, provider groups, and facilities)								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Facility Prof. Both	Data Supplier Instructions/Notes
56	FTIN	1119	1127	9	Char	The federal tax ID of the provider.	B	
57	Last_Update	1128	1137	10	Char	Last time provider data updated	B	MM/DD/CCYY
58	Reserved	1138	1187	50	Char	Reserved for future use	B	Fill with blanks
59	Current_Assigned_Enrollees	1188	1193	6	Num	(Primary Care Clinics & Primary Care Physicians)The total number of patients assigned to the provider. If individual provider or clinic has patient assignments	B	For primary care physicians, dentists and clinics that accept primary care assignment, enter the total number of patients assigned to the provider. This number is the sum of all patients assigned at each provider address. For specialist physicians enter the total number of patients in the providers panel for that location
60	PCP_Flag	1194	1194	1	Char	Provider or Clinic is designated as PCP by issuer	B	Applies to HMO and DHMO plans
61	Network_ID	1195	1205	11	Char	Network ID assigned by Covered California	B	See Appendix A: Network IDs for acceptable values
62	Network_Tier_ID	1206	1206	1	Num	Network Tier ID	B	If the network is a tiered network, enter "1" for the providers participating in the tier with the lowest cost share for enrollees; enter "2" for the providers participating in the tier with the next-lowest cost share for enrollees. Continue to number tiers accordingly, with the higher tier number correlating to higher cost-share for the enrollee.
63	Availability	1207	1207	1	Char	Available directly or with special authorization/referral	B	
64	Visibility	1208	1208	1	Char	Indicates whether provider is to be displayed on online directory	B	Certain providers considered part of the network that are not displayed publicly as being in-network

Medical Provider Detail Data Elements (for use with individual providers, provider groups, and facilities)								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Facility Prof. Both	Data Supplier Instructions/Notes
65	Covered_California_ID	1209	1224	16	Char	Used to flag ECP providers	F	If facility is identified as ECP provider as per Covered California's ECP reference list, use the CCID. List can be found at the following link: http://hbex.coveredca.com/stakeholders/plan-management/ecp-list/
66	ECP_Flag	1225	1225	1	Char		B	Indicated if provider is an ECP
67	Accepting_New_Patients	1226	1226	1	Char	Accepting New Patients Indicator	B	Enter "Y" to indicate the provider is accepting new patients at this location, enter "N" to indicate provider is not accepting new patients at this location. If the provider is only accepting existing patients or past patients, please enter "N" in this category.
68	Snapshot_Date	1227	1236	10	Char	Date of data extraction for file	B	This is the "No earlier than" date for data extraction
69	Issuer_Provider_ID	1237	1271	35	Char	Issuer assigned provider ID	B	
70	Issuer_PCP_ID	1272	1306	35	Char	Issuer assigned primary care provider ID	P	
71	Record_Type	1307	1307	1	Char	Type of Record: H for Header, D for Detail (non-Header and non-Trailer records) and T for Trailer Record	B	Header record should be hard coded to "H". Trailer record should be hard coded to "T". All records in between should be hard coded to "D"

Medical Provider Trailer Data Elements (for use with individual providers, provider groups, and facilities)								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Facility Prof. Both	Data Supplier Instructions/Notes
1	Data_Start_Date	1	10	10	Char	This is the first day of the month for which the data is provided	NA	Final record only

Medical Provider Trailer Data Elements (for use with individual providers, provider groups, and facilities)								
Field No.	Field Name	Start	End	Length	Type	Data Element Description	Facility Prof. Both	Data Supplier Instructions/Notes
2	Data_End_Date	11	20	10	Char	This is the last day of the month for which the data is provided	NA	Final record only
3	Record_Count	21	30	10	Num	Count of all records in file including header and trailer records	NA	Final record only. Count of all H,D and T Record Types
4	Filler	31	1306	1276	Char	Blank to complete record length	NA	Final record only.
5	Record_Type	1307	1307	1	Char	Type of Record: = T for Trailer Record	NA	Final record only. Hard coded to T

Attachment 8 – 2016 Rates – Individual Market

Attachment 9 – Rate Updates – Individual Exchange

Attachment 10 – 2016 Rates – Covered California for Small Business

Attachment 11 – Rate Updates – Covered California for Small Business

Attachment 12 – Overview of the Model QHP Addendum for Indian Health Care Providers



Overview of the Model QHP Addendum for Indian Health Care Providers

I. Purpose

CMS has developed the attached Model QHP Addendum for Indian health care providers to facilitate the inclusion of Indian Health Service (IHS), tribes and tribal organizations, and urban Indian organization (I/T/U) providers in qualified health plan (QHP) provider networks and help health insurance issuers comply with the QHP certification standards set forth in 45 C.F.R. Part 156. Similar to the standardized contract addendum used in the Medicare Part D program, this Model QHP Addendum has been developed for QHP issuers to use when contracting with I/T/U providers. This Model QHP Addendum is not required, but the U.S. Department of Health and Human Services (HHS) received several comments supporting the development and issuance of a model addendum for this purpose to assist QHP issuers in including I/T/U providers in their networks.

The federal government has a historic and unique government-to-government relationship with Indian tribes. In adhering to QHP certification standards, QHP issuers should reach out to I/T/U providers. A significant portion of American Indians and Alaska Natives (AI/ANs) access care through longstanding relationships with providers in the Indian health system. An important consideration in evaluating network adequacy and essential community provider accessibility will be the extent to which a QHP includes I/T/U providers and whether it can assure that services to AI/ANs will be accessible without unreasonable delay.

It is anticipated that the Model QHP Addendum will assist issuers to meet the QHP certification standards and facilitate acceptance of network contracts by I/T/U providers. We anticipate that offering contracts that include the Model QHP Addendum will provide QHP issuers with an efficient way to establish contract relationships with I/T/U providers, and also ensure that AI/ANs can continue to be served by their Indian provider of choice.

Indian tribes are entitled to special protections and provisions under federal law, which are described further in Section II. The Addendum identifies several specific provisions that have been established in federal law that apply when contracting with I/T/U providers. The use of this Model QHP Addendum benefits both QHP issuers and the I/T/U providers by lowering the perceived barriers to contracting, assuring QHP issuers comply with key federal laws that apply when contracting with I/T/U providers, and minimizing potential disputes. AI/ANs enrolled in QHPs will be better served when I/T/U providers can coordinate their care through the QHP issuer provider network.

II. Background on Indian Health Care

Indian tribes are afforded specific protections and provisions under federal laws, including the Indian Health Care Improvement Act (IHCA), the Indian Self-Determination and Education Assistance Act (ISDEAA), and the Patient Protection and Affordable Care Act (ACA). In order

to carry out its obligation to provide health care to American Indians and Alaska Natives (AI/ANs), the federal government has established a unique health care delivery system through the Indian Health Service (IHS). As part of the Indian health care system, health care services to AI/ANs are provided either directly by the IHS, by tribes or tribal organizations, or by urban Indian programs.

Today the Indian health care system includes 44 Indian hospitals (16 of which are tribally-operated and all of which are accredited) and nearly 570 Indian health centers, clinics, and health stations (of which 83 percent are tribally-operated). When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded Contract Health Services (CHS) program. Additionally, 33 urban programs offer services ranging from community health to comprehensive primary care.

III. Key Provisions in the Addendum

The following is a synopsis of key provisions outlined in the Addendum.

Persons Eligible for Items and Services from an Indian Health Care Provider: This section acknowledges that Indian health programs are generally not available to the public; they are established to serve AI/ANs, as provided in the IHCA. The applicable eligibility rules are generally set out in the IHS regulations at 42 C.F.R. Part 136. The IHCA § 813 (25 U.S.C. §1680c) sets out the circumstances under which certain non-AI/ANs connected with an AI/AN (such as minor children or a spouse) can receive services as beneficiaries. Also, the IHCA § 813 authorizes services to certain other non-AI/ANs if defined requirements are satisfied. Pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed as subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from an Indian health program.

Providers should note that 45 C.F.R. 80.3(d) is not an exemption from civil rights obligations generally. It simply clarifies that certain types of exclusions are not considered discrimination under Title VI of the Civil Rights Act of 1964. Providers may be subject to applicable federal nondiscrimination statutes.

Applicability of Other Federal Law: This section describes several federal laws that apply variously when contracting with I/T/U providers.

- *Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 450 et seq.* This law directs HHS at the request of an Indian tribe, to enter into a contract or compact with a tribe, a tribal organization, or an inter-tribal consortium to operate federal health programs for AI/ANs with the funds the IHS would have otherwise used to carry out the program directly. Through this law, many Indian tribes and tribal organizations have taken over direct operation of health programs from the IHS.
- *Federal Tort Claims Act (FTCA), 28 U.S.C. §§ 2671-2680.* Congress generally extended the FTCA to cover Indian tribes and tribal organizations operating federal programs pursuant to contracts or compacts under the ISDEAA, 25 U.S.C. § 450f. Urban Indian organization health providers who acquire Federally Qualified Health Center status under Section 224 of the Public Health Service Act can acquire FTCA coverage. Since a claim under the FTCA is

the exclusive remedy for actions against Indian health care providers that are covered by the FTCA, those entities are not required to obtain separate professional liability insurance.

- *Federal Medical Care Recovery Act (FMCRA)*, 42 U.S.C. §§ 2651-2653. This law authorizes federal agencies, including the IHS, to recover from a tortfeasor (or an insurer of a tortfeasor) the reasonable value of health services furnished to a tortfeasor's victim. The right of recovery under the FMCRA extends to Indian tribes and tribal organizations operating ISDEAA contracts and compacts. 25 U.S.C. § 1621.
- *Federal Privacy Act*, 5 U.S.C. § 552a, 45 C.F.R. Part 5b. This law and its regulations apply to the IHS, and may apply Indian tribes, tribal organizations, and urban Indian organizations that operate federally-funded health care programs. The Privacy Act governs the use and disclosure of personally identifiable information about individuals that is maintained in a federal system of records. While the Privacy Act generally applies to federal records maintained by a government contractor, patient records of a Tribal health program are not considered federal records for the purposes of chapter 5 of title 5 of the United States Code (including the Privacy Act and the Freedom of Information Act - see 25 U.S.C. § 4501).
- *Confidentiality of Alcohol and Drug Abuse Patient Records*, 42 C.F.R. Part 2. These regulations restrict disclosure and use of drug abuse patient records that are maintained in connection with the performance of any federally assisted alcohol or drug abuse program. The restrictions would apply to any such records maintained by the IHS, an Indian tribe, tribal organization, or urban Indian organization.
- *Health Insurance Portability and Accountability Act (HIPAA)*, (45 C.F.R. Parts 160 and 164). These regulations restrict access to and disclosure of protected health information maintained by covered entities, including covered health care providers operated by the IHS, Indian tribes, tribal organizations, and urban Indian organizations.
- *Indian Health Care Improvement Act (IHCIA)*, 25 U.S.C. § 1601 et seq. This law provides the comprehensive statutory framework for delivery of health care services to AI/ANs. It applies to all Indian health providers operating ISDEAA contracts and compacts from the Secretary of the HHS; and urban Indian organizations that receive grants from IHS under Title V of the IHCIA. Specific provisions of the IHCIA that would impact contracts between Indian health care providers and QHPs issuers are cited in various provisions of the Addendum.

Insurance and Indemnification: IHS, tribes and tribal organization providers are generally covered by the FTCA. Some urban Indian organizations are also covered under FTCA. Since a claim under the FTCA is the exclusive remedy for actions against FTCA covered I/T/U providers, those entities are not required to obtain professional liability insurance.

Licensure of Health Care Professionals: Section 221 of the IHCIA, 25 U.S.C. § 1621t, permits an Indian tribe or tribal organization to employ a health care professional who is subject to licensure if that individual is licensed in any state. Employees of the IHS obtain their "licensed in any state" status through other federal law.

Medical Quality Assurance Requirements: Section 805 of the IHCA, 25 U.S.C. § 1675, facilitates internal medical program quality reviews; shields participants in those reviews; and restricts disclosure of medical quality assurance records, subject to the exceptions in 25 U.S.C. 1675(d), which provides that medical quality assurance records created by or for I/T/U providers may not be disclosed to any person or entity. These disclosure limitations are also applicable to anyone to whom the I/T/U provider discloses such medical quality assurance records under the authority of 25 U.S.C. 1675(d). Although restrictive, we expect these limitations will have limited applicability to QHPs because there will be few, if any circumstances, where such records may be disclosed to a QHP under the law.

Claims Format: Section 206(h) of the IHCA, 25 U.S.C. § 1621e(h) is applicable to issuers when processing claims from an I/T/U provider. Section 206(h) of IHCA states that a health insurance issuer may not deny a claim submitted by the IHS, an Indian tribe or tribal organization based on the format on which the claim is submitted if the format complies with the Medicare claims format requirements.

Payment of Claims: Federal laws, including Section 206(a) and (i) of the IHCA, 25 U.S.C. § 1621e(a) and (i) and Title 45 Code of Federal Regulation, Part 156, Subpart E¹, are applicable to health insurance issuers when paying claims from I/T/U providers. Section 206(a) and (i) of IHCA provide that the IHS, an Indian tribe, tribal organization, and urban Indian organization have a right to recover the reasonable charges billed, or, if higher, the highest amount an insurance carrier would pay to other providers. However, this paragraph also notes if the issuer and I/T/U Provider mutually agree to rates or amounts specified in the QHP agreement as payment in full, the QHP issuer is deemed to be compliant with Section 206 of IHCA.

Contract Health Service Referral Requirements: In some instances, I/T/U providers may be subject to referral requirements under the contract health services program. For example, IHS may have existing contractual arrangements that require IHS to refer to specific providers and suppliers; or IHS may be prohibited from referring to a provider that has been excluded from Federal Health Care Programs, as defined in § 1128 of the Social Security Act. We believe these circumstances will be rare, but to the extent that they occur, the I/T/U provider may not be able to adhere to QHP issuer referral requirements to use in-network providers. This section acknowledges the potential for conflicting requirements, and that I/T/U providers may be prevented from following QHP issuer referral requirements in such instances. This section affirms that the I/T/U provider will otherwise comply with in network coordination of care and referral requirements.

IV. Database of Indian Providers

To assist issuers in identifying I/T/U providers in their service areas, please use the attached link to obtain a database of I/T/U provider locations, developed with the assistance of the Indian Health Service: <http://cciio.cms.gov/programs/exchanges/qhp.html>.

¹ Title 45 Code of Federal Regulation, Part 156, Subpart E describes rules for the elimination of cost sharing for EHB, for Indians at or below 300% of the Federal Poverty Level, and for no cost sharing for Indians receiving an item or service that is an EHB furnished by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization, or through referral under contract health services. 78 Fed. Reg. 15410, 15535-39 (Mar. 11, 2013).



Model QHP Addendum for Indian Health Care Providers

1. Purpose of Addendum; Supersession.

The purpose of this Addendum for Indian health care providers is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between _____ (herein "Qualified Health Plan issuer" and/or "QHP issuer") and _____ (herein "Provider"). To the extent that any provision of the Qualified Health Plan issuer's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

2. Definitions.

For purposes of the Qualified Health Plan issuer's agreement, any other addendum thereto, and this Addendum, the following terms and definitions shall apply:

- (a) "Contract health services" has the meaning given in the Indian Health Care Improvement Act (IHCIA) Section 4(5), 25 U.S.C. § 1603(5).
- (b) "Indian" has the meaning given in 45 C.F.R. 155.300.
- (c) "Provider" means a health program administered by the Indian Health Service, a tribal health program, an Indian tribe or a tribal organization to which funding is provided pursuant to 25 U.S.C. § 47 (commonly known as the "Buy Indian Act"), or an urban Indian organization that receives funding from the IHS pursuant to Title V of the IHCIA (Pub. L. 94-437), as amended, and is identified by name in Section 1 of this Addendum.
- (d) "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.
- (e) "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).
- (f) "Qualified Health Plan" (QHP) has the meaning given in Section 1301 of the Affordable Care Act, 42 U.S.C. § 18021.
- (g) "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).
- (h) "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).
- (i) "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of Provider.

The Provider identified in Section 1 of this Addendum is (check the appropriate box):

The IHS.

An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.

- /_/ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.
- /_/ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).
- /_/ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. Persons Eligible for Items and Services from Provider.

- (a) The parties acknowledge that eligibility for services at the Provider’s facilities is determined by federal law, including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the Provider’s programs.
- (b) No term or condition of the QHP issuer’s agreement or any addendum thereto shall be construed to require the Provider to serve individuals who are ineligible under federal law for services from the Provider. The QHP issuer acknowledges that pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the Provider. Provider acknowledges that the nondiscrimination provisions of federal law may apply.

5. Applicability of Other Federal Laws.

Federal laws and regulations affecting the Provider, include but are not limited to the following:

(a) The IHS as a Provider:

- (1) Anti-Deficiency Act, 31 U.S.C. § 1341;
- (2) ISDEAA, 25 U.S.C. § 450 et seq.;
- (3) Federal Tort Claims Act (“FTCA”), 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Federal Privacy Act of 1974 (“Privacy Act”), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (6) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;
- (7) Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Parts 160 and 164; and
- (8) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is a Provider:

- (1) ISDEAA, 25 U.S.C. § 450 et seq.;
- (2) IHCIA, 25 U.S.C. § 1601 et seq.;
- (3) FTCA, 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
- (6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is a Provider:

- (1) IHCAA, 25 U.S.C. § 1601 et seq. (including without limitation pursuant to the IHCAA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors);
- (2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
- (3) HIPAA, 45 C.F.R. Parts 160 and 164.

6. Non-Taxable Entity.

To the extent the Provider is a non-taxable entity, the Provider shall not be required by a QHP issuer to collect or remit any federal, state, or local tax.

7. Insurance and Indemnification.

- (a) *Indian Health Service.* The IHS is covered by the FTCA which obviates the requirement that IHS carry private malpractice insurance as the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. 28 U.S.C. §§ 2671-2680. Nothing in the QHP network provider agreement shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment. The IHS shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP will be held harmless from liability.
- (b) *Indian Tribes and Tribal Organizations.* A Provider which is an Indian tribe, a tribal organization, or employee of a tribe or tribal organization shall not be required to obtain or maintain professional liability insurance to the extent such Provider is covered by the FTCA pursuant to federal law (Public Law 101-512, Title III, § 314, as amended by Public Law 103-138, Title III, § 308 (codified at 25 U.S.C. § 450f note); and 25 C.F.R. Part 900, Subpart M; 25 U.S.C. §458aaa-15(a); and 42 C.F.R. § 137.220). Nothing in the QHP issuer network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such provider to operate outside of the scope of employment of such employee. Such Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP issuer will be held harmless from liability.
- (c) *Urban Indian Organizations.* To the extent a Provider that is an urban Indian organization is covered by the FTCA pursuant to Section 224(g)-(n) of the Public Health Service Act, as amended by the Federally Supported Health Centers Assistance Act, Public Law 104-73, (codified at 42 U.S.C. § 233(g)-(n)), 42 C.F.R. Part 6, such Provider shall not be required to obtain or maintain professional liability insurance. Nothing in the QHP issuer network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such Provider to operate outside of the scope of employment of such employee. Such Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP issuer will be held harmless from liability.

8. Licensure of Health Care Professionals.

- (a) *Indian Health Service.* States may not regulate the activities of IHS-operated health care programs nor require that IHS health care professionals be licensed in the state where they are providing services, whether the IHS employee is working at an IHS-operated facility or has been assigned to a health care program of a tribe, tribal organization, or urban Indian organization. The parties agree that during the term of the QHP issuer's agreement, IHS health care professionals shall hold state licenses in accordance with applicable federal law, and that IHS facilities shall be accredited in accordance with federal statutes and regulations.

- (b) *Indian tribes and tribal organizations.* Section 221 of the IHCA, 25 U.S.C. § 1621t, exempts a health care professional employed by an Indian tribe or tribal organization from the licensing requirements of the state in which such tribe or organization performs services, provided the health care professional is licensed in any state. The parties agree that these federal laws apply to the QHP issuer's agreement and any addenda thereto.
- (c) *Urban Indian organizations.* To the extent that any health care professional of an urban Indian provider is exempt from state regulation, such professional shall be deemed qualified to perform services under the QHP Sponsor's agreement and all addenda thereto, provided such employee is licensed to practice in any state. The parties agree that this federal law applies to the QHP issuer's agreement and any addenda thereto.

9. Licensure of Provider; Eligibility for Payments.

To the extent that the Provider is exempt from state licensing requirements, such Provider shall not be required to hold a state license to receive any payments under the QHP issuer's network provider agreement and any addendum thereto.

10. Dispute Resolution.

In the event of any dispute arising under the QHP issuer's network provider agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes prior to resolution of any disputes through any process identified in the network provider agreement. If the Provider is an IHS provider, the laws of the United States shall apply to any problem or dispute hereunder that cannot be resolved by and between the parties in good faith. Notwithstanding any provision in the provider network agreement, IHS shall not be required to submit any disputes between the parties to binding arbitration.

11. Governing Law.

The QHP issuer's network provider agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the QHP issuer's network provider agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

12. Medical Quality Assurance Requirements.

To the extent the QHP issuer imposes any medical quality assurance requirements on its network providers, any such requirements applicable to the Provider shall be subject to Section 805 of the IHCA, 25 U.S.C. § 1675.

13. Claims Format.

The QHP issuer shall process claims from the Provider in accordance with Section 206(h) of the IHCA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by a Provider based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

14. Payment of Claims.

The QHP issuer shall pay claims from the Provider in accordance with federal law, including Section 206 of the IHCA (25 U.S.C. §1621e), and 45 C.F.R., Part 156, Subpart E. The QHP issuer shall be deemed compliant with Section 206 to the extent the QHP issuer and Provider mutually agree to the rates or amounts specified in the QHP issuer agreement as payment in full.

15. Hours and Days of Service.

The hours and days of service of the Provider shall be established by the Provider. Though not required prior to the establishment of such service hours, the QHP issuer and the Provider may negotiate and agree on specific hours and days of service. At the request of the QHP issuer, such Provider shall provide written notification of its hours and days of service.

16. Contract Health Service Referral Requirements

The Provider shall comply with coordination of care and referral obligations of the QHP issuer except only in specific circumstances in which such referrals would conflict with federal law or that referral requirements applicable to Contract Health Services would not be met. The Provider will notify the QHP issuer when such circumstances occur.

17. Sovereign Immunity.

Nothing in the QHP issuer’s network provider agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

18. Endorsement.

An endorsement of a non-federal entity, event, product, service, or enterprise may be neither stated nor implied by the IHS Provider or IHS employees in their official capacities and titles. Such agency names and positions may not be used to suggest official endorsement or preferential treatment of any non-federal entity under this agreement.

APPROVALS

For the Qualified Health Plan Issuer:

For the Provider:

Date _____

Date _____

Attachment 13 – List of Required Reports

Attachment 13 - List of Required Reports

Contractor Reports to be provided to Covered CA

Below is a list of reports to be provided by the Contractor to Covered California on a monthly, quarterly or annual basis.

Report Name	Contract Section	Frequency	Due Date	Submit to:
Fraud, waste and abuse detection and prevention programs and report total moneys recovered by Contractor in the most recent 12-month period in relation to Services provided to Enrollees	1.16	Annually	February 28, 2017 – Report for prior calendar year 2016.	QHP@covered.ca.gov
Enrollment Reconciliation Comparison extract	2.1.2	Monthly	As required in 2.1.2	SFTP
Marketing Plan	2.4	Annually	30 days prior to open enrollment	QHPMarketingMaterials@covered.ca.gov
Marketing Plans of Retention and Renewal	2.4	Annually	30 days after open enrollment begins	QHPMarketingMaterials@covered.ca.gov
Marketing Actualized Spend Amounts	2.4	Annually	For open enrollment – 30 days after open enrollment closes; for the special enrollment period – 30 days after calendar year ends; and for retention and renewal, 30 days after open enrollment begins	QHPMarketingMaterials@covered.ca.gov
Description on Contractor’s standard agent compensation program and policies	2.2.6	Annually	60 days prior to open enrollment	QHP@covered.ca.gov
The following Reports for calendar year 2016 are due with the annual certification application for plan year 2017. Reporting Requirements in Attachment 7.				
Participation in Collaborative Quality Initiatives	Attachment 7 1.02	Annually	with the annual certification application	Submit responses via Covered CA eValue8
Reducing Health Disparities and Assuring Health Equity	Attachment 7 1.03(d)	Annually	with the annual certification application	Submit responses via Covered CA eValue8

The following Reports for calendar year 2016 are due with the annual certification application for plan year 2017. Reporting Requirement in Attachment 7 (Continued)

Hospital Quality Oversight	Attachment 7 3.02	Annually	with the annual certification application	Submit responses via Covered CA eValue8
Determining Enrollee Health Status and Use of Health Assessments	Attachment 7 3.05	Annually	with the annual certification application	Submit responses via Covered CA eValue8
Health and Wellness Services	Attachment 7 4.01	Annually	with the annual certification application	Submit responses via Covered CA eValue8
Community Health and Wellness Promotion	Attachment 7 4.02	Annually	with the annual certification application	Submit responses via Covered CA eValue8
Health and Wellness Enrollee Support Process	Attachment 7 4.03	Annually	with the annual certification application	Submit responses via Covered CA eValue8
Promoting Development and Use of Care Models	Attachment 7 5.02	Annually	with the annual certification application	Submit responses via Covered CA eValue8
Identification and Services for At-Risk Enrollees	Attachment 7 5.04	Annually	with the annual certification application	Submit responses via Covered CA eValue8
Provider Cost and Quality and Enrollee Cost and Transparency	Attachment 7 6.01 and 6.02	Annually	with the annual certification application	Submit responses via Covered CA eValue8
Enrollee Shared Decision-Making	Attachment 7 6.04	Annually	with the annual certification application	Submit responses via Covered CA eValue8
Value-Based Reimbursement Inventory and Performance	Attachment 7 7.02	Annually	with the annual certification application	Submit responses via Covered CA eValue8
Value-Pricing Programs	Attachment 7 7.04	Annually	with the annual certification application	Submit responses via Covered CA eValue8
Payment Reform and Data Submission	Attachment 7 7.05	Annually	with the annual certification application	Submit responses via Covered CA eValue8

The following Reporting Requirements in Attachment 14

Customer Service Performance Standards	Attachment 14 Groups 1 & 2	Monthly	The 10 th of the following month	QHP@covered.ca.gov
Quality, Network Management & Delivery System Standards	Attachment 14 Group 3 Questions 3.1 - 3.3	Annually	For calendar year 2016, due date to be determined by CMS	Data submitted to CMS for review.
Quality, Network Management & Delivery System Standards	Attachment 14 Group 3 Question 3.4	Annually	For calendar year 2016, due with the annual certification application (Same as Attachment 7 items on the prior page).	Submit responses via Covered CA eValue8
Quality, Network Management & Delivery System Standards	Attachment 14 Group 3 Question 3.5	Quarterly	As requested	Provider Data Submitted via the Extranet. (Same report as Contract Section 3.4.4 above)
Dental Quality Alliance (DQA) Pediatric Measure Set – for embedded pediatric dental	Attachment 14 Group 5	Annually	For calendar year 2016 due on April 30, 2017	QHP@covered.ca.gov

Financial Management Division – Required Reports				
<p>Payment Reconciliation – Schedule of Notifications</p> <p>Contractors participating in the individual market shall report delinquent full or partial payments of premiums to the Exchange. The schedule shall include a record of all notifications, including phone calls and letters, to participants of delinquent accounts.</p>		Monthly	Report for the prior month on the first of the following month.	Accounting SCRtickets@covered.ca.gov
<p>Billing Detail – Discrepancy Report</p> <p>Contractors participating in the individual market shall use the PM/PM (per member, per month) member level billing detail template to communicate billing discrepancies to the Exchange. Contractor shall use the PM/PM member level billing detail, as provided by the Exchange, to compare against the Contractor’s confirmed enrollment to identify discrepancies. Contractor shall use the “comments” column, on the far right of the PM/PM member level billing detail template to identify billing discrepancies such as member duplication, cancellation, termination, missing Covered CA, missing Carrier, effective date, or plan difference. Contractor shall submit the completed template in both a format and secure manner approved by the Exchange. Furthermore, Contractor understands submittal of the completed billing discrepancy template does not extend or revise the invoice due date.</p>		Monthly	Report for the prior month on the first of the following month. Use FMD Issuer Billing Discrepancy Report Template.	Accounting SCRtickets@covered.ca.gov

Attachment 14 – Performance Measurement Standards

Attachment 14. Performance Measurement Standards

In the event that the reporting requirements identified herein include Personal Health Information, Contractor shall provide the Exchange only with de-identified Personal Health Information as defined in 45 C.F.R. Section 164.514. Contractor shall not be required to provide the Exchange any data, information or reports that would violate peer review protections under applicable laws and regulations.

During the term of this Agreement, Contractor shall meet or exceed the Performance Measurement Standards identified in this Attachment. Contractor shall be liable for payment of penalties that may be assessed by the Exchange with respect to Contractor's failure to meet or exceed the Performance Measurement Standards in accordance with the terms set forth at Section 6.1 of the Agreement and in this Attachment.

The assessment of the penalties by the Exchange shall be determined in accordance with the computation methodology set forth in this Attachment and shall be based on the following conditions: (i) the total amount at risk with respect to Contractor's failure to comply with the Performance Measurement Standards shall not exceed ten percent (10%) of the total Participation Fee that is payable to the Exchange in accordance with the terms set forth in Section 5.1.3 of the Agreement for the Individual Market and four percent (4%) for Covered California for Small Business, and (ii) the amount of performance penalty to be assessed with respect to Contractor's failure to meet a Performance Measurement Standard shall be offset (i.e., reduced) by a Service Level Credit that is provided in the event that Contractor exceeds a Performance Measurement Standard in a separate category. The performance measurement standards in Group 1 and 2 will be based on the final calendar year-end data for each performance standard.

The Exchange will also comply with the Performance Measurement Standards as described in Group 4 herein. In the event that the Exchange does not satisfy a Performance Measurement Standard, based on the final calendar year-end data, the Exchange will provide credits to Contractor which can be applied to any penalties accrued to Contractor. Such credits may reduce up to 25% of Contractor's performance penalties that may be assessed

The Exchange will calculate penalties and credits based on the Contractor's final year-end data for each performance standard beginning with Group 1 and 2 and the Exchange's final year-end data for Group 4 at the end of the calendar year. The Exchange's calculations will be provided to Contractor through the Initial Contractor Performance Measurement Standard Evaluation Report, covering Groups 1, 2, and 4, which the Exchange will send to the Contractor for review within 30 calendar days after the end of the calendar year. The Exchange shall also include any credits against the Contractor's penalty amount in the Performance Measurement Standard Evaluation Report, if a credit is due based on the Exchange's failure to meet performance measurement standards. In no event shall the total credits to Contractor exceed the total amount of the performance penalty that may be assessed.

Contractor's Performance Measurement Standards for Group 3, for calendar year 2016, will be due on as stated in Attachment 13. When the results of Group 3 are reviewed and finalized by the Exchange, Contractor's results will be calculated by the Exchange based on the performance measurement standards. The Exchange will then provide Contractor with a Final Contractor Performance Measurement Standard Evaluation Report within 30 calendar days of receipt of the Group 3 results.

Contractor shall remit payment to the Exchange within 30 calendar days of receiving the Final Contractor Performance Measurement Evaluation Report and invoice.

If the Contractor does not agree with either the Initial or Final Performance Measurement Standard Evaluation Report, Contractor may dispute the Report in writing within thirty (30) calendar days of receipt. The notification of dispute shall provide a detailed explanation of the basis for the dispute. The Exchange shall review and provide a written response to the Contractor's dispute within thirty (30) calendar days of receipt of Contractor's notification of dispute. If the Contractor still disputes the findings of the Exchange, Contractor may pursue additional remedies in accordance with Section 12.1 of the Agreement.

An example of how penalties and credits will be assessed is attached hereto as Appendix 2.

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

1. Call Center Operations

- (a) 800 Numbers: Contractor shall make information available regarding the Exchange pursuant to Contractor's toll-free hotline (i.e., 1-800 number) that shall be available to enrollees of Contractor both inside and outside the Exchange. The hotline and information services shall be staffed and operated in accordance with the Customer Service Standards set forth at Section 3.6.1 to provide support to Exchange Enrollees and in a manner designed to assure compliance with these Performance Measurement Standards.
- (b) Reporting: Contractor shall provide the following minimum reports to the Exchange at the specified time and frequency at no additional charge to the Exchange:
 - Performance Measurement Standards reporting: Customer Service, Operational and Quality, Network Management and Delivery System Reform: monthly, quarterly and annually.
 - Monthly accumulative monitoring scoring.

2. Performance Measurement Standards Reporting - Group 1 - Customer Service and Group 2 – Operational, Performance Standards 1.1 – 1.8 and 2.1 – 2.5

- (a) **Monthly Performance Report:** Beginning January 1, 2016, Contractor shall monitor and track its performance each month against the Performance Measurement Standards set forth herein. Contractor shall provide detailed supporting information (as mutually agreed by the parties) for each Monthly Performance Report to the Exchange in electronic format. **Contractor shall report on Exchange business only and shall report Contractor's Exchange Enrollees in the Individual Exchange separate from Contractor's Exchange Enrollees in Covered California for Small Business.**
- (b) **Measurement Rules:** Except as otherwise specified below in the Performance Measurement Standards Table, the reporting period for each Performance Guarantee shall be one calendar month; all references to time of day shall be to Pacific Standard Time; all references to hours will be actual hours during a calendar day; and all references to days, months, and quarters shall be to calendar days, calendar months, and calendar quarters, respectively.

(c) **Penalty Assessment: Except as otherwise specified in the Performance Measurement Standards table, the penalty and credit assessment will be based on the total annual performance for each Performance Measurement Standard.**

(d) **Performance Measurement Standards:**

- i. General - The Performance Measurement Standards Table sets forth the categories of Performance Measurement Standards and their associated measurements. In performing its services under this Agreement, Contractor shall use commercially reasonable efforts to meet or exceed the Performance Measurement Standards.
- ii. Root Cause Analysis/Corrective Action - If Contractor fails to meet any Performance Measurement Standard in any calendar month (whether or not the failure is excused), Contractor shall promptly (a) investigate and report on the root cause of the problem; (b) develop a corrective action plan (where applicable); (c) to the extent within Contractor's control, remedy the cause of the performance failure and resume meeting the affected Performance Measurement Standards; (d) implement and notify the Exchange of measures taken by Contractor to prevent recurrences if the performance failure is otherwise likely to recur; and (e) make written recommendations to the Exchange for improvements in procedures.
- iii. Performance Guarantee Exceptions; Contractor shall not be responsible for any failure to meet a Performance Guarantee if and to the extent that the failure is excused pursuant to Section 12.7 of the Agreement (Force Majeure) or the parties agree that the lack of compliance is due to the Exchange's failure to properly or timely perform (or cause to be properly or timely performed) any responsibility, duty, or other obligation under this Agreement, provided that Contractor timely notifies the Exchange of the problem and uses commercially reasonable efforts to perform and meet the Performance Measurement Standards notwithstanding the Exchange's failure to perform or delay in performing.

If Contractor wishes to avail itself of one of these exceptions, Contractor shall indicate in the applicable performance report delivered in the second month following the failure to meet such Performance Measurement Standard: (a) the identity of the Performance Measurement Standard that is subject to the exception, and (b) the circumstances that gave rise to the exception in sufficient detail to permit the Exchange to evaluate whether Contractor's claim of exception is valid. Notwithstanding anything to the contrary herein, in no event shall any failure to meet a Customer Satisfaction Performance Guarantee fall within an exception.

The Exchange will also comply with the Performance Measurement Standards set forth herein to the extent that such measurements are applicable to Exchange's operations. In the event that Exchange fails to meet a Performance Measurement Standard with respect to its operations during the calendar year, the Contractor will receive a credit against any penalty amount owed based on the Contractor's performance.

- iv. Agreed Adjustments/Service Level Relief - In addition, the Parties may agree on Performance Measurement Standard relief or adjustments to Performance

Measurement Standards from time to time, including, the inclusion of new and/or temporary Performance Measurement Standards.

- v. Performance Measurement Defaults - If the Exchange elects to assess sanctions for failure to meet Performance Measurement Standards, it will so notify Contractor in writing following the Exchange's receipt of the Monthly Performance Report setting forth the performance level attained by Contractor for the calendar quarter to which the sanctions relate. If Contractor does not believe it is appropriate for the Exchange to assess sanctions for a particular calendar quarter or calendar year (as applicable), it shall so notify the Exchange in writing within thirty (30) days after receipt of the Exchange's notice of assessment and, in such event, the Exchange will meet with Contractor to consider, in good faith, Contractor's explanation of why it does not believe the assessment of sanctions to be appropriate; provided, however, that it is understood and agreed that the Exchange, acting in good faith, will make the final determination of whether or not to assess the sanctions.
- vi. Service Level Credits - For certain measures of the performance standards set forth in the Performance Measurement Table, Contractor will have the opportunity to earn service level credit ("Service Level Credits") for performance that exceeds the Performance Measurement Standards. The Service Level Credits shall be used to offset (i.e., reduce) any sanctions that are imposed during any Contract Year.
- vii. Performance Measurement Tables - The Performance Measurement Standards are set forth in the table herein, Covered California Performance Standards for Contractor.

Performance Measurement Standards Reporting-Group 3- Quality, Network Management and Delivery System Reform, Performance Standards 3.1-3.5

QHP issuers are required by CMS in 2017 to collect and submit third-party validated QRS measure data, for measurement year 2016 that will be used by CMS to calculate QHP scores and ratings. Covered California will use a subset of these measures to create a Covered California specific Performance Guarantee for measurement year 2016 to be applied in 2017 per the attachment below. Covered California will publicly report the QRS scores and ratings that are produced by CMS.

Performance Measurement Standards Reporting – Group 5 - Dental Quality Alliance (DQA) Pediatric Measure Set

Contractor shall annually report on the required dental performance measurement standards in Group 5. Reporting will be on embedded pediatric dental for the 2016 contract term. Report will be due in the first quarter of 2017.

Covered California Performance Standards for Contractor

Group 1: Customer Service Performance Standards				
25% of Total Performance Penalty or Credit				
Performance Standard		Individual	Small Business	Performance Requirements
1.1	Inbound Call Volume	X	X	<p>Reporting Required Only. No penalty or credit. Volume will be used in calculation of performance standards 1.3 and 1.4</p> <p>Total number of calls received by the ACD.</p>
1.2	Abandoned Call Volume	X	X	<p>Reporting Required Only. No penalty or credit. Volume will be used in calculation of performance standards 1.3 and 1.4</p> <p>Number of calls offered to the service center by the ACD, but terminated by the person originating the call outside of the service level.</p>
1.3	Call Answer Timeliness	X	X	<p><u>Expectation:</u> 80% of calls answered 30 seconds or less. 5% of total performance penalty at risk.</p> <p><u>Performance Level:</u> <80%: 5% performance penalty. 80%-90%: no penalty. >90%: 5% performance credit.</p>
1.4	Telephone Abandonment Rate	X	X	<p><u>Expectation:</u> No more than 3% of incoming calls in a calendar month. 5% of total performance penalty at risk.</p> <p><u>Performance Level:</u> >3% abandoned: 5% performance penalty. 2-3% abandoned: no penalty. <2% abandoned: 5% performance credit.</p>

Covered California Performance Standards for Contractor

Group 1: Customer Service Performance Standards				
25% of Total Performance Penalty or Credit				
	Performance Standard	Individual	Small Business	Performance Requirements
1.5	Initial Call Resolution	X	X	<p><u>Expectation:</u> 85% of enrollee issues will be resolved within one (1) business day of receipt of the issue. 5% of total performance penalty at risk.</p> <p><u>Performance Level:</u> <85%: 5% performance penalty. 85-95%: no penalty. >95%: 5% performance credit.</p>
1.6	Grievance Resolution	X	X	<p><u>Expectation:</u> 95% of enrollee grievances resolved within 30 calendar days of initial receipt. 5% of total performance penalty at risk. <u>Performance Level:</u> <95% resolved within 30 calendar days of initial receipt: 5% performance penalty. 95% or greater resolved within 30 calendar days of initial receipt: no penalty. 95% or greater resolved within 15 calendar days of initial receipt: 5% performance credit.</p>
1.7	Member Email or Written Inquiries	X	X	<p>Reporting Required Only. No penalty or credit. Volume will be used in calculation of performance standard 1.8</p> <p>Total number of member email or written inquiries received.</p>
1.8	Member Email or Written Inquiries Answered and Completed	X	X	<p><u>Expectation:</u> 90% of member email or written inquiries answered and completed within 15 business days of the inquiry. Does not include appeals or grievances. 5% of total performance penalty at risk.</p> <p><u>Performance Level:</u> <90%: 5% performance penalty. 90-95%: no penalty. >95% in 15 days: 5% performance credit.</p>

Group 2: Operational Performance Standards

30% of Total Performance Penalty

Performance Standard		Individual	Small Business	Performance Requirements
2.1	ID Card Processing Time	<u>X</u>	<u>X</u>	<p><u>For the Individual Exchange:</u></p> <p><u>Expectation:</u> 99% of ID cards issued within 10 business days of receiving complete and accurate enrollment information and binder payment for a specific consumer(s)</p> <p>For Small Business:</p> <p>Expectation: 99% of ID cards issued within 10 business days of receipt of complete and accurate enrollment information for a specific consumer(s).</p> <p><u>Performance Level:</u> <99%: 5% performance penalty.</p>
2.2	<p>Enrollment and payment transactions</p> <p>3 month pilot period: 3/1/16-6/30/16</p> <p>Measurement period: 7/1/16-12/31/16</p>	<u>X</u>		<p><u>Expectation:</u> The Exchange will receive the 999 file within two to three business days of receipt of the 834 file 85% of the time.</p> <p><u>Performance Level:</u> <85%: 5% performance penalty.</p>
2.3	<p>Reconciliation of Pended Status Enrollee(s)</p> <p>3 month pilot period: 3/1/16-/30/16</p> <p>Measurement period: 7/1/16-12/31/16</p>	<u>X</u>		<p><u>Expectation:</u> The Exchange will receive the effectuation 834 file within 60 days from effective date of member 90% of the time.</p> <p><u>Performance Level:</u> <90%: 5% performance penalty</p>

Group 2: Operational Performance Standards

30% of Total Performance Penalty

Performance Standard		Individual	Small Business	Performance Requirements
2.4	<p>Reconciliation Process</p> <p>3 month pilot period: 3/1/16-3/30/16</p> <p>Measurement period: 7/1/16-12/31/16</p>	<u>X</u>		<p><u>Expectation:</u> For non-payment, the Exchange will receive an 834 cancellation file within 60 days of the members intended effective date 90% of the time.</p> <p>Performance Level: <90%: 5% performance penalty</p>
2.5	<p>Data Submission specific to contract Section 3.4.4 Provider Directory and Attachment 7, Section 3.03 Data Submission</p>	<u>X</u>	<u>X</u>	<p><u>Expectation:</u> Full and regular submission of data according to the standards outlined. 10% of total performance penalty at risk.</p> <p><u>Performance Level:</u> Incomplete, irregular, late or non-useable data submission: 10% penalty of total performance requirement. Full and regular submission according to the formats specified and useable by Covered California within 5 business days of each monthly reporting cycle: no penalty.</p>

Group 3: Covered California Performance Standards

Quality, Network Management and Delivery System Standards

**45% of total Performance Penalty or Credit for Measurement Year 2016 and thereafter
(Applies to Individual Marketplace)**

Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.

Performance Standard		Performance Requirements
3.1	Quality Rating System (QRS)- Access to Care; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14.	<u>Expectation</u> : Access to Care Domain Rating - QHP Enrollee Survey (product type reporting): <u>Performance Level</u> : <50th PCT: 5% performance penalty. 50-75th PCT: no penalty. >75th PCT: 5% performance credit. The credit/penalty will be based on a national blended marketplace benchmark. Covered California will use a single benchmark for all product types.

Group 3: Covered California Performance Standards

Quality, Network Management and Delivery System Standards

45% of total Performance Penalty or Credit

Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.

Performance Standard		Performance Requirements
3.2	Quality Rating System (QRS) - Doctors & Care; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14.	<p><u>Expectation:</u> -Doctors and Care Domain Rating - QHP Enrollee Survey -(product type reporting)</p> <p><u>Performance Level:</u> <50th PCT: 5% performance penalty. 50-75th PCT: no penalty. >75th PCT: 5% performance credit. The credit/penalty will be based on a national blended marketplace benchmark. Covered California will use a single benchmark for all product types.</p>
3.3	Quality Rating System (QRS) - Plan Service; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14.	<p><u>Expectation:</u> Plan Service Domain Rating - QHP Enrollee Survey (product type reporting)</p> <p><u>Performance Level:</u> <50th PCT: 5% performance penalty. 50-75th PCT: no penalty. >75th PCT: 5% performance credit. The credit/penalty will be based on a national blended marketplace benchmark. Covered California will use a single benchmark for all product types.</p>

Group 3: Covered California Performance Standards

Quality, Network Management and Delivery System Standards

45% of total Performance Penalty or Credit

Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.

Performance Standard		Performance Requirements
3.4	QHP Contract Compliance: Completion of Covered California eValue8 Request For Information (RFI) will be due with the annual certification application pursuant to Section 3.04 of Attachment 7	<p>Expectation: Covered California eValue8 performance, 20% of total performance penalty at risk.</p> <p><u>Performance Level:</u></p> <ol style="list-style-type: none"> 1. < 40% of total points: 20% performance penalty. 2. 40-74% of total points: no penalty. 3. 75% or greater of total points: 20% performance credit.
3.5	Essential Community Providers – Article 3, Section 3.3.3	<p>Expectation: 10% of total performance penalty at risk. Contractor shall maintain a network that includes a sufficient geographic distribution of essential community providers to provide reasonable and timely access to Covered Services for low income populations in regions served by Contractor.</p> <p>Contractor to demonstrate provider agreements with at least 15% of 340B non-hospital providers in each applicable rating region.</p> <p>Contractor to demonstrate provider agreements that reflect a mix of essential community providers (hospital and non-hospital) reasonably distributed to serve the low-income, populations.</p> <p><u>Performance Level:</u></p> <ol style="list-style-type: none"> 1. Sufficient ECP participation: 10% performance credit. 2. Developing ECP participation: no penalty or credit. 3. Insufficient ECP participation: 10% performance penalty. <p>Alternate Standard Contractor</p> <p>Expectation: Contractor to produce access map to demonstrate low income, medically underserved enrollee access to health care services. Low income, 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:</p> <ul style="list-style-type: none"> • Individuals with HIV/AIDS • American Indians and Alaska Natives • Low income and underserved individuals seeking women’s

		<p>health and reproductive health services</p> <ul style="list-style-type: none"> • 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. <p>Performance level:</p> <p>Alternate Standard Contractors shall not be eligible for performance credits, nor shall they be subject to performance penalties. Submission of the above required mapping is a contract compliance requirement.</p>
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Group 4: Covered California Performance Standards for Covered California	
Potential 25% Credit	
Customer Service Measures	Covered California Performance Requirements
4.1	Call Answer Timeliness for Covered California
	<p><u>Expectation:</u> 80% of calls answered in 30 seconds or less. 6.25% of total performance penalty at risk available as a potential credit towards Contractor's performance penalties.</p> <p><u>Performance Level:</u> <80%: 6.25% performance credit. 80%-90%: no credit. >90%: 6.25% reduction in performance credit.</p>
4.2	Telephone Abandonment Rate for Covered California
	<p><u>Expectation:</u> No more than 3% of incoming calls in a calendar month. 6.25% of total performance penalty at risk available as a potential credit towards Contractor's performance penalties.</p> <p><u>Performance Level:</u> >3% abandoned: 6.25% performance credit. 2-3% abandoned: no credit. <2% abandoned: 6.25% reduction in performance credit.</p>
4.3	Initial Call Resolution for Covered California
	<p><u>Expectation:</u> 85% of enrollee issues will be resolved within one (1) business day of receipt of the issue. 6.25% of total performance penalty at risk available as a potential credit towards Contractor's performance penalties.</p> <p><u>Performance Level:</u> <85%: 6.25% performance credit. 85-95%: no credit. >95%: 6.25% reduction in performance credit.</p>
4.4	Complaint Resolution for Covered California
	<p><u>Expectation:</u> 95% of enrollee complaints resolved within 30 calendar days. 6.25% of total performance penalty at risk available as a potential credit towards Contractor's performance penalties.</p> <p><u>Performance Level:</u> <95% resolved within 30 calendar days: 6.25% performance credit. 95% or greater resolved within 30 calendar days: no credit. 95% or greater resolved within 15 calendar days: 6.25% reduction in performance credit</p>

Group 5: Dental Quality Alliance (DQA) Pediatric Measure Set

Measure	Description	Numerator	Denominator	QDP Performance Rate	Expectation
Utilization of Services	Percentage of all enrolled children under age 19 who received at least one dental service within the reporting year.	Unduplicated number of children who received at least one dental service.	Unduplicated number of all enrolled children under age 19.	NUM/DEN	75%
Oral Evaluation	Percentage of enrolled children under age 19 who received a comprehensive or periodic oral evaluation within the reporting year.	Unduplicated number of children who received a comprehensive or periodic oral evaluation as a dental service.	Unduplicated number of enrolled children under age 19.	NUM/DEN	75%
Sealants in 6 – 9 years	Percentage of enrolled children in the age category of 6-9 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth within the reporting year.	Unduplicated number of all enrolled children age 6-9 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth as a dental service.	Unduplicated number of enrolled children age 6 - 9 years at “elevated” risk (i.e., “moderate” or “high”).	NUM/DEN	75%

Sealants in 10 – 14 years	Percentage of enrolled children in the age category of 10-14 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent second molar tooth within the reporting year.	Unduplicated number of enrolled children age 10-14 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent second molar tooth as a dental service.	Unduplicated number of enrolled children age 10-14 years at “elevated” risk (i.e., “moderate” or “high”).	NUM/DEN	75%
Topical Fluoride for Children at Elevated Caries Risk	Percentage of enrolled children aged 1-18 years who are at “elevated” risk (i.e. “moderate” or “high”) who received at least 2 topical fluoride applications within the reporting year.	Unduplicated number of children at “elevated” risk (i.e. “moderate” or “high”) who received at least 2 topical fluoride applications as a dental service.	Unduplicated number of enrolled children aged 1-18 years at “elevated” risk (i.e. “moderate” or “high”).	NUM/DEN	75%
Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children	Number of emergency department (ED) visits for caries-related reasons per 100,000 member months for all enrolled children.	Number of ED visits with caries-related diagnosis code among all enrolled children.	All member months for enrollees 0 through 20 years during the reporting year.	(NUM/DEN) x 100,000	< 15%
Follow-Up After ED Visit by Children for Dental Caries	The percentage of caries-related emergency department visits among children 0 through 18 years in the reporting year for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit.	Number of caries-related ED visits in the reporting year for which the member visited a dentist within (a) 7 days (NUM1) and (b) 30 days (NUM2) of the ED visit.	Number of caries-related ED visits in the reporting year.	NUM1/DEN and NUM2/DEN	75%

Appendix 1 to Attachment 14. Quality, Network Management and Delivery Systems Standards

Covered California Performance Requirements, Group 3, 3.1-3.3

3.1 Quality Rating System – (QRS) - Access to Care Member Experience

Access to Care Domain Rating
Getting Care Quickly Composite <ul style="list-style-type: none">• In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed?• In the last 12 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
Getting Needed Care Composite <ul style="list-style-type: none">• In the last 12 months, how often was it easy to get appointments with specialists?• In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?

3.2 Quality Rating System – (QRS) – Doctors and Care Member Experience

Doctor and Care Domain Rating
Global Rating of Health Care
Global Rating of Personal Doctor
Global Rating of Specialist

3.3 Quality Rating System (QRS) - Plan Service Member Experience

Plan Service Domain Rating
Customer Service Composite <ul style="list-style-type: none">• In the last 12 months, how often did your health plan's customer service give you the information or help you needed?• In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?
Global Rating of Plan

Individual Group 1: Customer Service Performance Standards - 25% of Total Performance Penalty or Credit								
		Total Participation Fee Penalty or Credit in Percentages		Total Participation Fee Penalty or Credit in Dollars		Expectation		
#	Performance Measure	Maximum Penalty	Maximum Credit	Maximum Penalty	Maximum Credit	Maximum Penalty	No Penalty	Credit
1.1	Inbound Call Volume	Reporting Measures Only						
1.2	Abandoned Call Volume							
1.3	Call Answer Timeliness	-0.5%	0.5%	(\$0.07)	\$0.07	<80%	80%-90%	>90%
1.4	Telephone Abandonment Rate	-0.5%	0.5%	(\$0.07)	\$0.07	>3%	2%-3%	<2%
1.5	Initial Call Resolution	-0.5%	0.5%	(\$0.07)	\$0.07	<85%	85%-95%	>95%
1.6	Grievance Resolution	-0.5%	0.5%	(\$0.07)	\$0.07	<95%	>95%	>95% ¹
1.7	Member Email or Written Inquiries	Reporting Measure Only						
1.8	Member E-Mail or Written Inquiries Answered	-0.5%	0.5%	(\$0.07)	\$0.07	<90%	90%-95%	>95%
Total Group 1 Customer Service Performance		-2.5%	2.5%	(\$0.35)	\$0.35			

Note 1. Credit is based on 95% or greater resolved with 15 calendar days of receipt

Individual Group 2: Operational Performance Standards - 30% of Total Performance Penalty								
		Total Participation Fee Penalty in Percentages		Total Participation Fee Penalty in Dollars		Expectation		
#	Performance Measure	Maximum Penalty	Maximum Credit	Maximum Penalty	Maximum Credit	Maximum Penalty	No Penalty	Credit
2.1	ID Card Processing Time	-0.5%	N/A	(\$0.07)	N/A	<99%	99% or greater	N/A
2.2	Enrollment and Payment Transactions	-0.5%	N/A	(\$0.07)	N/A	<85%	85% or greater	N/A
2.3	Reconciliation of Pended Status Enrollee(s)	-0.5%	N/A	(\$0.07)	N/A	<90%	90% or greater	N/A
2.4	Reconciliation Process	-0.5%	N/A	(\$0.07)	N/A	<90%	90% or greater	N/A
2.5	Data Submission specific to contract Section 3..4.4 and Attach 7, Section 3.03	-1.0%	N/A	(\$0.14)	N/A	>30 days	30 days or less	N/A
Total Group 2 Operational Performance Standards		-3.0%	N/A	(\$0.42)	N/A			N/A

Individual Group 3: Quality, Network Management and Delivery Standards 45% of Total Performance Penalty or Credit								
		Total Participation Fee Penalty or Credit in Percentages		Total Participation Fee Penalty or Credit in Dollars		Expectation		
#	Area of Performance	Maximum Penalty	Maximum Credit	Maximum Penalty	Maximum Credit	Maximum Penalty	No Penalty	Credit
3.1	Quality Rating System (QRS)-Access to Care; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14	-0.5%	0.5%	(\$0.07)	\$0.07	<50th PCT	50-75th PCT	>75th PCT
3.2	Quality Rating System (QRS) - Doctors & Care; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14	-0.5%	0.5%	(\$0.07)	\$0.07	<50th PCT	50-75th PCT	>75th PCT
3.3	Quality Rating System (QRS) - Plan Service; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14	-0.5%	0.5%	(\$0.07)	\$0.07	<50th PCT	50-75th PCT	>75th PCT
3.4	QHP Contract Compliance: Completion of Covered California eValue8 Request For Information (RFI) annual submission - specific to Attachment 7, Section 3.04, Appendix 2 to Attachment 7, Reports 4.1 - 4.15	-2.0%	2.0%	(\$0.28)	\$0.28	<40%	40-74%	75% or greater
3.5	Essential Community Providers - Article 3, Section 3.3.3	-1.0%	1.0%	(\$0.14)	\$0.14	<15%	developing	15% or greater
Total Group 3 Operational Performance Standards		-4.5%	4.5%	(\$0.63)	\$0.63			
Total Groups 1-3 Performance Standards ²		-10.0%	7.0%	(\$1.40)	\$0.98			

Note 2. Performance Measurement Standards at risk is 10% of Participation Fee which is \$13.95 PMPM in 2016

Group 4: Covered California Performance Standards - Individual								
		Total Participation Fee Credit or Credit Reduction in Percentages		Total Participation Fee Credit or Credit Reduction in Dollars		Expectation		
#	Performance Measure	Maximum Credit	Maximum Credit Reduction	Maximum Credit	Maximum Credit Reduction	Maximum Credit	No Credit	Reduction in Performance Credit
4.1	Call Answer Timeliness	-0.625%	0.625%	(\$0.09)	\$0.09	<80%	80%-90%	>90%
4.2	Telephone Abandonment Rate	-0.625%	0.625%	(\$0.09)	\$0.09	>3%	2%-3%	<2%
4.3	Initial Call Resolution	-0.625%	0.625%	(\$0.09)	\$0.09	<85%	85%-95%	>95%
4.4	Complaint Resolution	-0.625%	0.625%	(\$0.09)	\$0.09	<95%	>95%	>95% ¹
Total Group 4 Customer Service Performance		-2.5%	2.5%	(\$0.36)	\$0.36			

Note 1. Reduction in Performance Credit is based on 95% or greater resolved in 15 calendar days of receipt

Small Business Group 1: Customer Service Performance Standards - 62% of Total Performance Penalty or Credit									
		Total Participation Fee Penalty or Credit in Percentages		Total Participation Fee Penalty or Credit in Dollars		Expectation			
#	Performance Measure	Maximum Penalty	Maximum Credit	Maximum Penalty	Maximum Credit	Maximum Penalty	No Penalty	Credit	
1.1	Inbound Call Volume	Reporting Measures Only							
1.2	Abandoned Call Volume								
1.3	Call Answer Timeliness	-0.5%	0.5%	(\$0.09)	\$0.09	<80%	80%-90%	>90%	
1.4	Telephone Abandonment Rate	-0.5%	0.5%	(\$0.09)	\$0.09	>3%	2%-3%	<2%	
1.5	Initial Call Resolution	-0.5%	0.5%	(\$0.09)	\$0.09	<85%	85%-95%	>95%	
1.6	Grievance Resolution	-0.5%	0.5%	(\$0.09)	\$0.09	<95%	>95%	>95% ¹	
1.7	Member Email or Written Inquiries	Reporting Measure Only							
1.8	Member E-Mail or Written Inquiries Answered	-0.5%	0.5%	(\$0.09)	\$0.09	<90%	90% - 95%	>95%	
Total Group 1 Customer Service Performance		-2.5%	2.5%	(\$0.45)	\$0.45				

Note 1. Credit is based on 95% or greater resolved within 15 calendar days of receipt

Small Business Group 2: Operational Performance Standards - 38% of Total Performance Penalty or Credit								
		Total Participation Fee Penalty or Credit in Percentages		Total Participation Fee Penalty or Credit in Dollars		Expectation		
#	Performance Measure	Maximum Penalty	Maximum Credit	Maximum Penalty	Maximum Credit	Maximum Penalty	No Penalty	Credit
2.1	ID Card Processing Time	-0.5%	N/A	(\$0.09)	N/A	<99%	99% or greater	N/A
2.5	Data Submission specific to contract Section 3.4.4 and Attach 7, Section 3.03	-1.0%	N/A	(\$0.19)	N/A	>30 days	30 days or less	N/A
Total Group 2 Operational Performance Standards		1.5%	0.0%	(\$0.28)	\$0.00			
Total Groups 1-2 Performance Standards ²		4.0%	2.5%	(\$0.73)	\$0.45			

Note 2. Performance Measurement Standards at risk is 4.0% of Participation Fee which is \$18.60 PMPM in 2016

Group 4: Covered California Performance Standards - Small Business								
#	Performance Measure	Total Participation Fee Credit or Credit Reduction in Percentages		Total Participation Fee Credit or Credit Reduction in Dollars		Expectation		
		Maximum Credit	Maximum Credit Reduction	Maximum Credit	Maximum Credit Reduction	Maximum Credit	No Credit	Reduction in Performance Credit
4.1	Call Answer Timeliness	-0.625%	0.625%	(\$0.12)	\$0.12	<80%	80%-90%	>90%
4.2	Telephone Abandonment Rate	-0.625%	0.625%	(\$0.12)	\$0.12	>3%	2%-3%	<2%
4.3	Initial Call Resolution	-0.625%	0.625%	(\$0.12)	\$0.12	<85%	85%-95%	>95%
4.4	Complaint Resolution	-0.625%	0.625%	(\$0.12)	\$0.12	<95%	>95%	>95% ¹
Total Group 4 Customer Service Performance		-2.5%	2.5%	(\$0.48)	\$0.48			

Note 1. Reduction in Performance Credit is based on 95% or greater resolved in 15 calendar days of receipt