SF HIV FOG
Open Enrollment
Boot Camp V

Monday, October 7, 2019

UCSF Mission Bay
550 16th Street
San Francisco

Resource Guide

Part I
Covered California

Table of Contents

2020 Marketplace Plan Renewal Flowchart

Are you or your staff helping clients enroll or renew health care coverage for 2020? This guide provides a timeline for enrollment and renewals for 2020 coverage, and asks key questions to guide the renewal process. It explains that clients need to update their information in the Marketplace to ensure continued financial assistance and avoid gaps in coverage.

RWHAP staff can use this guide to:

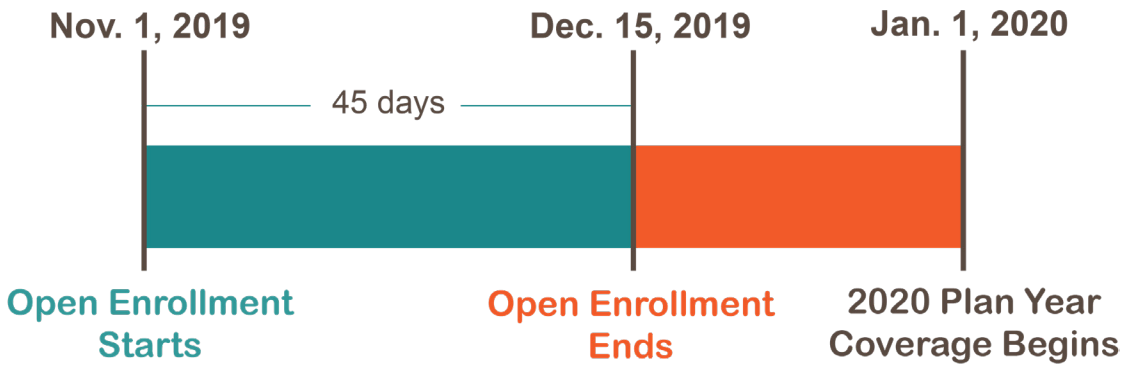
- Understand how to guide clients through the plan renewal process.
- Understand why enrolled clients need to update their Marketplace applications for coverage and financial assistance.

An important message about Open Enrollment and plan renewals:

- Clients who will change plans must enroll by December 15, 2019 in most states* to avoid a gap in coverage and ensure that their new plans begin on January 1, 2020.

Revised June 2019

Open Enrollment Timeline for 2020 Marketplace Coverage*



(includes all states using HealthCare.gov)

* In state-based and partnership Marketplace states, RWHAP providers and case managers should check with their Marketplace or regulating agency on the redetermination and renewal process, and to confirm the time period for Open Enrollment.

- Six-week enrollment period applies to both federally-facilitated marketplace states (FFMs) and state-based marketplaces (SBMs).

Marketplace Plan Renewal Flowchart for 2020 Coverage

1 Was your client enrolled in a qualified health plan (QHP) in 2019?

NO.
Eligible clients can choose and apply for a QHP during Open Enrollment.

YES.
Most clients will automatically be re-enrolled in coverage, with the exception of discontinued plans. Whether or not renewal is automatic, clients should log into their Marketplace application to compare plan options. Clients can select a new plan during Open Enrollment and update their income and household information.

Use the **ACE TA Center's Health Care Plan Selection Worksheet** to help clients find the best plan for them.

Use the **ACE TA Center's Pre-Enrollment Worksheet** to help clients prepare for their first visit with an enrollment assister.

TIP Even if the client is not eligible for as much financial help in 2020, s/he can review plans to compare costs and coverage for medications and services. RWHAP remains available to ensure coverage completion and may be able to help cover remaining premium and out-of-pocket expenses.

TIP Tell your clients that the Marketplace mails a *Health Insurance Marketplace Statement* each February with information they will need to complete Form 8962, which is a form that will get submitted with their tax return.

2 Is your client's QHP available in 2020?

NO.
If plan is discontinued at the end of 2019, the client may be auto-enrolled in a similar plan from the same insurer if one is available. If the insurer is leaving the Marketplace, the client may be auto-enrolled in a similar plan from another insurer. Encourage clients to examine **any new plan** carefully to ensure it still meets their needs. If a similar plan is not available, auto-renewal will not occur unless s/he actively chooses a new plan.

YES.
Even if your client's same plan is offered in 2020, encourage him/her to review new plan options to compare costs and coverage options, and see if s/he qualifies for financial help to lower the price of a new plan.

3 Did your client receive financial assistance, such as premium tax credits (PTCs) and/or cost-sharing reductions (CSRs), in 2019?

YES.
The Marketplace will use the client's tax information to calculate the amount of PTCs or CSRs the client is eligible for in 2020.

NO.
The client can apply for help paying for premiums and out-of-pocket expenses in 2020. Clients with incomes up to 400% FPL may be eligible for PTCs. Clients with incomes up to 250% FPL may also be eligible for CSRs.

4 Did the client file taxes this year?

YES.
Great! Clients who filed the previous years' taxes will have an automatic redetermination of their PTC/CSR in the new year.

See **Tax Credits and Cost Sharing: Federal Support for Health Insurance** for more information.

NO.
Clients must file a tax return for every year that they receive a PTC/CSR to continue to be eligible for future PTC/CSRs. Clients who were enrolled for the first time in 2018 and received a PTC/CSR will need to file their 2019 taxes in 2020.

5 Did the client authorize the collection of tax data from the IRS in 2019?

YES.
The Marketplace will use the client's tax information to calculate the amount of PTCs or CSRs the client is eligible for in 2020.

NO.
Tell your clients that without updated tax data, current financial help in the form of PTCs and CSRs will end on 12/31/19.

TERMS TO KNOW

QHP (QUALIFIED HEALTH PLAN)
A health insurance plan that is approved by and sold in the Marketplace.

PTC (PREMIUM TAX CREDIT)
Tax credit applied to premium costs of a QHP to help pay for health coverage.

CSR (COST SHARING REDUCTION)
A discount that lowers out-of-pocket costs for health insurance.

ELIGIBILITY DETERMINATION
When the Marketplace uses the client's tax information to calculate the client's financial assistance.

Marketplace Plan Renewal Flowchart

This resource is/was prepared by JSI Research & Training Institute, Inc., and supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U69HA30143: Building Ryan White HIV/AIDS Program Recipient Capacity to Engage People Living with HIV in Health Care Access. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government. **www.targethiv.org/ace**

ACE TA CENTER

What you'll need to enroll

The following is needed for every household member who will be covered:

- Proof of current household income*
- California ID or driver's license for adults
- Proof of citizenship or satisfactory immigration status (e.g., U.S. passport, legal resident card, certificate of citizenship or naturalization document)**
- Birth date
- Social Security number or Individual Taxpayer Identification number, if you have one
- Home ZIP Code

Sign up

Oct. 15, 2018 — Jan. 15, 2019

Sign up by Dec. 15 to be covered by Jan. 1

Medi-Cal enrollment is year round.

Even if you only need coverage for a just few months, look to Covered California throughout the year for your health insurance needs.

*Proof of current income of all members in the tax household such as a recent tax return, W-2, or pay stub. A dependent's income should only be included if their income level requires them to file a tax return. A household is defined as the person who files taxes as primary tax filer and all the dependents claimed on that person's taxes. If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal.

**You can apply for your child even if you are not eligible. Households that include members who are not lawfully present can also apply.

You have options

Covered California offers four levels of coverage: Bronze, Silver, Gold and Platinum. Insurance companies pay a portion of covered services, and the benefits offered within each level are the same no matter which insurance company you choose.

COVERAGE LEVEL	ANNUAL DEDUCTIBLE	AVERAGE PAID BY INSURANCE COMPANY	AVERAGE PAID BY YOU
Bronze	YES	60%	40%
Silver	YES	70%	30%
Gold	NO	80%	20%
Platinum	NO	90%	10%

- **Choose Platinum or Gold** and you'll pay a higher monthly premium, but you'll pay less for medical services.
- **Choose Silver or Bronze** and you'll pay a lower monthly premium, but you'll pay more for medical services.
- **A minimum coverage plan** is available to those under 30 or those 30 and over who have received a hardship exemption from U.S. Department of Health and Human Services.

*Silver is the only level where your deductible and other costs may be lower based on your household income.

For more information or to find free, local, in-person help, please contact:

CoveredCA.com | 800.300.1506

Covered California Can Help You Get Affordable Health Coverage

What you need to know

COVERED CALIFORNIA

Welcome to Covered California

See if you can get help paying for your health insurance.

We've got you covered.

Covered California is where Californians can shop for and compare quality health plans among a variety of brand-name insurance companies. You may even get help paying for it.

We're here to help.

Covered California offers free, local, in-person enrollment help, online chat, and telephone assistance in thirteen languages as well as for the hearing-impaired.

Are you eligible? Find out here.

Maximum Annual Household Income to Qualify for Financial Help

FAMILY SIZE	MEDI-CAL	COVERED CALIFORNIA
1	$16,754	$48,560
2	$22,715	$65,840
3	$28,677	$83,120
4	$34,638	$100,400
5	$40,600	$117,680
6	$46,652	$134,960
	You may be eligible for low or no-cost Medi-Cal.	*You may be eligible for financial help through Covered California.*

All numbers listed above are estimates. For larger households, please visit the Shop and Compare tool at CoveredCA.com to find out if your family qualifies.

Shop and Compare

Visit CoveredCA.com and choose "Shop and Compare" to see which brand-name health plans are right for you.

More questions?

Watch our "Welcome to Answers" videos at **CoveredCA.com/find-help/FAQS**

COVERED CALIFORNIA

To get started, visit **CoveredCA.com** or call **800.300.1506.**

COVERED CALIFORNIA

A step-by-step guide to enrolling in quality health coverage

We've got you covered.

Covered California is where Californians can shop for and compare quality health plans among a variety of brand-name insurance companies. You may even get help paying for it.

This guide will help you better understand your coverage options so you can enroll in the health plan that best fits your needs.

We're here to help.

Covered California offers free, local, in-person enrollment help, online chat, and telephone assistance in 13 languages as well as for the hearing-impaired. For help at any point during the enrollment process, call **800.300.1506** or visit **CoveredCA.com**.

Step one:
See if you qualify for help paying for health coverage

Based on your annual household income, you may qualify for what's called an Advanced Premium Tax Credit (APTC) to help reduce your monthly premiums. Or you may qualify for low or no-cost coverage through Medi-Cal.

Coverage Year 2019

Maximum Annual Household Income to Qualify for Financial Help

FAMILY SIZE	MEDI-CAL	COVERED CALIFORNIA
1	$16,754	$48,560
2	$22,715	$65,840
3	$28,677	$83,120
4	$34,638	$100,400
5	$40,600	$117,680
6	$46,652	$134,960
	You may be eligible for low or no-cost Medi-Cal.	*You may be eligible for financial help through Covered California.*

All numbers listed above are estimates. For larger households, please visit the Shop and Compare tool at CoveredCA.com to find out if your family qualifies. Medi-Cal enrollment is year-round.

Sign up Oct. 15 – Jan. 15 | **To be covered by Jan. 1 sign up by Dec. 15**

Enrolling in quality health coverage

Step two:
Explore your coverage options

Covered California offers four levels of coverage: Bronze, Silver, Gold and Platinum. Insurance companies pay a portion of covered services, and the benefits offered within each level are the same no matter which insurance company you choose.

- **Choose Platinum or Gold** and you'll pay a higher monthly premium, but you'll pay less for medical services.
- **Choose Silver or Bronze** and you'll pay a lower monthly premium, but you'll pay more for medical services.
- **A minimum coverage plan** is available to those under 30 or those 30 and over who have received a hardship exemption from U.S. Department of Health and Human Services.

Shop and Compare

Visit CoveredCA.com and choose "Shop and Compare" to see which brand-name health plans are right for you.

Standard coverage benefits by level

KEY BENEFITS	BRONZE Covers 60% of average annual cost	SILVER Covers 70% of average annual cost	GOLD Covers 80% of average annual cost	PLATINUM Covers 90% of average annual cost
Individual/Family Deductible	$6,300/$12,600	$2,500/$5,000**	No deductible	No deductible
Annual Preventive Care Visit	No cost	No cost	No cost	No cost
Primary Care Visit Copay	$75*	$40	$30	$15
Urgent Care Visit Copay	$75*	$40	$30	$15
Emergency Room Copay	Full cost up to deductible	$350	$325	$150
Generic Medication Copay	Full cost up to $500 deductible	$15	$15	$5
Annual Out-of-Pocket Maximum for One	$7,550	$7,550	$7,200	$3,350
Annual Out-of-Pocket Maximum for Family**	$15,100	$15,100	$14,400	$6,700

Chart does not include all medical copays and coinsurance rates. For complete information, visit CoveredCA.com.

* For Bronze Plans, the deductible is waived for the first three primary care or urgent care visits. Additional visits are charged at full cost until deductible is met.

** Silver is the only level where your deductible and other costs may be lower based on your household income.

COVERED CALIFORNIA

Enrolling in quality health coverage

Step three:
What you need to enroll

The following is needed for every household member who is applying for coverage:

- ☐ Proof of current household income*
- ☐ California ID or driver's license for adults
- ☐ Social Security number or Individual Taxpayer Identification number, if you have one
- ☐ Birth date
- ☐ Home ZIP Code
- ☐ Proof of citizenship or satisfactory immigration status (e.g., U.S. passport, legal resident card, certificate of citizenship or naturalization document)**

The Affordable Care Act (ACA)

As part of the ACA, Covered California is a program where most legal residents of California and their families can compare quality health plans and choose the one that works best for their health needs and budget. The law requires that:

- Preexisting health conditions cannot prevent someone from being covered.
- Your plan cannot be canceled because you are sick or injured.
- Young adults can be covered under their parents' plan until the age of 26.
- All plans include free preventive care.

The ABCs of HMOs, PPOs and EPOs

Most insurance companies offer three types of plans:

HMOs
Health Maintenance Organizations only cover medical services inside the plan's network. HMOs often require members to get a referral from their primary care doctor to see a specialist.

PPOs
Preferred Provider Organizations pay for medical services both inside and outside the plan's network, but members pay a higher amount of the cost for out-of-network care. No referral is required to see a specialist.

EPOs
Exclusive Provider Organizations generally don't cover care outside the plan's network, but members may not need a referral to see an in-network specialist.

It's important to note that not all HMOs, PPOs and EPOs are the same. Before choosing a plan, use the Shop and Compare tool at CoveredCA.com to get details like what doctors and hospitals are covered and what it will cost to see a doctor out-of-network.

* Proof of current income of all members in the tax household, such as a recent tax return, W-2, or pay stub. A dependent's income should only be included if their income level requires them to file a tax return. A household is defined as the person who files taxes as the primary tax filer and all the dependents claimed on that person's taxes. If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal.

** You can apply for your child even if you are not eligible. Households that include members who are not lawfully present can also apply.

Enrolling in quality health coverage

Step four:
Create an account and enroll

Enroll in your plan at CoveredCA.com. Simply create a user account and follow the enrollment process with the information in step three.

As always, we're here to help. If you have questions or to find free, local, in-person help, please visit **CoveredCA.com** or call **800.300.1506**.

Step five:
Save your info

Be sure to keep a record of key information regarding your application.

USERNAME

PASSWORD

APPLICATION ID NUMBER

ACCESS CODE

CASE NUMBER

HEALTH INSURANCE COMPANY'S NAME

INSURANCE PLAN INFORMATION (PLAN NUMBER, GROUP NUMBER, ETC.)

NAME AND CONTACT INFORMATION OF THE CERTIFIED ENROLLMENT COUNSELOR (CEC), CERTIFIED INSURANCE AGENT OR PLAN-BASED ENROLLER (PBE) WHO HELPED YOU ENROLL

Step six:
Pay your premium

Be sure to pay your monthly premium in full and on time to ensure that your coverage continues. Failing to pay your premium may disrupt or even cancel your health coverage.

For more information or to find free, local, in-person help, please contact:

Health Insurance Renewal Tracking Checklist

Use this checklist to track the key steps to support Ryan White HIV/AIDS Program (RWHAP) clients who are re-enrolling in health insurance.

Revised September 2017

Some renewal processes differ between states and health insurance programs. Please check with your local Marketplace or state agency about specific procedures.

Clients will require different levels of assistance during the renewal process. Clients changing health care plans or health insurance programs may need more help. Follow the checklist steps that are relevant to each client.

Enrollment Steps

Step 1: Get started.

- ☐ Describe the renewal process, the Open Enrollment time frame, how to submit renewal information, how long it will take, and when renewed benefits start.
- ☐ Describe how the Marketplace will automatically redetermine the client's eligibility for financial help.
- ☐ Discuss the importance of logging into the Marketplace to update information, such as income and household size, and the potential consequences of not reporting changes.

Step 2: Address client concerns, questions, and fears about health insurance.

- ☐ Discuss the client's concerns about renewal and/or insurance.
- ☐ Discuss any changes to the client's current health plan that will take effect in the next year.
- ☐ Talk to the client about his/her current health needs and whether his/her current plan meets those needs.
- ☐ Explain that RWHAP can still provide services not covered by insurance and may help pay some of the costs for health coverage, such as premiums and co-pays.
- ☐ Explain the importance of filing taxes to maintain financial assistance. Tell clients to reconcile their tax credits each year by completing tax Form 8962- using Form 1095-A.

Step 3: Fill-in application.

- ☐ If you do not provide renewal assistance, contact an enrollment assister to help. Help the client find assistance in another language, if necessary.
- ☐ Begin the renewal process, including updating the client's Marketplace or Medicaid information.
- ☐ Explain that to be eligible for tax credits, the client must allow the Marketplace to collect tax information.

Keep track of important dates, outcomes and notes.

Step 3: Fill-in application (continued)

- ☐ Review the client's current health care plan and discuss why and how to change health plans.
- ☐ Help the client select a health care plan. Check with your local ADAP to see if they recommend and/or provide financial support for certain health care plans.
- ☐ Keep track of important dates, outcomes and notes.
- ☐ Submit application.
- ☐ Follow-up on submitted application.

Step 4: Submit application.

- ☐ Explain what happens after the renewal information is submitted, including letters the client may receive.
- ☐ Copy the renewal information for the client and file it (if allowed/ applicable).
- ☐ Submit the renewal application and keep track of the application number, if applicable.

Step 5: Follow-up on submitted application.

- ☐ Support the client to check the status of their renewal application.
- ☐ Update other RWHAP programs, including ADAP, about the client's new enrollment status, including completing any required paperwork.
- ☐ Discuss the client's questions and concerns about his/her renewal status.

Step 6: Use benefits.

- ☐ Talk with the client about how to use insurance, including access to covered medications and services, such as primary and specialty care.
- ☐ Explain how ADAP and other RWHAP providers and services will work with the client's insurance.
- ☐ Discuss what costs the client may be responsible for, and the importance of paying premiums and other costs on time.
- ☐ If needed, help client find a doctor covered by his/her plan.

Step 7: Stay enrolled.

- ☐ Explain when and how to report life changes that may change the client's eligibility for insurance and/or ADAP and allow him/her to qualify for a Special Enrollment Period (SEP).
- ☐ Contact the client before open enrollment begins, or 60-90 days before the renewal date.
- ☐ Talk to the client about how and when to renew health insurance and ADAP eligibility, including the need for client to log into his/her Marketplace account each year to start the redetermination process, review health plan options, and/or pick a new plan.

Keep track of important dates, outcomes and notes.

Are you or your staff helping clients enroll or renew health care coverage for 2018?
Use the ACE TA Center Marketplace Plan Renewal Deadlines and Flowchart as a guide.

This tool was prepared by JSI Research & Training Institute, Inc. and supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under Grant #UF2HA26520, Supporting the Continuum of Care: Building Ryan White Program Grantee Capacity to Enroll Eligible Clients in Affordable Care Act Health Coverage Programs. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

2020 Health Care Plan Selection Worksheet

Use this worksheet to help your client choose the best health care plan. The ACE TA Center's Plain Language Glossary of Health Care Enrollment Terms also provides easy to understand explanations of the health care terms in this worksheet. *Revised June 2019.*

Step 1: Get client's current information.

Current prescription medications			HIV-related medication?
1	Drug name		_____ Yes _____ No
2	Drug name		_____ Yes _____ No
3	Drug name		_____ Yes _____ No
4	Drug name		_____ Yes _____ No
5	Drug name		_____ Yes _____ No
6	Drug name		_____ Yes _____ No
7	Drug name		_____ Yes _____ No

Current sources of care

Primary care provider (PCP) _____

Clinic or hospital where PCP is seen _____

Is PCP also an HIV specialist? _____ Yes _____ No

Is PCP certified in specialty infectious disease? _____ Yes (If yes, specialty?) _____ _____ No

HIV specialist (if different than PCP) _____ Clinic or hospital where seen _____

Facility (clinic/hospital) where client goes when sick _____

Mental health provider _____ Clinic or office where seen _____

Substance use provider _____ Clinic or office where seen _____

The ACE TA Center helps RWHAP recipients and subrecipients enroll diverse clients, especially people of color, in health insurance. **www.targethiv.org/ace**

JSI ACE TA CENTER

Other specialist(s)

1. Provider name _____ Clinic or hospital where seen _____

2. Provider name _____ Clinic or hospital where seen _____

Income information

Client household income as a percentage of Federal Poverty Level (FPL)		
$	Percentage (%) FPL	Number of people in household
Note: Federal poverty guidelines change each year. To determine the percent FPL for your client's income, go to https://aspe.hhs.gov/poverty-guidelines		
With this income, can client get ADAP premium/cost-sharing assistance in your area? *Note: Eligibility guidelines and availability of assistance vary in different areas and may only be offered for certain health plans. Use the extra space to write any specific guidelines about the ADAP assistance.*		
Premium assistance	_____ Yes _____ No	Notes:
Co-pay assistance	_____ Yes _____ No	Notes:
Deductible assistance	_____ Yes _____ No	Notes:
Assistance purchasing medications	_____ Yes _____ No	Notes:
With this income, does client qualify for financial help with health insurance costs through the Marketplace? *Note: See Appendix A.*		
Premium tax credits to help lower monthly premium costs	_____ Yes _____ No	
Cost-sharing reductions to lower out-of-pocket costs for deductibles, copays, and coinsurance	_____ Yes _____ No	

Step 2: Compare plans.

	Plan 1 Name:	Plan 2 Name:	Plan 3 Name:
	Company offering plan:	**Company offering plan:**	**Company offering plan:**
Plan general information & cost			
Circle plan "metal" *To receive cost-sharing reductions through the Marketplace, eligible clients must select a Silver level plan.*	Bronze Silver Gold Platinum	Bronze Silver Gold Platinum	Bronze Silver Gold Platinum
Is plan eligible for ADAP premium or co-pay assistance in your area?	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
Premium client will pay Full premium minus advance premium tax credit or other premium assistance, including ADAP assistance *Note the amount of premium assistance provided by ADAP and the premium tax credit.*	Monthly Premium (minus tax credit or other premium assistance) x 12 = Annual Premium Amount	Monthly Premium (minus tax credit or other premium assistance) x 12 = Annual Premium Amount	Monthly Premium (minus tax credit or other premium assistance) x 12 = Annual Premium Amount
Annual deductible The client may have a lower annual deductible if s/he qualifies for financial help through the Marketplace.	_____In-network _____Out-of-network	_____In-network _____Out-of-network	_____In-network _____Out-of-network

	Plan 1 **Name:**	Plan 2 **Name:**	Plan 3 **Name:**
Does the plan have a separate annual prescription drug deductible? **If yes, what is the amount?**	____No ____Yes $_____	____No ____Yes $_____	____No ____Yes $_____
What coinsurance is the client responsible for? The plan may have different coinsurance percentages for different services. If so, note the percentage for each service. *Note the amount of cost-sharing assistance provided.*			
Out-of-pocket maximum for plan The client may have a lower out-of-pocket maximum if s/he qualifies for financial help through the Marketplace (cost-sharing reductions).			
What is the co-pay for each health service? *If your client is receiving cost-sharing assistance, note the reduced co-pay.* **How many times does the client estimate they will use each health service in the next year?** *Specialty care could include routine HIV care if client's HIV provider is a specialist.*	Primary care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Primary care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Primary care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*
	Specialty care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Specialty care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Specialty care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*
	TOTAL ESTIMATED CO-PAYS/CO-INSURANCE *Add up total estimate client cost in each column.*		
	Plan 1 total co-pay costs:$_____	Plan 2 total co-pay costs:_____	Plan 3 total co-pay costs:_____

	Plan 1 **Name:**	Plan 2 **Name:**	Plan 3 **Name:**
How much will the client pay in co-pays? *This is only an estimation of co-pays for the client.*	Urgent care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Urgent care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Urgent care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*
	Emergency room visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Emergency room visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Emergency room visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*
	Inpatient care (hospitalization) $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Inpatient care (hospitalization) $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Inpatient care (hospitalization) $_____ co-pay x _____ number of visits = *$_____estimated client cost*
	Lab work $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Lab work $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Lab work $_____ co-pay x _____ number of visits = *$_____estimated client cost*
	Mental health visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Mental health visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Mental health visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*
	Substance use disorder visit $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Substance use disorder visit $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Substance use disorder visit $_____ co-pay x _____ number of visits = *$_____estimated client cost*
	TOTAL ESTIMATED CO-PAYS/CO-INSURANCE *Add up total estimate client cost in each column.*		
	Plan 1 total co-pay costs:$_____	Plan 2 total co-pay costs:_____	Plan 3 total co-pay costs:_____

	Plan 1 **Name:**	Plan 2 **Name:**	Plan 3 **Name:**
What is the co-pay for each medication? *If your client is receiving cost-sharing assistance, note the reduced co-pay.* **How many refills does the client estimate in the next year?** **How much will the client pay for medication?** *If client has more than five medications use a blank page to calculate additional costs.*	Medication 1 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 1 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 1 $_____ co-pay x _____ number of refills = $_____*estimated client cost*
	Medication 2 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 2 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 2 $_____ co-pay x _____ number of refills = $_____*estimated client cost*
	Medication 5 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 5 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 5 $_____ co-pay x _____ number of refills = $_____*estimated client cost*
	Medication 4 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 4 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 4 $_____ co-pay x _____ number of refills = $_____*estimated client cost*
	Medication 5 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 5 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 5 $_____ co-pay x _____ number of refills = $_____*estimated client cost*
	TOTAL ANNUAL ESTIMATED MEDICATION COSTS *Add up total estimate client cost in each column.*		
	Plan 1 total medication costs:$_____	Plan 2 total medication costs:$_____	Plan 3 total medication costs:$_____

	Plan 1 **Name:**		Plan 2 **Name:**		Plan 3 **Name:**	
Provider network						
Are the client's current providers included in-network, out-of-network or both? (Circle)	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Does the plan consider the client's current HIV provider to be a primary care provider or a specialist?	_____ Primary care provider _____ Specialist		_____ Primary care provider _____ Specialist		_____ Primary care provider _____ Specialist	
If a specialist, would the client need a referral from a primary care provider to see his/her HIV specialist?	_____ Yes _____ No		_____ Yes _____ No		_____ Yes _____ No	
Are the client's preferred medical facilities, such as a specific hospital, included in the plan?	_____ Yes _____ No		_____ Yes _____ No		_____ Yes _____ No	
Is the client allowed to see out-of-network providers? If yes, what does the client have to do to get approval?	_____ Yes _____ No *If yes, note approval process:*		_____ Yes _____ No *If yes, note approval process:*		_____ Yes _____ No *If yes, note approval process:*	
Do out-of-network visits cost more? **Is yes, what is the additional cost?** Clients who plan to use out-of-network providers and/or facilities should note any additional costs in the estimated co-pay cost above.	_____ Yes _____ No $_____		_____ Yes _____ No $_____		_____ Yes _____ No $_____	
Are plan providers located conveniently for client?	_____ Yes _____ No		_____ Yes _____ No		_____ Yes _____ No	

	Plan 1 Name:	Plan 2 Name:	Plan 3 Name:
Pharmacy			
Does the plan allow use of ADAP pharmacy/ pharmacies?	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
Does the plan's drug formulary include the client's current HIV-related drugs? Plans must include at least one drug in each class of core ART medications for ADAP to help with costs.	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
Are the client's current non-HIV drugs covered by the plan?	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
Are there restrictions on drug coverage? For example: Required use of specialty or mail-order pharmacy, prior authorization, step therapy.	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No

	Plan 1 **Name:**			Plan 2 **Name:**			Plan 3 **Name:**		
Access to additional services									
		Covered Service	Referral Required		Covered Service	Referral Required		Covered Service	Referral Required
What other needed services are covered by the plan? *Check all that apply.* **Would the client require a referral to access these services?** *Check all that apply.*	Mental/behavioral health			Mental/behavioral health			Mental/behavioral health		
	Substance use disorder			Substance use disorder			Substance use disorder		
	Vision			Vision			Vision		
	Oral health/dental			Oral health/dental			Oral health/dental		
	Chiropractic care			Chiropractic care			Chiropractic care		
	Laboratory services			Laboratory services			Laboratory services		
	X-ray/imaging services			X-ray/imaging services			X-ray/imaging services		
	Durable medical equipment			Durable medical equipment			Durable medical equipment		
	Home health services			Home health services			Home health services		
	Nutritional counseling/medical nutrition therapy			Nutritional counseling/medical nutrition therapy			Nutritional counseling/medical nutrition therapy		
	Case management			Case management			Case management		
	Other_____			Other_____			Other_____		
Does the plan limit the number of visits for specific services?	Mental health	Yes	No	Mental health	Yes	No	Mental health	Yes	No
	Substance use disorder	Yes	No	Substance use disorder	Yes	No	Substance use disorder	Yes	No
	Dental	Yes	No	Dental	Yes	No	Dental	Yes	No
	Other	Yes	No	Other	Yes	No	Other	Yes	No

Adapted from:

- Colorado Consumer Health Initiative CoveredU.org
  http://coveredu.org/shop/intro
- National Health Council Putting Patients First Estimate My Costs Calculator
  http://www.puttingpatientsfirst.net/calc
- Harvard Law School Center for Health Law & Policy Innovation's Marketplace Health Plans Assessment Workbook
  http://www.hivhealthreform.org/wp-content/uploads/2013/10/HLP-Market-Place-Health-Plan-Assesment-Tool-updated-10.23.pdf
- HIV Health Reform's Passport to Health Care
  http://www.hivhealthreform.org/wp-content/uploads/2013/10/ACA-Passport-how-I-get-my-care.pdf
- NASTAD's Health Reform Issue Brief: Plan Assessment Tools for Insurance
  http://www.nastad.org/Docs/045101_HCA-Brief-Plan%20Assessment-10.25.13.pdf

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Appendix A

Quick check chart: Do I qualify to save on health insurance coverage?

To learn if you qualify for lower costs on health coverage, find your estimated 2020 household income and household size on the chart below.

Choose the column for your household size.* The column on the left shows income levels that qualify for lower costs on premiums and out-of-pocket costs for private health insurance, and for low-cost health care through Medicaid. Remember to update your income and/or household size information if there are any changes throughout the year so that any financial assistance with premium and out-of-pocket costs is accurately calculated.

		Number of people in your household					
		1	2	3	4	5	6
Private Marketplace Health Plans	You may qualify for **lower premiums on a Marketplace insurance plan** (Premium Tax Credits) if your yearly income is between… *See next row if your income is at the lower end of this range*	$12,490-$49,960	$16,910-$67,640	$21,330-$85,320	$25,750-$103,000	$30,170-$120,680	$34,590-$138,360
	You may qualify **for lower premiums AND out-of-pocket costs for Marketplace insurance** (Premium Tax Credits and cost-sharing reductions) if your yearly income is between…	$12,490-$31,225	$16,910-$42,275	$21,330-$53,325	$25,750-$64,375	$30,170-$75,425	$34,590-$86,475
Medicaid Coverage	If your state has expanded Medicaid: You may qualify for **Medicaid coverage** if your yearly income is below…	$17,236	$22,335	$29,435	$35,535	$41,634	$47,734
	If your state isn't expanding Medicaid: **You may not qualify for any Marketplace savings programs** if your yearly income is below…	$12,490	$16,910	$21,330	$25,750	$30,170	$34,590

*Include in your household everyone you will claim as a dependent on your tax return and any children who live with you. To view instructions on calculating income, see: https://www.healthcare.gov/how-can-i-save-money-on-marketplace-coverage-chart/. Adapted from HealthCare.gov

COVERED CALIFORNIA™

2020 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers **0%** until out-of-pocket maximum is met	Covers **60%** average annual cost	Covers **70%** average annual cost	Covers **73%** average annual cost	Covers **87%** average annual cost	Covers **94%** average annual cost	Covers **80%** average annual cost	Covers **90%** average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	**$24,981 to $31,225 (>200% to ≤250% FPL)**	**$18,736 to $24,980 (>150% to ≤200% FPL)**	**up to $18,735 (100% to ≤150% FPL)**	N/A	N/A
Annual Wellness Exam	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Vist	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	$65*	$40	$35	$15	$5	$30	$15
Urgent Care		$65*	$40	$35	$15	$5	$30	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$95*	$80	$75	$25	$8	$65	$30
Emergency Room Facility		40% after deductible is met	$400	$400	$150	$50	$350	$150
Laboratory Tests		$40	$40	$40	$20	$8	$40	$15
X-Rays and Diagnostics		40% after deductible is met	$85	$85	$40	$8	$75	$30
Imaging			$325	$325	$100	$50	$275 copay or 20% coinsurance***	$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	$18**	$16**	$16**	$5 or less	$3 or less	$15 or less	$5 or less
Tier 2 (Preferred Drugs)		40% up to $500 after drug deductible is met	$60**	$55**	$25**	$10 or less	$55 or less	$15 or less
Tier 3 (Non-preferred Drugs)			$90**	$85**	$45**	$15 or less	$80 or less	$25 or less
Tier 4 (Specialty Drugs)			20% up to $250** per script	20% up to $250** per script	15% up to $150** per script	10% up to $150 per script	20% up to $250 per script	10% up to $250 per script
Medical Deductible	N/A	Individual: $6,300 Family: $12,600	Individual: $4,000 Family: $8,000	Individual: $3,700 Family: $7,400	Individual: $1,400 Family: $2,800	Individual: $75 Family: $150	N/A	N/A
Pharmacy Deductible	N/A	Individual: $500 Family: $1,000	Individual: $300 Family: $600	Individual: $275 Family: $550	Individual: $100 Family: $200	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$8,150 individual only	$7,800 individual $15,600 family	$7,800 individual $15,600 family	$6,500 individual $13,000 family	$2,700 individual $5,400 family	$1,000 individual $2,000 family	$7,800 individual $15,600 family	$4,500 individual $9,000 family

Drug prices are for a 30 day supply.

* Copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, future visits will be at full cost until the medical deductible is met.

** Price is after pharmacy deductible amount is met.

*** See plan Evidence of Coverage for imaging cost share.

Medical Networks:

Health Maintenance organization (HMO)

Upside of an HMO	Downside of an HMO
✓ You typically pay less premiums and co-pays	▪ You need to choose a PCP
✓ You typically have no or low deductibles	▪ You need a referral to see a specialist
✓ Your PCP manages your healthcare	▪ You typically pay the full amount in healthcare costs for out-of-network care
✓ HMOs emphasize preventative and routine care (physicals, screenings, and immunizations)	▪ You typically have a smaller network of doctors to chose from
✓ Coverage for emergency care, even if out-of-network	▪ Your PCP decides which specialist you see
	▪ Dependents must see in network doctors even if they live away from home

Medical Networks:

Preferred provider Organization (PPO)

Upside of a PPO	Downside of a PPO
✓ You don't need to choose a PCP ✓ You don't need a referral from a PCP to see a specialist ✓ You'll pay the least amount of costs if you stay in network ✓ You can visit any doctor at anytime ✓ You have a wider network of doctors to choose form	▪ You typically have to pay more in monthly premiums and out-of-pocket costs ▪ You find your own specialist and health care facilities ▪ You plan when you see a doctor for routine or specialized care ▪ Out-of-network services may be covered at a lower percentage, and you pay the difference.

Medical Networks:

Exclusive provider organization (EPO)

Upside of a EPO	Downside of a EPO
✓ Typically medium to low premium costs ✓ Copay costs are predetermined based on facility ✓ You don't need to choose a PCP ✓ You don't need a referral from a PCP to see a specialist ✓ You'll have a network of pre-approved doctors within the EPO network ✓ Emergency and Urgent care services are covered even if outside of network	▪ You are restricted to a limited network ▪ Any services or doctors you see outside of the network are not covered, (except emergency and urgent care) ▪ You find your own doctors and facilities within network lists.

Immigration Status and Eligibility

What You Need to Know

What if I'm from a Mixed Immigration Status Family?

If your family includes some noncitizens that are not lawfully present, you can still apply for health care through Covered California. When applying, remember that family members who are not lawfully present are not eligible for Covered California health plans, but may be eligible for Medi-Cal.

Interpreters are available for callers seeking help in other languages

CoveredCA.com
(800) 300-1506

Welcome to Covered California

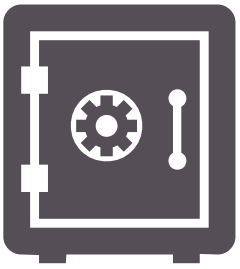
Covered California™ is a place where you can compare and shop for private health insurance plans, and get financial assistance to pay for health coverage if you qualify.

Who is Eligible for Covered California?

All U.S. citizens, U.S. nationals and noncitizens lawfully present in California may apply for health care through Covered California.

Who is Not Eligible for Covered California?

If you are not lawfully present in California, you are not eligible for a Covered California plan. However, you can still apply through Covered California to find out if you are eligible for Medi-Cal or to find coverage for family members who are lawfully present. For example, if your child is a U.S. citizen, you can apply on his or her behalf. You only need to provide information on immigrant status for family members applying for coverage.



Your Immigration Status Will Be Kept Confidential

All immigration information provided to Covered California will be kept private and secure. It will not be shared with or used by any immigration agency to enforce immigration laws.

Signing Up for Covered California Will Not Affect Your Immigrant Status

In general, receiving help to pay for a Covered California health plan or receiving coverage through Medi-Cal will not affect immigration status or the chances of becoming a citizen or lawful permanent resident of the U.S.

For more information or to find free, confidential local help, please contact:

El estado migratorio y la elegibilidad

Lo que debes saber

Bienvenido a Covered California

Covered California™ es un lugar donde puedes buscar y comparar planes de seguro de salud privados, y obtener asistencia financiera para pagar por tu cobertura de salud si calificas.

¿Quiénes califican para Covered California?

Todos los ciudadanos de los Estados Unidos, los nacionalizados y no ciudadanos con presencia legal en California pueden solicitar cobertura de salud a través de Covered California.

¿Quiénes no califican para Covered California?

Si no estás legalmente presente en California, no calificas para un plan de salud a través de Covered California. Sin embargo, puedes solicitar a través de Covered California para saber si calificas para Medi-Cal o para encontrar cobertura para los miembros de tu familia que sí están presentes legalmente. Por ejemplo, puedes solicitar en nombre de un hijo que es ciudadano de los Estados Unidos. Sólo tienes que proveer información del estado migratorio de los miembros de la familia que solicitan cobertura.

Tu estado migratorio permanecerá confidencial

Toda la información sobre tu estado migratorio que proveas a Covered California permanecerá privada y segura. No compartiremos información con agencias de inmigración ni será usada para ejercer leyes migratorias.

Inscribirte a través de Covered California no afectará tu estado migratorio

Por lo general, tu estado migratorio o tus posibilidades de convertirte en ciudadano o residente legal permanente de los Estados Unidos no se verán afectadas si recibes ayuda para pagar por un plan de salud a través de Covered California, o cobertura a través de Medi-Cal.

Para más información, o para encontrar ayuda gratis y confidencial, por favor comunícate con nosotros:

¿Qué pasa si el estado migratorio de mi familia es mixto?

Aun si tu familia incluye personas no ciudadanas y sin presencia legal, puedes solicitar cobertura de salud a través de Covered California. Cuando solicites, recuerda que los familiares que no están presentes legalmente no califican para planes de salud a través de Covered California, pero sí podrían calificar para Medi-Cal.

Tenemos intérpretes disponibles para los consumidores que quieran obtener ayuda en otros idiomas

CoveredCA.com/espanol
(800) 300-0213

PROGRAM ELIGIBILITY BY FEDERAL POVERTY LEVEL FOR 2019

Medi-Cal and Covered California have various programs with overlapping income limits.

COVERED CALIFORNIA

PREMIUM ASSISTANCE

AMERICAN INDIAN / ALASKA NATIVE PLANS

ENHANCED SILVER PLANS (100%-250%)

SILVER 94 (100%-150%) | SILVER 87 (>150%-200%) | SILVER 73 (>200%-250%)

HOUSEHOLD SIZE	% OF FPL	100%	138%	150%	200%	213%	250%	266%	300%	322%	400%
	1	$12,140	$17,237	$18,210	$24,280	$26,604	$30,350	$33,224	$36,420	$40,218	$48,560
	2	$16,460	$23,336	$24,690	$32,920	$36,019	$41,150	$44,981	$49,380	$54,451	$65,840
	3	$20,780	$29,436	$31,170	$41,560	$45,433	$51,950	$56,738	$62,340	$68,683	$83,120
	4	$25,100	$35,535	$37,650	$50,200	$54,848	$62,750	$68,495	$75,300	$82,915	$100,400
	5	$29,420	$41,635	$44,130	$58,840	$64,263	$73,550	$80,253	$88,260	$97,148	$117,680
	6	$33,740	$47,735	$50,610	$67,480	$73,677	$84,350	$92,010	$101,220	$111,380	$134,960
	7	$38,060	$53,834	$57,090	$76,120	$83,092	$95,150	$103,767	$114,180	$125,613	$152,240
	8	$42,380	$59,934	$63,570	$84,760	$92,506	$105,950	$115,524	$127,140	$139,845	$169,520
	each additional person, add	$4,320	$6,100	$6,480	$8,640	$9,415	$10,800	$11,758	$12,960	$14,233	$17,280

DHCS California Department of HealthCareServices

MEDI-CAL FOR ADULTS | MEDI-CAL FOR PREGNANT WOMEN | MEDI-CAL ACCESS PROGRAM (FOR PREGNANT WOMEN)

MEDI-CAL FOR KIDS (0-18 yrs.) | COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM

Medi-Cal uses FPL limits of the current year to determine eligibility for its programs. The column headings shaded in purple are associated with eligibility ranges for Medi-Cal programs:

- Medi-Cal for Adults up to 138% FPL
- Medi-Cal for Children up to 266% FPL
- Medi-Cal for Pregnant Women: up to 213% FPL
- MCAP: over 213% - 322% FPL
- CCHIP: over 266% - 322% FPL

The shaded columns display 2019 FPL values according to the Department of Health Care Services (see annual values on page 4) which administers the Medi-Cal program.

Covered California uses FPL limits from the prior year to determine eligibility for its programs as required by regulation. The unshaded columns are associated with Covered California eligibility ranges:

Premium Assistance **100% - 400% FPL**

Enhanced Silver Plans *100% - 250% FPL*

- Silver 94 100% - 150% FPL
- Silver 87 over 150% - 200% FPL
- Silver 73 over 200% - 250% FPL

American Indian/ Alaska Native Plans *100% - 300% FPL*

The unshaded columns display 2018 FPL values to determine eligibility for premium tax credits and cost sharing reductions for health plans effective in 2019. The unshaded columns, including the 100% column, display 2018 FPL values as published by the Department of Health and Human Services.

Qualified Dental Plan Application
Plan Year 2020
Covered California for Small Business
March 1, 2019

Table of Contents

1 Application Overview

1.1 Purpose

The California Health Benefit Exchange (Exchange) is accepting applications from eligible Dental Issuers[1] (Applicants) to submit proposals to offer, market, and sell qualified dental plans (QDPs) through the Exchange beginning in 2019, for coverage effective January 1, 2020. All Health Insurance Issuers currently licensed at the time of application response submission are eligible to apply for certification of proposed Qualified Health Plans (QHPs) for the 2020 Plan Year. QDP Issuers contracted for Plan Year 2019 will complete a simplified certification application since those issuers have a contract with the Exchange that imposes ongoing requirements that are similar to or satisfy the requirements in the certification application and consideration of this contract performance is included in the evaluation process. The Exchange will exercise its statutory authority to selectively contract for health care coverage offered through the Exchange for Plan Year 2020. The Exchange reserves the right to select or reject any Applicant or to cancel this Application at any time.

1.2 Background

Soon after the passage of national health care reform through the Patient Protection and Affordable Care Act of 2010 (ACA), California enacted legislation to establish a qualified health benefit exchange. (California Government Code § 100500 et seq). The California state law is referred to as the California Patient Protection and Affordable Care Act (CA-ACA).
The Exchange offers a statewide health insurance exchange to make it easier for individuals to compare plans and buy health insurance in the private market. Although the focus of the Exchange is on individuals who qualify for tax credits and subsidies under the ACA, the Exchange's goal is to make insurance available to all qualified individuals. The vision of the Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care coverage. The mission of the Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.
The Exchange is guided by the following values:

- **Consumer-Focused**: At the center of the Exchange's efforts are the people it serves. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those it serves.
- **Affordability**: The Exchange will provide affordable health insurance while assuring quality and access.
- **Catalyst**: The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.

- **Integrity**: The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
- **Transparency**: The Exchange will be fully transparent in its efforts and will make opportunities available to work with consumers, providers, health plans, employers, purchasers, government partners, and other stakeholders to solicit and incorporate feedback into decisions regarding product portfolio and contract requirements.
- **Results**: The impact of the Exchange will be measured by its contributions to decrease the number of uninsured, have meaningful plan and product choice in all regions for consumers, improve access to quality healthcare, promote better health and health equity, and achieve stability in healthcare premiums for all Californians.

In addition to being guided by its mission and values, the Exchange's policies are derived from the federal Affordable Care Act which calls upon Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that are in the process of being implemented, the health insurance marketplace is transforming from one that has prioritized profitability through a focus on risk selection to one that rewards better care, affordability, and prevention. The Exchange needs to address these issues for the millions of Californians who enroll through the Exchange to get coverage, but it is also part of broader efforts to improve care, improve health, and stabilize rising health care costs throughout the state.

The Exchange must operate within the federal standards in law and regulation. Beyond what is framed by the federal standards, California's legislature shapes the standards and defines how the new marketplace for individual and small group health insurance operates in ways specific to their context. Within the requirements of the minimum Federal criteria and standards, the Exchange has the responsibility to "certify" the Qualified Health Plans (QHPs) that will be offered in the Exchange.

The state legislation to establish the Exchange gave authority to the Exchange to selectively contract with issuers so as to provide health care coverage options that offer the optimal combination of choice, value, quality, and service and to establish and use a competitive process to select the participating health issuers.

These concepts, and the inherent trade-offs among the Exchange values, must be balanced in the evaluation and selection of the Qualified Health Plans that will be offered in Covered California for Small Business.

This application has been designed consistent with the policies and strategies of the Exchange Board which calls for the QHP selection to influence the competitiveness of the market, the cost of coverage, and how value is added through health care delivery system improvement.

1.3 Application Evaluation and Selection

The evaluation of QDP Certification Applications will not be based on a single, strict formula; instead, the evaluation will consider the mix of health and dental plans for each region of California that best meet the needs of consumers in that region and the Exchange's goals. The Exchange wants to provide an appropriate range of high quality health plans to participants at the best available price that is balanced with the need for consumer stability and long-term affordability. In consideration of the mission and values of the Exchange, the Board of the Exchange articulated guidelines for the selection and oversight of Qualified Health Plans which are used when reviewing the Applications for 2020. These guidelines are:

Promote affordability for the consumer– both in terms of premium and at point of care

The Exchange seeks to offer health plans, plan designs and provider networks that are as affordable as possible to consumers both in premiums and cost sharing, while fostering competition and stable premiums. The Exchange will seek to offer health plans, products, and provider networks that will attract maximum enrollment as part of its effort to lower costs by spreading risk as broadly as possible.

Encourage "Value" Competition Based upon Quality, Service, and Price

While premium will be a key consideration, contracts will be awarded based on the determination of "best value" to the Exchange and its participants. The evaluation of Issuer QDP proposals will focus on quality and service components, including history of performance, administrative capacity, reported quality and satisfaction metrics, quality improvement plans and commitment to serve the Exchange population. This commitment to serve the Exchange population is evidenced through general cooperation with the Exchange's operations and contractual requirements which include provider network adequacy, cultural and linguistic competency, programs addressing health equity and disparities in care, innovations in delivery system improvements and payment reform. The application responses, in conjunction with the approved filings, will be evaluated by the Exchange and used as part of the selection criteria to offer issuers' products on the Exchange for the 2020 plan year.

Encourage Competition Based upon Meaningful QDP Choice and Product Differentiation: Patient-Centered Benefit Plan Designs[2]

The Exchange is committed to fostering competition by offering QDPs with features that present clear choice, product and provider network differentiation. QDP Applicants are required to adhere to the Exchange's standard benefit plan designs in each region for which they submit a proposal. The Exchange is interested in having HMO and PPO products offered statewide. Within a given product design, the Exchange will look for differences in network providers and the use of innovative delivery models. Under such criteria, the Exchange may choose not to contract with two plans with broad

overlapping networks within a rating region unless they offer different innovative delivery system or payment reform features.

Encourage Competition throughout the State
The Exchange must be statewide. Issuers must submit QDP proposals in all geographic service areas in which they are licensed and have an adequate network, and preference will be given to Issuers that develop QDP proposals that meet quality and service criteria while offering coverage options that provide reasonable access to the geographically underserved areas of the state.

Encourage Alignment with Providers and Delivery Systems that Serve the Low-Income Population
Performing effective outreach, enrollment and retention of the low-income population that will be eligible for premium tax credits and cost sharing subsidies through the Exchange is central to the Exchange's mission. Responses that demonstrate an ongoing commitment to the low-income population or demonstrate a capacity to serve the cultural, linguistic and health care needs of the low income and uninsured populations beyond the minimum requirements adopted by the Exchange will receive additional consideration. Examples of demonstrated commitment include: having a higher proportion of essential community providers to meet the criteria of sufficient geographic distribution, having contracts with Federally Qualified Health Centers, and supporting or investing in providers and networks that have historically served these populations to improve service delivery and integration.

Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform
One of the values of the Exchange is to serve as a catalyst for the improvement of care, prevention and wellness to reduce costs. The Exchange wants QDP offerings that incorporate innovations in delivery system improvement, prevention and wellness, and/or payment reform that will help foster these broad goals. This will include models of patient-centered medical homes, targeted quality improvement efforts, participation in community-wide prevention, or efforts to increase reporting transparency to provide relevant health care comparisons and to increase member engagement in decisions about their course of care.

Demonstrate Administrative Capability and Financial Solvency
The Exchange will review and consider Applicant's degree of financial risk to avoid potential threats of failure which would have negative implications for continuity of patient care and for the healthcare system. The Issuer's technology capability is a critical component for success on the Exchange, so Applicant's technology and associated resources are heavily scrutinized as this relates to long term sustainability for consumers. Additionally, in recognition of the significant investment that will continue to be needed in areas of quality reform and improvement programs, the Exchange offered a multi – year contract agreement through the 2017 application. Application responses that demonstrate a commitment to the long-term success of the Exchange's mission are strongly encouraged.

Encourage Robust Customer Service
The Exchange is committed to ensuring a positive consumer experience, which requires Issuers to maintain adequate resources to meet consumers' needs. To successfully serve Exchange consumers, Issuers must invest in and sustain adequate staffing, including hiring of bilingual and bicultural staff as appropriate and maintaining internal training as needed. Issuers demonstrating a commitment to dedicated administrative resources for Exchange consumers will receive additional consideration.

1.4 Availability

Applicant must be available immediately upon contingent certification of its plans as QDPs to start working with the Exchange to establish all operational procedures necessary to integrate and interface with the Exchange information systems, and to provide additional information necessary for the Exchange to market, enroll members, and provide dental plan services effective January 1, 2020. Successful Applicants will also be required to adhere to certain provisions through their contracts with the Exchange, including meeting data interface requirements of the system operated by Pinnacle HCMS. Successful Applicants must execute the QDP Issuer contract before public announcement of contingent certification. Failure to execute the QDP Issuer contract may preclude Applicant from offering QDPs through the Exchange. The successful Applicants must be ready and able to accept enrollment as of October 1, 2019.

1.5 Application Process

The application process shall consist of the following steps:

- Release of the Final Application;
- Submission of Applicant responses;
- Evaluation of Applicant responses;
- Discussion and negotiation of final contract terms, conditions and premium rates; and
- Execution of contracts with the selected QDP Issuers.

1.6 Intention to Submit a Response

Applicants interested in responding to this application must submit a non-binding Letter of Intent to Apply, identifying their proposed products and service areas. Only those Applicants who submit the Letter of Intent will continue to receive application-related correspondence throughout the application process.

Applicant's Letter of Intent must identify the contact person for the application process, along with contact information that includes an email address and a telephone number. On receipt of the Letter of Intent, the Exchange will issue instructions and a password to gain access to the online Application. A Letter of Intent will be considered confidential and not available to the public. However, the Exchange reserves the right to release aggregate information about all Applicants' responses. Final Applicant information is not expected to be released until the selected Issuers and QDPs are announced. Applicant information will not be released to the public but may be shared with appropriate regulators as part of the cooperative arrangement between the Exchange and the regulators.

The Exchange will correspond with only one (1) contact person per Application. It is Applicant's responsibility to immediately notify the Application Contact identified in this section, in writing, regarding any revision to the contact information. The Exchange is not responsible for application correspondence not received by Applicant if Applicant fails to notify the Exchange, in writing, of any changes pertaining to the designated contact person.

Application Contact: Meiling Hunter
QHPCertification@covered.ca.gov
(916) 228-8696

1.7 Key Action Dates

Action	Date/Time
Release of Draft Application for Comment	December 2018
Letters of Intent due to the Exchange	February 15, 2019
Application Opens	March 1, 2019
Completed Applications Due (include 2020 Proposed Rates & Networks)	June 1, 2019
Negotiations between Applicants and Covered California	July 2019
Final QDP Contingent Certification Decisions	August 2019
QDP Contract Execution	September 2019
Final QDP Certification	October 2019

1.8 Preparation of Application Response

Application responses are completed in an electronic proposal software program. Applicants will have access to a Question and Answer function within the portal and may submit questions related to the Application through this mechanism.
Applicants must respond to each Application question as directed by the response type. Responses should be succinct and address all components of the question. Applicants may not submit documents in place of responding to individual questions in the space provided.

2 Administration and Attestation

Questions 2.1 and 2.3 are required for currently contracted Applicants. All questions required for new entrant Applicants.

2.1 Attestation

Applicant must complete the following:
No space for details provided.

Issuer Legal Name	*10 words.*
Entity name used in consumer-facing materials or communications	*10 words.*
NAIC Company Code	*10 words.*
NAIC Group Code	*10 words.*
Regulator(s)	*10 words.*
Federal Employer ID	*10 words.*
HIOS/Issuer ID	*10 words.*
Applicant tax status	*Single, Pull-down list.* 1: Not-for-profit, 2: For-profit
Year Applicant was founded	*10 words.*
Corporate Office Address	*10 words.*
City	*10 words.*
State	*10 words.*
Zip Code	*10 words.*
Primary Contact Name	*10 words.*
Contact Title	*10 words.*
Contact Phone Number	*10 words.*
Contact Email	*10 words.*
Applicant Eligibility	*Single, Pull-down list.* 1: Contracted in 2019, 2: New Entrant Applicant
Indicate if Applicant has completed the Qualified Dental Plan Application Plan Year 2020 Individual Marketplace.	*Single, Pull-down list.* 1: Yes, application will be completed, 2: No, application will not be completed

On behalf of Applicant stated above, I hereby attest that I meet the requirements in this Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that the Exchange may review the validity of my attestations and the information provided in response to this Application and if any Applicant is selected to offer Qualified Dental Plans, may decertify those Qualified Dental Plans should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the issuer stated above to the terms of this Application.	
Date	*10 words.*
Signature	*10 words.*
Printed Name	*10 words.*
Title	*10 words.*

2.2 Applicant must attach a functional organizational chart of key personnel who will be assigned to the Exchange. The chart will identify key individual(s) who will have primary responsibility for servicing the Exchange account and flow of responsibilities. The functional organizational chart should include the following representatives with contact information:

- Chief Executive Officer
- Chief Finance Officer
- Chief Operations Officer
- Contracts
- Plan and Benefit Design
- Network and Quality
- Enrollment and Eligibility
- Legal
- Marketing and Communications
- Information Technology
- Information Security
- Policy
- Dedicated Liaison

No space for details provided.
Single, Pull-down list.
Answer and attachment required
1: Attached,
2: Not attached

2.3 Does Applicant anticipate making material changes in corporate structure in the next 24 months, including but not limited to:

- Mergers
- Acquisitions
- New venture capital
- Management team
- Location of corporate headquarters or tax domicile

- Stock issue
- Other

If yes, Applicant must describe the material changes.
Single, Radio group.
1: Yes, describe [200 words] ,
2: No

2.4 Attach a copy of Applicant's Certificate of Insurance to verify that it maintains the following insurance:

Commercial General Liability	Limit of not less than $1,000,000 per occurrence/ $2,000,000 general aggregate
Comprehensive Business Automobile Liability	Limit of not less than 1,000,000 per accident
Employers Liability Insurance	Limits of not less than $1,000,000 per accident for bodily injury by accident and $1,000,000 per employee for bodily injury by disease and $1,000,000 disease policy limit.
Umbrella Policy	An amount not less than $10,000,000 per occurrence and in the aggregate
Crime Coverage	At such levels reasonably determined by Contractor to cover occurrences
Professional Liability or Errors and Omissions	Coverage of not less than $1,000,000 per claim/ $2,000,000 general aggregate.
Statutory CA's Workers' Compensation Coverage	Provide Proof of Coverage

If Applicant's organization does not carry the coverages or limits listed above, provide an explanation why Applicant has elected not to carry each coverage or limit.
Answer and attachment required
Single, Radio group.
1: Yes, attached,
2: No, attached, describe: [200 words]

2.5 Indicate any experience Applicant has participating in exchanges or marketplace environments
No space for details provided.

State-based Marketplace(s), specify state(s) and years of participation	*100 words.*
Federally-Facilitated Marketplace, specify state(s) and years of participation	*100 words.*

Private Exchange(s), specify exchange(s) and years of participation	*100 words.*

3 Licensed and Good Standing

Questions required only for new entrant Applicants.

3.1 Indicate Applicant license status below:
Single, Radio group.
1: Applicant currently holds all of the proper and required licenses from the California Department of Managed Health Care to operate as a dental issuer as defined herein in the commercial small group market,
2: Applicant currently holds all of the proper and required licenses from the California Department of Insurance to operate as a dental issuer as defined herein in the commercial small group market,
3: Applicant is currently applying for licensure from the California Department of Managed Health Care to operate as a dental issuer as defined herein in the commercial small group market. If Yes, enter date application was filed: [To the day] ,
4: Applicant is currently applying for licensure from the California Department of Insurance to operate as a dental issuer as defined herein in the commercial small group market. If yes, enter date application was filed: [To the day]

3.2 In addition to holding or pursuing all proper and required licenses to operate as a Dental Issuer, Applicant must confirm that it has had no material fines, no material penalties levied or material ongoing disputes with applicable licensing authorities in the last two years (See Appendix A Definition of Good Standing). The Exchange, in its sole discretion and in consultation with the appropriate dental insurance regulator, determines what constitutes a material violation for the purpose of determining Good Standing. Applicant must check the appropriate box. If Applicant does not confirm, the Application will be disqualified from consideration.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed
Attached Document(s): Appendix A Definition of Good Standing.pdf

3.3 If not currently holding a license to operate in California, confirm that Applicant has had no material fines, no material penalties levied, and no material ongoing disputes with applicable licensing authorities in the last two years.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed,
3: Not applicable

4 Applicant Health Plan Proposal

Questions 4.3 - 4.6 are required for currently contracted Applicants. Questions 4.1 – 4.5 are required for new entrant Applicants.

Applicant must submit a dental plan proposal in accordance with all requirements outlined in this section.

In addition to being guided by its mission and values, the Exchange's policies are derived from the Federal Affordable Care Act which calls upon the Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that have been implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability and prevention.

Applicant may submit proposals to offer both a Children's Dental Plan and a Family Dental Plan. Applicant may submit DPPO and DHMO product proposals in its proposed rating regions. Applicant's proposal must include coverage of its entire licensed geographic service area for which it has adequate network. Applicant may not submit a proposal that includes a tiered network. Applicants must adhere to the Exchange's standard benefit plan designs and the requirements in this section without deviation unless approved by the Exchange.

4.1 Applicant must certify its proposal includes a dental product including the pediatric dental Essential Health Benefit meeting an actuarial value of 85% for each individual plan it proposes to offer in a rating region. If not, Applicant's response will be disqualified from consideration.
No space for details provided.
Single, Pull-down list.
1: Yes, proposal meets requirements,
2: No

4.2 Applicant must confirm it will adhere to Exchange naming conventions for on-Exchange plans and off-Exchange mirror products where applicable, pursuant to Government Code 100503(f).
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

4.3 Preliminary Premium Proposals: Final negotiated and accepted premium rates shall be in effect for coverage effective January 1, 2020. Premium proposals are considered preliminary and may be subject to negotiation as part of QDP certification and selection. Premium proposals must be submitted with the Application. To submit premium proposals for Individual products, Applicant must complete and upload through System for Electronic Rate and Form

Filing (SERFF) the Rates Template available at: https://www.qhpcertification.cms.gov/s/QHP. Premium may vary only by geography (rating region), by age, and by actuarial value.

Dental plan premiums for adults 21 and over will be additive and calculated on a per member basis. The same rate must be charged for adults 19 years and older. The single adult rate will be assessed for each adult in the plan. The same rate must be charged for children age 0 – 18. The single child rate will be multiplied by two for a policy covering two children and by three for policies covering two or more children. Individuals ages 19 and 20 will be assessed the single adult rate, and only for purposes of summing total family premium will be considered as children when limiting the total family premium to no more than the three oldest covered children premiums together with covered adult premiums.

Applicant shall provide, in connection with any negotiation process as reasonably requested by the Exchange, detailed documentation on the Exchange-specific rate development methodology. Applicant shall provide justification, documentation, and support used to determine rate changes, including adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange-specific rate development process. This information may be necessary to support the assumptions made in forecasting and may be supported by information from Applicant's actuarial systems pertaining to the Exchange-specific account.
No space for details provided.
Single, Pull-down list.
1: Template Uploaded,
2: Template not Uploaded

4.4 Applicant must certify that for each rating region in which it submits a health plan proposal, it is submitting a proposal that covers the entire geographic service area for which it is licensed within that rating region. Complete Attachment A (Plan Type by Rating Region (Small Business Market)) to indicate the rating regions and number and type of plans for which Applicant is proposing a QHP in the Individual Exchange. To indicate which zip codes are within the licensed geographic service area by proposed Exchange product, complete and upload through SERFF the Service Area Template located at: https://www.qhpcertification.cms.gov/s/QHP.
No space for details provided.
Single, Pull-down list.
1: Yes, dental plan proposal covers entire licensed geographic service area; template uploaded, and attachment submitted,
2: No, dental plan proposal does not cover entire licensed geographic service area; template uploaded, and attachment submitted
Attached Document(s): Attachment A - Plan Type by Rating Region - Zip Code CCSB QDP.xlsx

4.5 Applicant must indicate if it is requesting changes to licensed geographic service area with the regulator, and if so, submit a copy of the applicable exhibit filed with regulator.
No space for details provided.
Single, Pull-down list.

1: Yes, filing service area expansion, exhibit attached,
2: Yes, filing service area withdrawal, exhibit attached,
3: No, no changes to service area

4.6 Applicant must complete and upload through SERFF the Plan ID Crosswalk located at: https://www.qhpcertification.cms.gov/s/QHP.
Single, Pull-down list.
1: Template completed and uploaded,
2: Template not completed and uploaded

5 Benefit Design

All questions are required for currently contracted Applicants and new entrant Applicants.

5.1 Applicant must certify its proposed dental products include the pediatric dental Essential Health Benefit meeting an actuarial value of 85% for each individual plan it proposes to offer in a rating region. If not, Applicant's response will be disqualified from consideration.
No space for details provided.
Single, Pull-down list.
1: Yes,
2: No

5.2 If applicable, Applicant must certify its proposed dental products include coverage of Diagnostic, Preventive, Restorative, Periodontics, Endodontics, Prosthodontics and Oral Surgery services for adults age 19 years and older comparable to those benefits found in Applicant's commercially available dental plan products for each individual plan it proposes to offer in a rating region. If not, Applicant's response will be disqualified from consideration.
No space for details provided.
Single, Pull-down list.
1: Yes,
2: No,
3: Not Applicable, only offering Children's Dental Plan

5.3 Applicant must comply with 2020 Patient-Centered Benefit Plans Designs. Applicant must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Plans and Benefits template located at: https://www.qhpcertification.cms.gov/s/QHP.
No space for details provided.
Single, Pull-down list.
1: Confirmed, template submitted,
2: Not confirmed, template not submitted

5.4 Applicant must submit, as an attachment, draft Evidence of Coverage or Policy language and draft Schedules of Benefits describing proposed 2020 QDP benefits.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached

5.5 Applicant must indicate how it provides plan enrollees with current information regarding annual out-of-pocket costs to date. Select all that apply.
Multi, Checkboxes.
1: Status of out-of-pocket costs provided through member login to the dental plan website,
2: Status of out-of-pocket costs provided by mailed document upon request,
3: Status of out-of-pocket costs available upon member request to customer service,
4: Other, describe: [20 words] ,
5: Status of out-of-pocket costs not provided

5.6 Applicant must indicate how it provides plan enrollees with current information regarding total oral health care services received to date. Select all that apply.
Multi, Checkboxes.
1: Status of oral health services received to date provided through member login to the dental plan website,
2: Status of oral health services received to date provided by mailed document upon request,
3: Status of oral health services received to date available upon member request to customer service,
4: Other, describe: [20 words] ,
5: Status of oral health services received to date not provided

5.7 If applicable, Applicant must indicate how it provides plan enrollees with current information regarding annual status of deductible and status of benefit limit. Select all that apply.
Multi, Checkboxes.
1: Status of deductible and benefit limit provided through member login to the dental plan website,
2: Status of deductible and benefit limit provided by mailed document upon request,
3: Status of deductible and benefit limit available upon member request to customer service,
4: Other, describe: [20 words] ,
5: Status of deductible and benefit limit not provided,
6: Not Applicable

5.8 Applicant must indicate if proposed QDPs will include coverage of non-emergent out-of-network services.
Single, Radio group.
1: Yes, proposed DPPO QDPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe the administration of out-of-network benefits including consumer communications, pricing methodology, and claims adjudication: [50 words] ,
2: No, proposed DPPO QDPs will not include coverage of non-emergent out-of-network services.,
3: No, offering a DHMO QDPs

6 Operational Capacity

6.1 Issuer Operations and Account Management Support

Questions 6.1.1 - 6.1.2 are required for currently contracted Applicants. All questions required for new entrant Applicants.

6.1.1 Applicant must complete Attachments C1 Current and Projected Enrollment and C2 California Off-Exchange Enrollment. Applicant must complete all data points for their lines of business (including Employer-Based coverage, Individual Market, and Government Payers) to provide current enrollment and enrollment projections. Failure to complete Attachments C1 and C2 will require a resubmission of the templates.
No space for details provided.
Single, Pull-down list.
Answer and attachment required
1: Attachments completed,
2: Attachments not completed
Attached Document(s): Attachments C1 C2 - CCSB QDP.xlsx

6.1.2 Applicant must provide a description of any initiatives over the next 24 months which may impact the delivery of services to Exchange enrollees including but not limited to: System changes or migrations, Call center openings, closings, or relocations, Network re-contracting, and vendor changes or other changes during the contract period. Applicant must include including a timeline, either current or planned.
200 words.

6.1.3 Does Applicant routinely subcontract any significant portion of its operations or partner with other companies to provide dental plan coverage? If yes, identify which operations are performed by subcontractor or partner and provide the name of the subcontractor.
No space for details provided.

	Response	Description	Conducted outside of the United States?
Billing, invoice, and collection activities	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*	*Single, Pull-down list.* 1: Yes, 2: No
Database and/or enrollment transactions	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*	*Single, Pull-down list.* 1: Yes, 2: No
Claims processing and invoicing	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*	*Single, Pull-down list.* 1: Yes, 2: No

Membership/customer service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*	*Single, Pull-down list.* 1: Yes, 2: No
Welcome package (ID cards, member communications, etc.)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*	*Single, Pull-down list.* 1: Yes, 2: No
Other (specify)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*	*Single, Pull-down list.* 1: Yes, 2: No

6.1.4 Applicant must provide a summary of its operational capabilities, including how long it has been a licensed dental issuer. For example, enrollment system, claims, provider services, sales, etc.
100 words.

6.2 Implementation Performance
Question 6.2.1 required for currently contracted Applicants. All questions are required for new entrant Applicants.
6.2.1 Applicant must complete Attachment F Implementation Organizational Chart and include a detailed implementation plan.
Answer and attachment required
Attached Document(s): Attachment F Implementation Organizational Chart.xlsx
Single, Radio group.
1: Yes attached, describe: [100 words] ,
2: No; Not attached,
3: No, Applicant is currently operating in the Exchange

6.2.2 Applicant must submit a Renewal and Open Enrollment Readiness Plan. Applicant must include in their plan a timeline (dates) for Communications (Regulated and Marketed), system and website updates and readiness, and trainings for staff and agents.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached

6.2.3 Applicant must describe current or planned procedures for managing new enrollees. Address availability of customer service prior to coverage effective date, new member orientations, and describe what member communications regarding change in plans are provided to new enrollees.
200 words.

6.2.4 Identify the percentage increase of membership that will require adjustment to Applicant's current resources:
No space for details provided.

Resource	Membership Increase (as % of Current Membership)	Resource Adjustment (specify)	Approach to Monitoring
Members Services	*Percent.*	*50 words.*	*50 words.*
Claims	*Percent.*	*50 words.*	*50 words.*
Account Management	*Percent.*	*50 words.*	*50 words.*
Clinical staff	*Percent.*	*50 words.*	*50 words.*
Disease Management staff	*Percent.*	*50 words.*	*50 words.*
Implementation	*Percent.*	*50 words.*	*50 words.*
Financial	*Percent.*	*50 words.*	*50 words.*
Administrative	*Percent.*	*50 words.*	*50 words.*
Actuarial	*Percent.*	*50 words.*	*50 words.*
Information Technology	*Percent.*	*50 words.*	*50 words.*
Other (List)	*Percent.*	*50 words.*	*50 words.*

7 Customer Service

Questions required only for new entrant Applicants.

7.1 Applicant must confirm it will respond to and adhere to the requirements of California Health and Safety Code Section 1368 relating to consumer grievance procedures.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

7.2 If certified, Applicant will be required to meet certain member services performance standards. During Open Enrollment, Exchange operating hours are 8 am to 8 pm Monday through Friday (except holidays) and 8 a.m. to 6 p.m. Saturdays. Applicant must confirm it will match Exchange Open Enrollment Customer Service operating hours. Describe how Applicant will modify customer service center operations to meet Exchange-required operating hours if applicable. Describe how Applicant will modify current Interactive Voice Response (IVR) system to meet exchange required operating hours.
Single, Radio group.
1: Confirmed, explain: [100 words] ,
2: Not confirmed

7.3 Applicant must list internal daily monitored Service Center Statistics. What is the daily service level goal? For example, 80% of calls answered within 30 seconds.
50 words.

7.4 Applicant must provide the ratio of Customer Service Representatives to members for teams that support Exchange business.
10 words.

7.5 Applicant must indicate which of the following training modalities are used to train new Customer Service Representatives, check all that apply:
Multi, Checkboxes.
1: Instructor-Led Training Sessions,
2: Virtual Instructor-Led Training Sessions (live instructor in a virtual environment),
3: Video Training,
4: Web-Based training (not Instructor-Led),
5: Self-led Review of Training Resources,
6: Other, describe: [50 words]

7.6 Applicant must indicate which training tools and resources are used during Customer Service Representative training, check all that apply:
Multi, Checkboxes.
1: Case-Study,
2: Roleplaying,
3: Shadowing,
4: Observation,

5: Pre-tests,
6: Post-tests,
7: Training Evaluations,
8: Other, describe: [50 words]

7.7 What is the length of the entire training period for new Customer Service Representatives? Include total time from point of hire to completion of training and release to work independently.
50 words.

7.8 How frequently are refresher trainings provided to all Customer Service Representatives? Include trainings focused on skills improvement as well as training resulting from changes to policy and procedures.
50 words.

7.9 Applicant must indicate languages spoken by Customer Service Representatives, and the number of bilingual Representatives who speak each language. Do not include languages supported only by a language line.
Multi, Checkboxes.
1: Arabic: [Integer] ,
2: Armenian: [Integer] ,
3: Cantonese: [Integer] ,
4: English: [Integer] ,
5: Hmong: [Integer] ,
6: Korean: [Integer] ,
7: Mandarin: [Integer] ,
8: Farsi: [Integer] ,
9: Russian: [Integer] ,
10: Spanish: [Integer] ,
11: Tagalog: [Integer] ,
12: Vietnamese: [Integer] ,
13: Lao: [Integer] ,
14: Cambodian: [Integer] ,
15: Other, specify: [50 words]

7.10 Does Applicant use language line to support consumers that speak languages other than those spoken by Customer Service Representatives?
Single, Radio group.
1: Yes, specify vendor: [20 words] ,
2: No

7.11 Applicant must describe any modifications to equipment, technology, consumer self-service tools, staffing ratios, training content and procedures, quality assurance program (or any other items that may impact the customer experience) that may be necessary to provide quality service to Exchange consumers.
100 words.

7.12 Applicant must indicate what information and tools are utilized to monitor consumer experience, check all that apply:
Multi, Checkboxes.
1: Customer Satisfaction Surveys,
2: Monitoring Social Media,
3: Monitoring Call Drivers,
4: Common Problems Tracking,
5: Observation of Representative Calls,
6: Other, describe: [50 words]

7.13 List all Customer Service Representative Quality Assurance metrics used for scoring of monitored call.
50 words.

7.14 Applicant must identify how many calls per Representative, per week are scored.
20 words.

8 Financial Requirements

Questions required only for new entrant Applicants.

8.1 Applicant must confirm it can provide detailed documentation as defined by Covered California in the NOD 23 (Gross to Network Report) as specified in Appendix J Issuer Payment Discrepancy Resolution and Appendix K NOD 23 Report Glossary.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed
Attached Document(s): Appendix K NOD 23 Report Glossary.pdf, Appendix J Issuer Payment Discrepancy Resolution.pdf

8.2 Applicant must confirm and describe in detail it can perform financial reconciliation at a member and group level for each monthly coverage period. For example: list validation steps taken.
Single, Radio group.
1: Yes, confirmed: [200 words] ,
2: No, not confirmed: [200 words]

9 Fraud, Waste and Abuse Detection

Questions 9.2.6 and 9.2.11 are required for currently contracted Applicants. All questions required for new entrant Applicants.

The Exchange is committed to working with its QDP issuers to minimize fraud, waste and abuse. The framework for managing fraud risks is detailed in Appendix O (located on the Manage Documents page) U.S. Government Accountability Office circular GAO-15-593SP (available in Manage Documents). The Exchange expects QDP issuers to adopt leading practices outlined in the framework to the extent applicable. Fraud prevention is centered on integrity and expected behaviors from employees and others. All measures to detect, deter, and prevent fraud before it occurs are vital to all Issuer and Exchange operations.

Definitions:

Fraud – Consists of an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury. (CA Civil Code §3294 (c)(3), CA Penal Code §§ 470-483.5). Prevention and early detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include, but are not limited to, false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered.

Waste - Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls.

Abuse – Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include, but not limited to, excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services.

External Audit – A formal process that includes an independent and objective examination of an organization's programs, operations, and records performed by a third party to evaluate and improve the effectiveness of its policies and procedures. The results, conclusions, and findings of an audit are formally communicated through an audit report delivered to management of the audited entity.

Internal Audit - Is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its

objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

Review – A second inspection and verification of documents for accuracy, validity, and authorization for compliance with procedural requirements.

9.1 Prevention / Detection / Response

9.1.1 Describe the roles and responsibilities of those tasked with carrying out dedicated antifraud and fraud risk management activities throughout the organization. If there is a dedicated unit responsible for fraud risk management describe how this unit interacts with the rest of the organization to mitigate fraud, waste and abuse.
200 words.

9.1.2 Applicant must describe anti-fraud strategies and controls including data analytics and fraud risk assessments to circumvent fraud, waste and abuse.
200 words.

9.1.3 Applicant must describe how findings/trends are communicated to the Exchange and other federal/state agencies, law enforcement, etc.
200 words.

9.1.4 Applicant must describe how they safeguard against Social Security number and identity theft within its organization.
200 words.

9.1.5 Once fraud is detected/or discovered what steps are taken to prevent fraudulent services to be paid. Applicant must describe the process to recoup erroneously paid claims from providers.
200 words.

9.1.6 Applicant must describe specific activities Applicant does to identify any violations in the Special Enrollment Period (SEP) policy. Describe the procedures in place to prevent and detect SEP violations. How are the adverse actions communicated to the Exchange?
200 words.

9.1.7 Indicate the types of claims and providers that Applicant typically reviews for possible fraudulent activity. Check all that apply
No space for details provided.
Multi, Checkboxes.
1: General Practice Dentist,
2: Pediatric Dentist,
3: Endodontist,
4: Oral and Maxillofacial Surgeon,
5: Orthodontist,
6: Periodontist,
7: Prosthodontist

9.1.8 Describe the different approaches Applicant takes to monitor the types of providers indicated above in question 9.1.7 for possible fraudulent activity. Applicant must provide an explanation why any provider types not indicated in 9.1.7 are not typically reviewed for possible fraudulent activity.
200 words.

9.1.9 Based on the definition of fraud in the introduction to this section, what was Applicant's recovery success rate and dollars recovered for fraudulent activities for each year below?
No space for details provided.

	Total Loss from Fraud Covered California book of business, if applicable	**Total Loss from Fraud** Total Book of Business	**% of Loss Recovered** Covered California book of business, if applicable	**% of Loss Recovered** Total Book of Business	**Total Dollars Recovered** Covered California book of business, if applicable	**Total Dollars Recovered** Total Book of Business
Calendar Year 2016	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*
Calendar Year 2017	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*
Calendar Year 2018	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*

9.1.10 If applicable, explain any trends attributing to the total loss from fraud for Exchange business.
200 words.

9.2 Audits and Reviews
9.2.1 Based on the definition of review in the introduction to this section, indicate how frequently reviews are performed for each of the following areas:
No space for details provided.

	Response	If other

Claims Administration Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*
Customer Service Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*
Eligibility and Enrollment Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*
Utilization Management Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*
Billing Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*

9.2.2 Based on the definition of internal audit in the introduction to this section, does Applicant maintain an independent, internal audit function? If yes, provide a brief description of Applicant's internal audit function, its reporting structure and what oversight authority is there over the internal audit function? For example: does the internal audit function report to a board, audit committee, or executive office?
Single, Radio group.
1: Yes, describe: [200 words] ,
2: No

9.2.3 If Applicant answered yes to 9.2.2, provide a copy of the organization's internal audit function's annual audit plan applicable to claims administration, eligibility and enrollment, billing, and network providers.
No space for details provided.
Single, Pull-down list.

1: Attached,
2: Not attached

9.2.4 If Applicant answered yes to 9.2.2, based on the definition of internal audit in the introduction to this section, indicate how frequently internal auditing is performed for the following areas:
No space for details provided.

	Response	If other
Audits of Claims Administration and Oversight	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other:	*10 words.*
Audits of Network Providers	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other:	*10 words.*
Audits of Eligibility and Enrollment Processes and Compliance with Requirements	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other:	*10 words.*
Audits of Billing Process	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other:	*10 words.*

9.2.5 What audit authority does Applicant have over network and non-network providers and contractors (for example: does Applicant conduct audits of network and non-network providers and contractors)?
200 words.

9.2.6 Based on the definition of external audit in the introduction to this section, indicate what external audits were conducted over the last three years by State and Federal Regulatory Agencies? For each audit, specify the year of the audit and the name of the agency that conducted the audit.

200 words.

9.2.7 Describe Applicant's approach to reviewing claims submitted by non-contracted providers, and steps taken when claims received exceed the reasonable and customary threshold.
200 words.

9.2.8 Describe Applicant's approach to the use of the National Practitioner Data Bank as part of the credentialing and re-credentialing process for contracted providers and any additional steps Applicant takes to verify a provider and facility is a legitimate place of business.
200 words.

9.2.9 Describe Applicant's controls in place to monitor referrals of enrollees to any health care facility or business entity in which the provider may have full or partial ownership or own shares. Attach a copy of the applicable conflict of interest statement.
200 words.

9.2.10 Applicant must describe in detail it's policy to validate provider information during initial contracting and when a provider reports a change (including demographic information, address, and network or panel status).
200 words.

9.2.11 Applicant must confirm that, if certified, it will agree to subject itself to the Exchange for audits and reviews, either by the Exchange or its designee, or the California Department of General Services, the California State Auditor or its designee, as they deem necessary to determine the correctness of premium rate setting, the Exchange's payments to agents based on the Issuer's report, questions pertaining to enrollee premium payments and participation fee payments Issuer made to the Exchange. Applicant also agrees to all audits subject to applicable State and Federal laws and regarding the confidentiality of and release of confidential Protected Health Information (PHI) of enrollees.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

10 System for Electronic Rate and Form Filing (SERFF)

All questions are required for currently contracted Applicants and new entrant Applicants.

10.1 Is Applicant able to populate and submit SERFF templates in an accurate, appropriate, and timely fashion at Exchange request for:

- Rates
- Service Area
- Benefit Plan Designs
- Network
- Plan ID Crosswalk

No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

10.2 Applicant confirms that it will submit and upload corrections to SERFF within three (3) business days of notification by the Exchange, adjusted for any SERFF downtime. Applicant must adhere to amendment language specifications when any item is corrected in SERFF.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

10.3 Applicant may not make any changes to its SERFF templates once submitted to the Exchange without providing prior written notice to the Exchange and only if the Exchange agrees in writing with the proposed changes.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

11 Electronic Data Interface

Questions 11.1 - 11.2 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

11.1 Applicant must provide an overview of its system, data model, vendors, and any anticipated changes interface partners, a copy of your release schedule and system lifecycle.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached

11.2 Applicant must be prepared and able to engage with the Exchange to develop data interfaces between Applicant's systems and the Exchange's systems, including the eligibility and enrollment system used by the Exchange, as early as May 2019. Applicant must confirm it will implement system(s) in order to accept and generate Group XML, 834, and other standard format electronic files for enrollment and premium remittance in an accurate, consistent and timely fashion and utilize the information received and transmitted for its intended purpose.

- See Appendix M 834 Companion Guide Design v2.2, Appendix Q CCSB 820 Companion Guide Design v2.0, and Appendix P CCSB Group XML Schema v2.1a for detailed transaction specifications.
- Note: The Exchange requires Applicants to sign an industry-standard agreement which establishes electronic information exchange standards to participate in the required systems testing.

No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed
Attached Document(s): Appendix Q CCSB EDI 820 Companion Guide V 2 0.pdf, Appendix P CCSB Group XML Schema v2.1a.pdf, Appendix M 834 Companion Guide Design v2.2.pdf

11.3 Applicant must describe its ability to produce financial, eligibility, and enrollment data monthly for reconciliation and experience processing and resolving errors identified by the Reconciliation Process as appropriate and in a timely fashion. Applicant must confirm that it has the capability to accept and complete non-electronic enrollment submissions and changes.
Single, Radio group.
1: Yes, confirmed: [200 words] ,
2: No, not confirmed: [200 words]

11.4 Applicant must communicate any testing or production changes to system configuration (URL, certification, bank information) to the Exchange in a timely fashion.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

11.5 Applicant must be prepared and able to conduct testing of data interfaces with the Exchange no later than August 1, 2019 and confirms it will plan and implement testing jointly with the Exchange to meet system release schedules. Applicant must confirm testing with the Exchange will utilize industry security standards: firewall, certification, and fingerprint. Applicant must confirm it will make dedicated, qualified resources available to participate in the connectivity and testing effort.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

11.6 Applicant must confirm and describe how they proactively monitor and measure system response time and performance processing new enrollment and enrollment changes?
Single, Radio group.
1: Yes, describe [100 words] ,
2: No, describe [100 words]

12 Healthcare Evidence Initiative

To fulfill its mission to ensure that consumers have available the plans that offer the optimal combination of choice, value, quality, and service, the Exchange relies on evidence about the enrollee experience with health care. The timely and accurate submission of QDP data is an essential component of assessing the quality and value of the coverage and health care received by Exchange enrollees.

This section not required if Applicant has completed the Qualified Dental Plan Application Plan Year 2020 Individual Marketplace.

Questions required only for new entrant Applicants.

12.1 Applicant must describe any contractual agreements with participating providers that preclude Applicant's organization from making contract terms transparent to plan sponsors and members.
Applicant must confirm that, if contracted as a QDP issuer, to the extent that any Participating Provider's rates are prohibited from disclosure to the Exchange by contract, Applicant shall identify such Participating Provider. Applicant shall, upon renewal of its Provider contract, but in no event later than July 1, 2020, make commercially reasonable efforts to obtain agreement by that Participating Provider to amend such provisions, to allow disclosure. In entering into a new contract with a Participating Provider, Applicant agrees to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to the Exchange (for example, enrollment, medical and prescription claims, and capitation data required by the Exchange's Healthcare Evidence Initiative (HEI) Vendor: allowed amounts; charge and charge submitted amounts; coinsurance, copayment, and deductible amounts; paid and net payment amounts; patient total out-of-pocket amounts; capitation amounts, etc.).

- What specific steps is Applicant taking to change these contract provisions going forward to make this information accessible?
- List provider groups or facilities for which current contract terms preclude provision of information to plan sponsors.
- List provider groups or facilities for which current contract terms preclude provision of information to members.

Single, Radio group.
1: Confirmed, describe [500 words] ,
2: Not confirmed, describe [500 words]

12.2 Applicant must provide the Exchange's HEI Vendor with monthly extracts of all requested detail from applicable fee-for-service (FFS) claims or encounter records for the following claim types. If not, or if yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic claim types, estimating the number and percentage of affected claims and encounters.
No space for details provided.

Claim Type	Response	If No or Yes with deviation, explain.

Professional	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Institutional	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Pharmacy, if applicable	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Drug (non-Pharmacy), if applicable	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

12.3 The Exchange is interested in QDP Issuer data that represents the cost of care. Can Applicant provide monthly extracts of complete financial detail for all applicable claims and encounters? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested financial detail, elaborate on problematic data elements, estimating the number and percentage of affected claims and encounters.
No space for details provided.

Financial Detail to be Provided	Response	If No or Yes with deviation, explain.
Submitted Charges	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Discount Amount	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Allowable Charges	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Copayment	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Coinsurance	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Deductibles	*Single, Pull-down list.*	*50 words.*

	1: Yes, 2: No	
Coordination of Benefits	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Plan Paid Amount (Net Payment)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Capitation Financials (per Provider / Facility) ***[1]*** *If a portion of Applicant provider payments are capitated. If capitation does not apply, check "No" and state "Not applicable, no provider payments are capitated" in the rightmost column.*	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

12.4 Can Applicant provide member and subscriber IDs assigned by the Exchange on all records submitted? In the absence of other Personally Identifiable Information (PII), these elements are critical for the HEI Vendor to generate unique encrypted member identifiers linking eligibility to claims and encounter data, enabling the HEI Vendor to follow the health care experience of each de-identified member, even if he or she moves from one plan to another. If not, or if yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic data elements, estimating the number and percentage of affected enrollments, claims, and encounters.
No space for details provided.

Detail to be Provided	Response	If No or Yes with deviation, explain.
Covered CA Member ID	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Covered CA Subscriber ID	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

12.5 Can Applicant supply dates, such as starting date of service, in full year / month / day format to the HEI Vendor for data aggregation? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic dates, estimating the number and percentage of affected enrollments, claims, and encounters
No space for details provided.

PHI Dates to be Provided in Full Year / Month / Day Format	Response	If No or Yes with deviation, explain.
Member Date of Birth	*Single, Pull-down list.*	*50 words.*

	1: Yes, 2: No	
Starting Date of Service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Ending Date of Service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

12.6 Can Applicant supply all applicable Provider Tax ID Numbers (TINs) and National Provider Identifiers (NPIs) for individual providers? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic Provider IDs, estimating the number and percentage of affected providers, claims, and encounters.
No space for details provided.

Provider IDs to be Supplied	Response	If No or Yes with deviation, explain.
TIN	*Single, Pull-down list.* 1: Yes, 2: Yes, unless values represent individual provider Social Security Numbers, 3: No	*50 words.*
NPI	*Single, Pull-down list.* 1: Yes, 2: Yes, unless values represent individual provider Social Security Numbers, 3: No	*50 words.*

12.7 Can Applicant provide detailed coding for procedures, etc. on all claims for all data sources? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested coding detail, elaborate on problematic coding, estimating the number and percentage of affected claims and encounters.
No space for details provided.

Coding to be Provided	Response	If No or Yes with deviation, explain.
Procedure Coding (CDT, HCPCS)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Revenue Codes (Facility Only)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

Place of Service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

12.8 Can Applicant submit all data directly to the HEI Vendor or is a third party required to submit the data on Applicant's behalf?
Single, Radio group.
1: Yes, describe [50 words] ,
2: No

12.9 If data must be submitted by a third party, can Applicant guarantee that the same information above will also be submitted by the third party?
Single, Radio group.
1: Yes, describe: [50 words] ,
2: No,
3: Not Applicable

13 Privacy and Security Requirements for Personally Identifiable Data

This section not required if Applicant has completed the Qualified Dental Plan Application Plan Year 2020 Individual Marketplace.

Questions required only for new entrant Applicants.

13.1 HIPAA Privacy Rule

Applicant must confirm that it complies with the following privacy-related requirements set forth within Subpart E of the Health Insurance Portability and Accountability Act [45 CFR §164.500 et. seq.]:

13.1.1 Individual access: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it provides enrollees with the opportunity to access, inspect and obtain a copy of any Protected Health Information (PHI) contained within their Designated Record Set [45 CFR §§164.501, 524].

No space for details provided.

Single, Pull-down list.

1: Yes, confirmed,

2: No, not confirmed

13.1.2 Amendment: Applicant must confirm that it provides enrollees with the right to amend inaccurate or incomplete PHI contained within their Designated Record Set [45 CFR §§164.501, 526].

No space for details provided.

Single, Pull-down list.

1: Yes, confirmed,

2: No, not confirmed

13.1.3 Restriction Requests: Applicant must confirm that it provides enrollees with the opportunity to request restrictions upon Applicant's use or disclosure of their PHI [45 CFR §164.522(a)].

No space for details provided.

Single, Pull-down list.

1: Yes, confirmed,

2: No, not confirmed

13.1.4 Accounting of Disclosures: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it provides enrollees with an accounting of any disclosures made by Applicant of the enrollee's PHI upon the enrollee's request [45 CFR §164.528].

No space for details provided.

Single, Pull-down list.

1: Yes, confirmed,

2: No, not confirmed

13.1.5 Confidential Communication Requests: Applicant must confirm that Applicant permits enrollees to request an alternative means or location for receiving their PHI than what Applicant would typically employ [45 CFR §164.522(b)].
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

13.1.6 Minimum Necessary Disclosure & Use: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that Applicant discloses or uses only the minimum necessary PHI needed to accomplish the purpose for which the disclosure or use is being made [45 CFR §§164.502(b) & 514(d)].
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

13.1.7 Openness and Transparency: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that Applicant currently maintains a HIPAA-compliant Notice of Privacy Practices to ensure that enrollees are aware of their privacy-related rights and Applicant's privacy-related obligations related to the enrollee's PHI [45 CFR §§164.520(a)&(b)].
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

13.2 Safeguards
13.2.1 Applicant must confirm that it has policy, standards, processes, and procedures in place and that its information system is configured with administrative, physical and technical security controls that meet or exceed those standards in the National Institute of Standards and Technology, Special Publication (NIST) 800-53 that appropriately protect the confidentiality, integrity, and availability of the Protected Health Information (PHI) and Personally Identifiable Information (PII) that it creates, receives, maintains, or transmits.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

13.2.2 Applicant must confirm that all Protected Health Information (PHI) and Personally Identifiable Information (PII) is encrypted - both at rest and in transit - employing the validated Federal Information Processing Standards (FIPS) Publication 140-2 Cryptographic Modules.
No space for details provided.
Single, Pull-down list.

1: Yes, confirmed,
2: No, not confirmed

13.2.3 Applicant must confirm that it operates in compliance with applicable federal and state security and privacy laws and regulations, and has an incident response policy, process, and procedures in place and can verify that the process is tested at least annually.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

13.2.4 Applicant must confirm that there is a contingency plan in place that addresses system restoration without deterioration of the security measures originally planned and implemented, and that the plan is tested at least annually.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

13.2.5 Applicant must confirm that when disposal of PHI, PII or the decommissioning of media occurs they adhere to the guidelines for media sanitization as described in the NIST Special Publication 800-88.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

14 Sales Channels

Question 14.1 is required for currently contracted Applicants. All questions required for new entrant Applicants.

14.1 Applicant must provide its Agent of Record (AOR) Commission Schedule for the small group market in California. Note: successful Applicants will be required to use a standardized Agent commission program with levels and terms that result in the same aggregate compensation amounts to Agents whether products are sold within or outside of the Exchange. Successful Applicants may not vary Agent compensation levels by metal tier and must pay the same commission during Open and Special Enrollment for each plan year.
No space for details provided.

Small Business Market - Commission Rate	**Off-Exchange Business**
Provide AOR Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any.	*50 words.*
Provide AOR Change Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any.	*50 words.*
Does the compensation level change as the business written by the agent matures? (i.e., Downgraded)	*50 words.*
Specify if the agent is compensated at a higher level as he or she attains certain levels or amounts of in force business.	*50 words.*
Does the compensation level apply to all plans or does it vary by plan? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	*50 words.*
Does compensation level vary by product? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	*50 words.*
Describe any business for which Applicant will not compensate Agents.	*50 words.*
Describe any business for which Applicant will not make changes to Agent of Record.	*50 words.*
Additional Comments	*100 words.*

14.2 Applicant must provide a copy of the sales team organizational chart. If applicable, Applicant must identify a primary point of contact for agent services and include the following contact information:

- Name (if applicable)
- Phone Number
- Email Address

50 words.

15 Marketing and Outreach Activities

Questions 15.4 and 15.5 required for currently contracted Applicants. All questions are required for new entrant Applicants.

15.1 The Exchange expects all successful Applicants to promote enrollment in their certified QDPs, including investment of resources and coordination with the Exchange's marketing and outreach efforts. Applicant must provide an organizational chart of its small group sales and/or marketing department(s), including names and titles. Applicant must identify the individual(s) with primary responsibility for sales and marketing of the Exchange Small Business product line, indicate where these individuals fit into the organizational chart and include the following contact information for those who will work on Covered California sales and marketing efforts: name, title, phone number, and email address. Indicate staff members who will oversee Member Communication, Social Media efforts, point of sales collateral materials, and submission of co-branded materials for Exchange review.
No space for details provided.
Single, Pull-down list.
Attachment required
1: Attached,
2: Not attached

15.2 Applicant must confirm that, upon contingent certification of its QDPs, it will cooperate with the Exchange Marketing Department and adhere to the Covered California Brand Style Guide, located at http://hbex.coveredca.com/toolkit/PDFs/Brand_Style_Guide.pdf, (and Marketing Guidelines, if applicable) when co-branding materials are issued to Exchange enrollees. If Applicant is certified, co-branded items must be submitted in a timely manner, but no later than before the material is used; ID cards must be submitted to the Exchange at least 30 days prior to Open Enrollment.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

15.3 Applicant must confirm it will cooperate with Exchange Marketing, Public Relations, and Outreach efforts, which may include: internal and external trainings, press events, social media efforts, collateral materials, member communications, and other efforts. This cooperative obligation includes contractual requirements to submit materials and updates according to deadlines established in the QDP Issuer Model Contract.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

15.4 Applicant submit the following for the Exchange Small Business Market: (1) Proposed Marketing Plan, including the following components:

- Strategy for employer and agent communications,
- Target audience parameters (company size, industry segment),

- (2) Attachment D2 Media Plan Flowchart

No space for details provided.
Single, Pull-down list.
1: Marketing Plan and Attachment D2 Attached,
2: Not attached
Attached Document(s): Attachments D2 D3 - CCSB QDP.xlsx

15.5 Applicant must use Attachment D3 Estimated Annual Marketing Budget by Geography template to indicate estimated total expenditures for Small Group Marketplace related to marketing and advertising functions.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached
Attached Document(s): Attachments D2 D3 - CCSB QDP.xlsx

16 Provider Network

16.1 Network Offerings

All questions are required for currently contracted Applicants and new entrant Applicants.

16.1.1 Applicant must indicate the different network products it intends to offer on the Exchange in the Covered California for Small Business market for coverage year 2020.
No space for details provided.

	Offered	New or Existing Network?	Has Network been Proposed for Individual Exchange Plan Year 2019?	Network Name(s)
HMO	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: New Network, 2: New to Exchange, 3: Existing Exchange	*Single, Pull-down list.* 1: Yes, 2: No	*10 words.*
PPO	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: New Network, 2: New to Exchange, 3: Existing Exchange	*Single, Pull-down list.* 1: Yes, 2: No	*10 words.*

16.1.2 Provider network data must be included in this submission for all geographic locations to which Applicant is applying for certification as a QDP. Submit provider data according to the data file layout in the Covered California Provider Data Submission Guide, https://hbex.coveredca.com/stakeholders/plan-management/library/Covered-California-Provider-Data-Submission-Guide-V1.9.pdf. The provider network submission for 2020 must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QDP Issuer. The Exchange requires the information, as requested, to allow cross-network comparisons and evaluations.
No space for details provided.
Single, Pull-down list.
1: Attached (confirming provider data is for plan year 2020),
2: Not attached

16.1.3 Applicant must complete and upload through SERFF the Network ID Template located at: https://www.qhpcertification.cms.gov/s/QHP.
No space for details provided.
Single, Pull-down list.
1: Template uploaded,
2: Template not uploaded

16.2 HMO

16.2.1 Network Strategy

All questions are required for Applicants that are new entrants or proposing new networks.

If network has been proposed for products offered in the Individual Exchange, this section is not required for that network.

16.2.1.1 Applicant must complete all tabs in Attachment K1 DHMO Provider Network Tables, for their HMO Network.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached
Attached Document(s): Attachment K1 DHMO Provider Network Tables.xlsx

16.2.1.2 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization?
No space for details provided.
Single, Pull-down list.
1: Applicant contracts and manages network,
2: Applicant leases network

16.2.1.3 If Applicant leases its network, describe the terms of the lease agreement:
No space for details provided.

	Response
Length of the lease agreement	*100 words.*
Start Date	*To the day.*
End Date	*To the day.*
Leasing Organization	*100 words.*

16.2.1.4 If Applicant leases network, does Applicant have the ability to influence provider contract terms for (select all that apply):
Multi, Checkboxes.
1: Transparency,
2: Implementation of new programs and initiatives,
3: Acquire timely and up-to-date information on providers,
4: Ability to obtain data from providers,
5: Ability to conduct outreach and education to providers if need arises,
6: Ability to add new providers,

7: If no, describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

16.2.1.5 Describe in detail how Applicant ensures access to care for all enrollees. This should include:

- If Applicant assesses geographic access to primary and specialist care based on enrollee residence describe tools and brief methodology
- If Applicant tracks ethnic and racial diversity in the population and ensure access to appropriate culturally competent providers, describe tools and brief methodology

200 words.

16.2.1.6 Many California residents live in counties bordering other states where the out of state services are closer than in-state services. Does Applicant offer coverage in a California county or region bordering another state?
No space for details provided.
Single, Radio group.
1: Yes. If yes, does Applicant allow out of state (non-emergency) providers to participate in networks to serve Exchange enrollees?,
2: No

16.2.1.7 If Applicant answered yes to 16.2.1.6, explain in detail how this coverage is offered.
500 words.

16.2.2 Network Quality

All questions are required for currently contracted Applicants and new entrant Applicants. If network has been proposed for products offered in the Individual Exchange, this section is not required for that network.

16.2.2.1 Does Applicant currently use patient safety as a criterion for provider selection for Exchange networks? If yes, describe in detail, including the assessment process, the source of the patient safety assessment data, specific measures and metrics, thresholds for inclusion and exclusion.
Single, Radio group.
1: Yes, explain: [100 words] ,
2: No

16.2.2.2 Does Applicant currently use cost efficiency as a criterion for provider selection for Exchange networks? If yes, describe in detail, including the assessment process, the source of the assessment data, specific measures and metrics, thresholds for inclusion and exclusion.
Single, Radio group.
1: Yes, explain: [100 words] ,
2: No

16.2.2.3 Does Applicant currently use patient reported experience as a criterion for provider selection for Covered California networks? If yes, describe in detail, including the assessment process, the source of the patient reported experience assessment data, specific measures and metrics, thresholds for inclusion and exclusion.
Single, Radio group.
1: Yes, explain: [100 words] ,
2: No

16.2.2.4 To what extent does Applicant encourage use of high quality network dental providers?
Multi, Checkboxes.
1: Auto-assign members to high-performing dental providers,
2: Identify high-performing providers through the provider directory or other web site location,
3: Customer service referral to dental provider,
4: Other (explain): [100 words] ,
5: Applicant does not encourage use of high-performing dental providers

16.2.2.5 If Applicant encourages use of high-performing dental providers, what criteria does Applicant use to identify high-performing providers?
Multi, Checkboxes.
1: Dental quality measures,
2: Health improvement initiatives,
3: Preventive services rendered,
4: Patient satisfaction,
5: Low occurrence of complaints and grievances,
6: Other (explain): [100 words] ,
7: Applicant does not encourage use of high-performing dental providers

16.2.2.6 If Applicant does not currently identify or encourages use of high-performing dental providers, report how Applicant intends to identify high-performing dental providers.
200 words.

16.2.3 Network Stability

All questions are required for currently contracted Applicants and new entrant Applicants. If network has been proposed for products offered in the Individual Exchange, this section is not required for that network.

16.2.3.1 Describe any plans for network additions, by product, including any new dental provider groups or clinic systems that Applicant would like to highlight for Exchange attention.
100 words.

16.2.3.2 Provide information on any known or anticipated potential network disruption that may affect Applicant's 2020 provider networks. For example: list any pending terminations of dental groups which can include Independent Practice Associations.
100 words.

16.3 PPO

16.3.1 Network Strategy

All questions are required for Applicants that are new entrants or proposing new networks. If network has been proposed for products offered in the Individual Exchange, this section is not required for that network.

16.3.1.1 Applicant must complete all tabs in Attachment K2 DPPO Provider Network Tables, for their PPO Network.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached
Attached Document(s): Attachment K2 DPPO Provider Network Tables.xlsx

16.3.1.2 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization?
No space for details provided.
Single, Pull-down list.
1: Applicant contracts and manages network,
2: Applicant leases network

16.3.1.3 If Applicant leases network, describe the terms of the lease agreement:
No space for details provided.

	Response
Length of the lease agreement	*100 words.*
Start Date	*To the day.*
End Date	*To the day.*
Leasing Organization	*100 words.*

16.3.1.4 If Applicant leases network, does Applicant have the ability to influence provider contract terms for (select all that apply):
Multi, Checkboxes.
1: Transparency,
2: Implementation of new programs and initiatives,
3: Acquire timely and up-to-date information on providers,
4: Ability to obtain data from providers,
5: Ability to conduct outreach and education to providers if need arises,
6: Ability to add new providers,

7: If no, please describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

16.3.1.5 Describe in detail how Applicant ensures access to care for all enrollees. This should include:

- If Applicant assesses geographic access to primary and specialist care based on enrollee residence, describe tools and brief methodology.
- If Applicant tracks ethnic and racial diversity in the population and ensure access to appropriate culturally competent providers, describe tools and brief methodology

200 words.

16.3.1.6 Many California residents live in counties bordering other states where the out of state services are closer than in-state services. Does Applicant offer coverage in a county or region bordering another state?
No space for details provided.
Single, Radio group.
1: Yes. If yes, does Applicant allow out of state (non-emergency) providers to participate in networks to serve Exchange enrollees?,
2: No

16.3.1.7 If Applicant answered yes to 16.3.1.6, explain in detail how this coverage is offered.
500 words.

16.3.2 Network Quality

All questions are required for currently contracted Applicants and new entrant Applicants. If network has been proposed for products offered in the Individual Exchange, this section is not required for that network.

16.3.2.1 Does Applicant currently use patient safety as a criterion for provider selection for Exchange networks? If yes, describe in detail, including the assessment process, the source of the patient safety assessment data, specific measures and metrics, thresholds for inclusion and exclusion.
Single, Radio group.
1: Yes, explain: [100 words] ,
2: No

16.3.2.2 Does Applicant currently use cost efficiency as a criterion for provider selection for Exchange networks? If yes, describe in detail, including the assessment process, the source of the assessment data, specific measures and metrics, thresholds for inclusion and exclusion.
Single, Radio group.
1: Yes, explain: [100 words] ,
2: No

16.3.2.3 Does Applicant currently use patient reported experience as a criterion for provider selection for Covered California networks? If yes, describe in detail, including the assessment process, the source of the patient reported experience assessment data, specific measures and metrics, thresholds for inclusion and exclusion.
Single, Radio group.
1: Yes, explain: [100 words] ,
2: No

16.3.2.4 To what extent does Applicant encourage use of high quality network dental providers?
Multi, Checkboxes.
1: Auto-assign members to high-performing dental providers,
2: Identify high-performing providers through the provider directory or other web site location,
3: Customer service referral to dental provider,
4: Other (explain): [100 words] ,
5: Applicant does not encourage use of high-performing dental providers

16.3.2.5 If Applicant encourages use of high-performing dental providers, what criteria does Applicant use to identify high-performing providers?
Multi, Checkboxes.
1: Dental quality measures,
2: Health improvement initiatives,
3: Preventive services rendered,
4: Patient satisfaction,
5: Low occurrence of complaints and grievances,
6: Other (explain): [100 words] ,
7: Applicant does not encourage use of high-performing dental providers

16.3.2.6 If Applicant does not currently identify or encourage use of high-performing dental providers, report how Applicant intends to identify high-performing dental providers.
200 words.

16.3.3 Network Stability

All questions are required for currently contracted Applicants and new entrant Applicants. If network has been proposed for products offered in the Individual Exchange, this section is not required for that network.

16.3.3.1 Describe any plans for network additions, by product, including any new dental provider groups or clinic systems that Applicant would like to highlight for Exchange attention.
100 words.

16.3.3.2 Provide information on any known or anticipated potential network disruption that may affect Applicant's 2020 provider networks. For example: list any pending terminations of dental groups which can include Independent Practice Associations.
100 words.

17 Essential Community Providers

Question required only for new entrant Applicants.

17.1 Applicant must demonstrate that its QDP proposals meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network. All the criteria below must be met.

1. Applicants must use Essential Community Provider Network Data Submission to indicate contracts with all providers designated as ECP.
2. Applicants must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area.

The Exchange will evaluate whether Applicant's essential community provider network has achieved the sufficient geographic distribution and requirements.

Federal regulations currently require health issuers to adhere to rules regarding payment to non-contracted FQHCs for services when those services are covered by the QDP's benefit plan. Certified QDPs will be required in their contract with the Exchange to operate in compliance with all federal regulations issued pursuant to the Affordable Care Act, including those applicable to essential community providers.

Essential Community Providers include dental providers included in the Covered California Consolidated Essential Community Provider List available at:
http://hbex.coveredca.com/stakeholders/plan-management/ecp-list/

Low-income is defined as a family at or below 200% of Federal Poverty Level. The ECP data supplied by Applicant will allow the Exchange to plot contracted ECPs on maps to compare contracted providers against the supply of ECPs and the distribution of low-income Covered California enrollees.

18 Quality

This section not required if Applicant has completed the Qualified Dental Plan Application Plan Year 2020 Individual Marketplace.

18.1 Quality Improvement Strategy

Questions 18.1.1 and 18.1.2 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

18.1.1 Consistent with the Exchange's mission to promote better care, better health and lower cost as part of a Quality Improvement Strategy, Applicants must confirm it will implement a quality assurance program in accordance with Title 2, CCR, Section 1300.70, for evaluating the appropriateness and quality of the covered services provided to member.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

18.1.2 Applicant must confirm it will maintain a system of accountability for quality improvement in accordance with all applicable statutes and regulations, monitoring, evaluating and taking effective action to address any needed improvements, as identified by the Exchange, in the quality of care delivered to members.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

18.1.3 QIP #1: Describe a Quality Improvement Project (QIP) conducted by Applicant within the last five (5) years. Include information about results of the QIP, why the QIP was undertaken and why it ended or has continued, if applicable. Describe the QIP scalability, if it was successful. Also include the following information:

- Start/End Dates:
- QIP Name/Title:
- Problem Addressed:
- Rationale (why selected):
- Targeted Population:
- Study Indicator(s):
- Baseline Measurement:
- Results:
- What best practices have been implemented to sustain Improvement (if any):

500 words.

18.1.4 QIP #2: Describe a second Quality Improvement Project (QIP) conducted by Applicant within the last five (5) years. Include information about results of the QIP, why the QIP was undertaken and why it ended or has continued, if applicable. Describe the QIP scalability, if it was successful. Also include the following information:

- Start/End Dates:

- QIP Name/Title:
- Problem Addressed:
- Rationale (why selected):
- Targeted Population:
- Study Indicator(s):
- Baseline Measurement:
- Results:
- What best practices have been implemented to sustain Improvement (if any):

500 words.

18.2 Care Management

All questions are required for currently contracted Applicants and new entrant Applicants.

18.2.1 Applicant must confirm it will make available to Exchange enrollees the following programs and services

No space for details provided.

Care Reminders	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed
Risk Assessments	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed
Disease Management Programs	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed

18.2.2 Which of the following activities are used or will be by Applicant to encourage use of diagnostic and preventive services?

Multi, Checkboxes.

1: Mailed printed materials about preventive services with $0 cost-share to members (oral exam, cleaning, X-rays),

2: Emails sent to membership about preventive services with $0 cost-share to members (oral exam, cleaning, X-rays),

3: Automated outbound telephone reminders about preventive services with $0 cost-share to members (oral exam, cleaning, X-rays),

4: Other (explain): [100 words] ,

5: No current activities used to encourage use of preventive services; discuss any planned activities to encourage use of diagnostic and preventive services: [100 words]

18.2.3 If Applicant indicated that any of the activities in 18.2.2 are used to encourage use of diagnostic and preventive services, upload as an attachment screenshots or other materials demonstrating these activities.

200 words.

18.2.4 Which of the following activities are used or will be by Applicant to communicate oral health and wellness (i.e. self-care for maintaining good oral health)?
Multi, Checkboxes.
1: Mailed printed materials about oral health self-care,
2: Emails sent to membership about oral health self-care,
3: Other (please explain): [100 words] ,
4: No current activities used to encourage oral health self-care; discuss any planned activities to communicate oral health and wellness information to Enrollees: [100 words]

18.2.5 If Applicant indicated that any of the activities in 18.2.4 are used to communicate oral health and wellness, please upload as an attachment screenshots or other materials demonstrating these activities.
200 words.

18.2.6 Indicate the availability of the following demand management activities and health information resources for Exchange members. (Check all that apply)
Multi, Checkboxes.
1: Teledentistry,
2: Decision support,
3: Self-care books,
4: Electronic Preventive care reminders,
5: Web-based health information,
6: Web-based self-care resources,
7: Integration with other health care vendors,
8: Other (describe): [200 words]

18.3 Health Status and Risk Assessment
All questions are required for currently contracted Applicants and new entrant Applicants.

18.3.1 Indicate features of the oral health risk assessment to determine enrollee oral health status. Select all that apply.
No space for details provided.
Multi, Checkboxes.
1: Oral health risk assessment offered online or in print,
2: Oral health risk assessment offered through telephone interview with a live person,
3: Oral health risk assessment offered in multiple languages,
4: Upon completion of oral health risk assessment, risk-factor education is provided to member based on member-specific risk, e.g. if member reports tobacco use, education is provided on gum disease risk,
5: Personalized oral health risk assessment report is generated with risk modification actions,
6: Member is directed to interactive intervention module for behavior change upon risk assessment completion,
7: Email on self-care generated based on enrollee responses,
8: Email or phone call reminders to schedule preventive or diagnostic visits generated based

on enrollee responses,
9: Oral health risk assessment not offered

18.3.2 Does Applicant collect information on enrollee oral health status using any of the following sources of data? Select all that apply.
Multi, Checkboxes.
1: Oral health risk assessment,
2: Claims data,
3: Other (please explain): [100 words] ,
4: Data on oral health status not collected

18.3.3 Discuss any planned activities to build capacity or systems to determine enrollee oral health status, including member outreach or communication strategies to encourage the use of oral health risk self-assessment offered by Applicant.
100 words.

18.3.4 Does Applicant use any of the following sources of data to track changes in oral health status among Plan Enrollees? Select all that apply.
Multi, Checkboxes.
1: Oral health risk assessment,
2: Claims data,
3: Other (please explain): [200 words] ,
4: Data on oral health status not used

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

18.3.6 How does Applicant currently identify at-risk enrollees, which may include members with existing or newly diagnosed needs for dental treatment or members with co-morbid conditions?
Single, Radio group.
1: Claims data,
2: Website registration prompts self-report of existing/newly diagnosed need for dental treatment and/or co-morbid conditions,
3: Oral health risk assessment,
4: Other (please explain): [200 words] ,
5: Plan does not currently identify at-risk enrollees

18.3.7 Discuss any planned activities to identify at-risk enrollees.
100 words.

18.3.8 Report the number of enrollees who have been identified as “at-risk.”
No space for details provided.

	Exchange Enrollees, if applicable	Book of Business
Number of enrollees who have been identified as “at-risk”	*Integer.*	*Integer.*
Number of enrollees	*Integer.*	*Integer.*

18.4 Enrollee Population Management
All questions are required for currently contracted Applicants and new entrant Applicants.

18.4.1 Describe practices in place to address population health management across enrolled members. Include measurement strategy and any specific ability to track impact on Exchange enrollees.
100 words.

18.4.2 Describe ability to track and monitor member satisfaction. Include measurement strategy and any specific ability to track impact on Exchange enrollees.
100 words.

18.4.3 Describe ability to track and monitor cost and utilization management. Include measurement strategy and any specific ability to track impact on Exchange enrollees.
100 words.

18.4.4 Describe ability to track and monitor clinical outcome quality. Include measurement strategy and any specific ability to track impact on Exchange enrollees.
100 words.

18.5 Innovations
Question required only for new entrant Applicants.

18.5.1 Describe institutional capacity to plan, implement, evaluate, and replicate future healthcare quality and cost innovations for Exchange Members. Of special interest to Exchange are programs with focus on at-risk enrollees (e.g.: communities at risk for health disparities, enrollees with chronic-conditions and those who live in medically underserved areas).
200 words.

18.6 Reducing Health Disparities and Ensuring Health Equity

All questions are required for currently contracted Applicants and new entrant Applicants.

18.6.1 Identify the sources of data used to gather members' race/ethnicity, primary language, and disability status. The response “enrollment form” pertains only to information reported directly by members or passed on by CalHEERS. Report on Exchange membership if applicable.

No space for details provided.

Data Element	Data Collection Method (Select all that apply)	Other, explain	Percent of membership for whom data is captured
Race/ethnicity	*Multi, Checkboxes.* 1: Enrollment form, 2: Oral health risk assessment, 3: Information requested upon website registration, 4: Inquiry upon call to customer service, 5: Indirect method such as surname or zip code analysis, 6: Other (please explain), 7: Data not collected	*50 words.*	*Percent.* N/A OK.
Primary language	*Multi, Checkboxes.* 1: Enrollment form, 2: Oral health risk assessment, 3: Information requested upon website registration, 4: Inquiry upon call to customer service, 5: Indirect method such as surname or zip code analysis, 6: Other (Please explain), 7: Data not collected	*50 words.*	*Percent.* N/A OK.
Disability	*Multi, Checkboxes.* 1: Enrollment form, 2: Oral health risk assessment, 3: Information requested upon website registration, 4: Inquiry upon call to customer service, 5: Indirect method such as surname or zip code analysis, 6: Other (Please explain), 7: Data not collected	*50 words.*	*Percent.* N/A OK.

18.6.2 If Applicant answered “data not collected” to 18.6.1, discuss how Applicant intends to collect data elements to support improving health equity.
200 words.

18.6.3 Indicate how race/ethnicity data are used to address quality improvement and health equity. Select all that apply.
Multi, Checkboxes.
1: Calculate dental quality performance measures by race/ethnicity, status,
2: Calculate member experience measures by race/ethnicity, status,
3: Identify areas for quality improvement,,
4: Identify areas for health education/promotion,
5: Share provider race/ethnicity/language data with member to enable selection of concordant dentists,
6: Share with dental network to assist them in providing culturally competent care,
7: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
8: Analyze disenrollment patterns,
9: Develop outreach programs that are culturally sensitive (please explain): [100 words] ,
10: Other (please explain): [100 words] ,
11: Race/ethnicity data not used for quality improvement or health equity

18.6.4 Indicate how primary language data are used to address quality improvement and health equity. Select all that apply.
Multi, Checkboxes.
1: Assess adequacy of language assistance to meet members' needs,
2: Calculate dental quality performance measures by language status,
3: Calculate member experience measures by language status,
4: Identify areas for quality improvement,
5: Identify areas for health education/promotion,
6: Share provider language data with member to enable selection of concordant dentists,
7: Share with dental network to assist them in providing language assistance and culturally competent care,
8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
9: Analyze disenrollment patterns,
10: Develop outreach programs that are culturally sensitive (please explain): [100 words] ,
11: Other (please explain): [100 words] ,
12: Language data not used for quality improvement or health equity

18.6.5 Indicate how disability status data are used to address quality improvement and health equity. Select all that apply.
Multi, Checkboxes.
1: Calculate dental quality performance measures by disability status,
2: Calculate member experience measures by disability status,
3: : Identify areas for quality improvement,,
4: Identify areas for health education/promotion,,

5: Share with dental network to assist them in providing culturally competent care,
6: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
7: Analyze disenrollment patterns,
8: Develop outreach programs that are culturally sensitive (please explain): [100 words] ,
9: Other (please explain): [100 words] ,
10: Disability data not used for quality improvement or health equity

18.7 Promotion, Development, and Use of Care Models

All questions are required for currently contracted Applicants and new entrant Applicants.

18.7.1 If applicable to Applicant's delivery system, report the number of enrollees who have been encouraged to select or assigned a primary care dentist.
No space for details provided.

	Exchange Enrollees, if applicable	Book of Business
Number of enrollees who have been encouraged to select or assigned a primary care dentist	*Integer.*	*Integer.*
Number of enrollees	*Integer.*	*Integer.*

18.7.2 If selection of or assignment to a primary care dentist is not required, describe how Applicant encourages member's use of dental home.
100 words.

18.7.3 If selection of or assignment to a primary care dentist is not required, describe how Applicant encourages contracted providers to retain patients for continued care.
100 words.

18.8 Provider Cost and Quality

All questions are required for currently contracted Applicants and new entrant Applicants.

18.8.1 Indicate how Applicant provides members with cost information for network providers. Select all that apply.
Multi, Checkboxes.
1: Web site includes a cost calculator tool for dental services (e.g. crowns, casts, endodontics, periodontics, etc.),
2: Web site provides information on average regional charges for dental services (e.g. crowns, casts, endodontics, periodontics, etc.),

3: Cost information on provider-specific contracted rates available upon request through Web site or customer service line,
4: Members directed to network providers to request cost information,
5: Other (please explain): [100 words] ,
6: Cost information not provided to membership

18.8.2 If the plan does not currently provide members with cost information, report how Applicant intends to make provider-specific cost information available to members.
100 words.

18.9 Community Health and Wellness Promotion

All questions are required for currently contracted Applicants and new entrant Applicants.

18.9.1 Applicant must indicate the type of initiatives, programs, and projects Applicant supports and describe how such activities specifically promote community health and/or address health disparities. Select all that apply and provide a narrative description in the "details" describing the activity.
No space for details provided.

Type of Activity	Response	Details
Internal facing, member-related efforts to promote oral health (e.g. oral health education programs)	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
External facing, high-level community facing activities (e.g. health fairs, attendance at community coalitions, participation in health collaboratives)	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
Engaged with non-profit health systems or local health agencies to conduct community risk assessments to identify high priority needs and health disparities related to oral health	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
Community oral health effort built on evidence-based program and policy interventions, and planned evaluation included in the initiative	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
Funded community health programs based on needs assessment or other activity	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*

Plan is currently planning a community oral health promotion activity	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
Plan does not conduct any community oral health initiatives	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*

18.10 Utilization

All questions are required for currently contracted Applicants and new entrant Applicants

18.10.1 Applicant must provide dental utilization for the most recent benefit year for the following utilization measures. Provide current Covered California membership if applicable, and California book of business. Pediatric membership is defined as younger than 19 years of age. Adult membership is defined as 19 years of age and older.
No space for details provided.

Pediatric Utilization	Exchange enrollees, if applicable	California Book of Business
Percentage of membership that received any covered dental service	*Percent.*	*Percent.*
Percentage of membership that received a preventive/diagnostic dental service	*Percent.*	*Percent.*
Percentage of members receiving dental treatment services (excluding preventive and diagnostic services)	*Percent.*	*Percent.*
Percentage of members who received a treatment for caries or a caries-preventive procedure	*Percent.*	*Percent.*
Percentage of members with one (1) or more fillings in the past year who received a topical fluoride or sealant application	*Percent.*	*Percent.*

Percentage of pediatric membership identified as moderate or high caries risk	*Percent.*	*Percent.*
Percentage of pediatric membership who reached their annual out-of-pocket maximum.	*Percent.*	*Percent.*
Adult Utilization	*Percent.*	*Percent.*
Percentage of membership that received any covered dental service	*Percent.*	*Percent.*
Percentage of membership that received a preventive/diagnostic dental service	*Percent.*	*Percent.*
Percentage of members receiving dental treatment services (excluding preventive and diagnostic services)	*Percent.*	*Percent.*
Percentage of members who received a treatment for caries or a caries-preventive procedure	*Percent.*	*Percent.*
Percentage of members with one (1) or more fillings in the past year who received a topical fluoride or sealant application	*Percent.*	*Percent.*
Percentage of membership identified as high risk	*Percent.*	*Percent.*
Percentage of members whom reached the plan's maximum annual benefit, if applicable	*Percent.*	*Percent.*

18.10.2 Applicant must submit copies of the most recent Dental Medical Loss Ratio Reports filed with the applicable regulator.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached

YOUR APPLICATION INFORMATION

If you were helped with an application, you may fill out the information on this card to help you remember who helped you apply and details of your account.

Who helped you with the application?

___ Certified Enrollment Counselor ___ County Medi-Cal Office Eligibility Worker ___ Certified Insurance Agent

___ Plan-Based Enroller ___ Service Center Representative

Certified Representative's Contact Information

Full Name: _____ Email: _____

Phone Number: _____ Enroller ID#, if applicable: _____

APPLICATION INFORMATION:

To check the status of your application you may contact your certified representative or Covered California at 1-800-300-1506.

Account Username: _____

Application ID#: _____ Case#: _____

Remember your account password and account PIN. If you forget your account password or PIN please contact Covered California at 1-800-300-1506.

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FOR EACH FAMILY MEMBER APPLYING

Proof of current income*

CA ID or driver's license of the person who is applying for the family

U.S. passport, legal resident card or certificate of citizenship or naturalization documentation

you should KNOW:

FOR EACH FAMILY MEMBER

Birth dates

Social Security Numbers**

Home ZIP code

GOT QUESTIONS? WE CAN HELP.

Don't forget to tell a friend
"I'm in. You should be too!"

*Proof of current income of all family members applying. (A dependent's income should only be included if their income level requires them to file a tax return.) A family is defined as the person who files taxes as head of household and all the dependents claimed on that person's taxes. If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal.

**Families that include unlawfully present immigrants can apply. You can apply for your child even if you are not eligible for coverage.

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