STATE OF CALIFORNIA
STANDARD AGREEMENT
STD 213_DHCS (Rev. 06/16)

REGISTRATION NUMBER	AGREEMENT NUMBER
	15-92349

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME (Also known as DHCS, CDHS, DHS or the State)
Department of Health Care Services

CONTRACTOR'S NAME (Also referred to as Contractor)
County of San Mateo

2. The term of this Agreement is: July 1, 2015 through September 30, 2019

3. The maximum amount of this Agreement is: **$** 16,410,038
Sixteen Million, Four Hundred Ten Thousand, Thirty-Eight Dollars

4. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of this Agreement.

Exhibit A – Scope of Work	2 pages
Exhibit A Attachment I – Project Specification	22 pages
Exhibit B – Budget Detail and Payment Provisions	11 pages
Exhibit B Attachment I – Confidential Rates of Payment	2 pages
Exhibit C * – General Terms and Conditions	GTC 04/2017
Exhibit D (F) – Special Terms and Conditions (Attached hereto as part of this agreement)	26 pages
Exhibit E – Additional Provisions	6 pages
Exhibit F – HIPAA Business Associate Addendum	15 pages
Exhibit G – Contractor Release	1 page

Items shown above with an Asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto.
These documents can be viewed at http://www.dgs.ca.gov/ols/Resources/StandardContractLanguage.aspx.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME *(if other than an individual, state whether a corporation, partnership, etc.)*
County of San Mateo

BY *(Authorized Signature)* ✍ | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Louise Rogers, Health System Chief

ADDRESS
225 37th Avenue
San Mateo, CA 94403

STATE OF CALIFORNIA

AGENCY NAME
Department of Health Care Services

BY *(Authorized Signature)* ✍ | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Don Rodriguez, Chief, Contract Management Unit

ADDRESS
1501 Capitol Avenue, Suite 71.2048, MS 1400, P.O. Box 997413,
Sacramento, CA 95899-7413

California Department of General Services Use Only

[X] Exempt per: W&I 15803 & 15854

Exhibit A
Scope of Work

1. Service Overview

Contractor agrees to provide to the California Department of Health Care Services (DHCS) the services described herein.

The Contractor is responsible for all aspects of the day-to-day administration and operations of the County Children's Health Initiative Program (CCHIP or Program) in the Contractor's county on behalf of DHCS. The Contractor may use designees/subcontractors to accomplish the administrative and operational tasks specified in this Agreement. These tasks include maintaining privacy and security of applicant information and subscriber information; download daily enrollment reports; mailroom functions; application processing; conducting outreach for information required to complete Conditionally Eligible applications; enrollment; disenrollment; transmission of data to healthcare plans and DHCS; development and maintenance of data systems; maintaining toll-free telephone line; providing customer service; developing and production of Program materials; carrying out Program financial administration; and conducting Program's appeal process as detailed in this exhibit.

2. Service Location

The services shall be performed at applicable facilities in the County of San Mateo.

3. Service Hours

The services shall be provided during normal Contractor working hours, Monday through Friday, excluding national and State holidays.

4. Program Representatives

A. The Program representatives during the term of this Agreement will be:

Department of Health Care Services	**County of San Mateo**
Alexandra Norton, Program Analyst Telephone: (916) 327-0409 Fax: (916) 552-9478 E-mail: Alexandra.Norton@dhcs.ca.gov	Sosefina Pita, Program Manager Telephone: (650) 573-2278 Fax: (650) 372-9396 E-mail: spita@smcgov.org

B. Direct all inquiries to:

Department of Health Care Services	**County of San Mateo**
Medi-Cal Eligibility Division Access Programs & Policy Branch Attention: Alexandra Norton 1501 Capitol Avenue, MS 4607 P.O. Box 997417 Sacramento, CA 95899-7417 Telephone: (916) 327-0409 Fax: (916) 552-9478 E-mail: Alexandra.Norton@dhcs.ca.gov	San Mateo County Health Systems Attention: Sosefina Pita 225 37th Avenue San Mateo, CA 94403 Telephone: (650) 573-2278 Fax: (650) 372-9396 E-mail: spita@smcgov.org

Exhibit A
Scope of Work

C. Either party may make changes to the Program Representatives information above by giving written notice to the other party. Said changes shall not require an amendment to this Agreement.

5. Americans with Disabilities Act

Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement shall comply with the accessibility requirements of **Section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973** as amended (29 U.S.C. § 794 (d), and regulations implementing that act as set forth in Part 1194 of Title 36 of the Federal Code of Regulations. In 1998, Congress amended the **Rehabilitation Act of 1973** to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code section 11135 codifies section 508 of the Act requiring accessibility of electronic and information technology.

6. Services to be Performed

See Exhibit A Attachment I for a detailed description of the services to be performed.

Exhibit A Attachment I
Project Specification

I. INTRODUCTION

A. Act and Regulation

This Agreement is in accord with and pursuant to Section 15850 et seq., Chapter 3 of Part 3.3 of Division 9 of the California Welfare and Institutions Code that continues the County Health Initiative Matching (CHIM) Fund, which provides funding for the CCHIP. This Agreement is also in accord and pursuant to Title XXI of the Social Security Act, Public Law 105-33 and its implementing federal regulations, which establish the State Children's Health Insurance Program (S-CHIP) and which provide authorization and federal funding for CCHIP and the Optional Targeted Low Income Children's Program (OTLICP). Title 10, Chapter 5.8 of the California Code of Regulations, which was adopted by the Managed Risk Medical Insurance Board to implement the Healthy Families Program (HFP), governs the OTLICP and shall hereinafter be called the HFP Regulations. The HFP program has been transitioned to DHCS and is now known as the OTLICP. Terms and conditions used in the HFP Regulations shall have the same and identical meanings in this Agreement. The CCHIP develops Program materials; receives and downloads a Daily Extract File (DEF) from DHCS, which contains a listing of applicants that are determined Eligible or Conditionally Eligible for CCHIP via the Single Streamlined Application (SSA); processes applications; conducts eligibility re-determinations; enrolls eligible applicants; and provides health, dental, and vision health coverage to S-CHIP eligible subscribers. Effective March 23, 2010, in accordance with the Affordable Care Act (ACA) of 2010, and under its Maintenance of Effort (MOE) provision to receive federal Medicaid funds, the State cannot impose eligibility and enrollment policies that are more restrictive than those in place at the time the ACA was enacted until 2019 for children in Medicaid and CHIP. This Agreement is for the purpose of administering the CCHIP and providing the eligible contractors access to federal funding through the CHIM Fund.

II. DELEGATION

A. Delegation, Delegates and Subcontractors

In Accordance with the Acts and Regulations cited in Exhibit A, Provision I of this Agreement and with the federal Centers for Medicare and Medicaid Services' (CMS) approval of California's Title XXI State Plan Amendment (SPA), this Agreement establishes a quarterly invoice submission for the purpose of using federal and state funding to support the CCHIP. In order to clarify the structure of the mechanism and this Agreement, the following items are set forth:

1. DHCS is contracting directly with a local county government and that entity shall be known as the Contractor within this Agreement.

2. The Contractor may delegate to or subcontract with other entities to provide contracted services or meet contract requirements. This may include delegating to, or subcontracting with, other branches of local county government. The Contractor is responsible to DHCS for the contracted activities and services provided by any and all delegates and subcontractors.

3. The Contractor shall subcontract with Department of Managed Health Care (DMHC) or Department of Insurance (DOI) licensed health care service plans (HCSPs) under the Knox-Keene HCSP Act of 1975 for the provision of covered health, dental, and specialized (vision) services and benefits that are required by this Agreement. The Contractor shall monitor and evaluate the performance of its subcontractors to assure

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Project Specification

DHCS that services are in compliance with the terms of this Agreement and all applicable statutes. These entities shall be known as the Contractor's plans.

4. The Contractor shall provide DHCS copies of all delegation and subcontract agreements entered into by the Contractor for the provision of services under this Agreement, upon request. DHCS reserves the right to verify and approve agreements' conformance with the terms of this Agreement.

III. CONTRACTOR ADMINISTRATION RESPONSIBILITIES-ELIGIBILITY AND ENROLLMENT OPERATIONS:

The Contractor is responsible for all aspects of the day-to-day administration and operations for the CCHIP under this Agreement. The Contractor may use designees/subcontractors to accomplish the administrative and operational tasks specified in this Agreement. These tasks include maintaining privacy and security of applicant information and subscriber information; initial receipt of the DEF; mailroom functions; application processing; conducting outreach for information required to complete applications; enrollment; disenrollment; transmission of data to healthcare plans and DHCS; development and maintenance of data systems; maintaining toll-free telephone line; providing customer service; developing and production of Program materials; carrying out Program financial administration; conducting re-determinations; and conducting services related to the Program's appeal process. The operational requirements are detailed in Exhibit A, Provision IV of this Agreement.

A. Initial Application Processing

1. The Contractor shall establish and conduct all application and enrollment processing, including mailroom functions; record tracking of all applications (e.g., initial applications received via the daily DEF and re-determinations) and supporting documentation received/processed. The record tracking process shall have the ability to identify and track applications by at least the following elements: date received, date processed, and applicants name for each person being enrolled.

2. The Contractor shall establish and maintain processing procedures for premium payments that are received by the Contractor. The procedures shall include record tracking, banking deposit requirements, account posting requirements and financial reconciliation processes.

   a. In accordance with the statutory and regulatory requirements specified in Exhibit A, Provision I of this Agreement, and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), effective November 1, 2009, premium payments are to be set at HFP Category C premium rates: twenty-one dollars ($21) per subscriber child with a maximum required family contribution of sixty-three dollars ($63) per month.

3. The Contractor shall establish and maintain procedures for evaluating and processing complete and incomplete applications.

4. The Contractor shall also follow Medi-Cal end dates indicated on the DEF to determine whether any person being applied for is eligible to be enrolled in CCHIP at the termination of that person's Medi-Cal coverage. If, as a result of the screening, it is determined that the person being applied for will still have active health coverage through no-cost Medi-Cal, CCHIP enrollment is not authorized.

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5. The Contractor shall utilize eligibility determinations on the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) DEF, as directed by DHCS, to comply with the Modified Adjusted Gross Income methodology requirements for CCHIP and to determine whether the persons applying for coverage qualify pursuant to the statutory and regulatory requirements specified in Exhibit A, Section 1 of this Agreement. The Contractor and DHCS shall cooperate to maintain and improve the eligibility determination procedure in accordance with applicable law.

B. Eligibility Determination

1. The Contractor shall utilize CalHEERS as the system of record for all eligibility information pertaining to CCHIP eligible subscribers.

2. The Contractor shall accept the eligibility determinations on the DEF as specified in Exhibit A, Provision I of this Agreement. The CCHIP eligibility period shall be twelve (12) consecutive months.

3. In accordance with the statutory and regulatory requirements specified in Exhibit A, Provision I of this Agreement, the Contractor shall establish and maintain procedures to notify applicants in writing of their enrollment in CCHIP for each person being applied for within ten (10) calendar days of receipt of eligibility determination via the DEF. The procedures shall include record tracking of all notifications and shall have the ability to track date notification sent, applicant's name, and enrollment date for persons being applied for.

4. The Contractor shall establish and maintain refund procedures for premium payments from applications subsequently determined to be ineligible.

C. Enrollment and Disenrollment

1. The Contractor shall establish and maintain procedures for enrollment of eligible applicants and disenrollment of no longer eligible subscribers. The procedures shall be in accordance with the CCHIP authorizing statutes, regulations and all other applicable statutes as specified in Exhibit A, Provision I of this Agreement.

2. The Contractor shall establish the effective date of coverage for each person being applied for within ten (10) calendar days of receipt of eligibility determination via the DEF. The Contractor shall notify the applicant and participating plans in writing and in accordance with Health Insurance Portability Accountability Act of 1996 (HIPAA) standards, of the languages spoken and written, the enrollment information, and the effective date of coverage for each person determined eligible on the application.

3. The Contractor shall establish and maintain a CCHIP Welcome Packet that shall include all necessary Program information for new subscribers. The Contractor shall send the Welcome Packet out prior to subscribers' effective dates of coverage by postal service in sufficient time to arrive prior to the effective date.

4. If a person has been determined ineligible for continued CCHIP coverage by the Contractor or by CalHEERS, the Contractor shall disenroll the person from the plan in which the person is enrolled. The Contractor's reasons for disenrollment shall include the following:

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a. The subscriber is found to no longer be eligible, or fails to provide the necessary information, during the annual eligibility review (AER) period; or

b. The subscriber attains an age that is no longer eligible for coverage; or

c. The subscriber is determined not to be a citizen, non-citizen national, or a qualified alien eligible for coverage or fails to provide required documentation within established time period; or

d. The applicant fails to pay the required family contribution within the established time period; or

e. The applicant declines CCHIP in the CalHEERS application or the subscriber or parent or guardian so requests in writing; or

f. The applicant has intentionally made false declarations in order to establish CCHIP eligibility for any subscriber; or

g. The subscriber has died; or

h. The subscriber reports a reduction in income that results in eligibility for a more advantageous Insurance Affordability Program and disenrollment from CCHIP.

5. The Contractor shall mail the applicant for any disenrolled subscribers a notice summarizing each subscriber's eligible months of creditable coverage while enrolled in CCHIP and the notice shall be in accordance with the federal HIPAA requirements.

D. Change in CCHIP Enrollment Status

1. The Contractor shall administer and record any changes in enrollment status during any CCHIP eligibility period. This includes the addition of new subscribers who were not eligible when the applicant applied to CCHIP, disenrollment of subscribers who are no longer eligible for the CCHIP, changes in subscribers' plan selections and AER evaluations.

2. The Contractor shall recalculate CCHIP family contribution when adding or disenrolling a subscriber and shall bill the subscriber to reflect the revised amounts due. The recalculated family contribution shall not affect the prepaid free month that the family had qualified for prior to the adding or disenrolling a subscriber. The Contractor's data systems shall maintain accessible CCHIP records including all changes in enrollment of all applicants/subscribers with the date of the enrollment status changes.

E. Processing Correspondence From Applicants/Subscribers

1. Written correspondence and requests from the applicant/subscriber that are not determined to be appeals pursuant to the statutory and regulatory requirements specified in Exhibit A, Section I of this Agreement, shall be defined as correspondence. The Contractor shall establish and maintain procedures to receive, review, process and respond to all correspondence received from applicants/subscribers.

2. The Contractor shall respond directly to the applicant/subscriber in writing, in order to inform the applicant/subscriber about the outcome of the Contractor's review or

evaluation of his or her inquiry. The written responses shall be completed within thirty (30) calendar days.

F. CCHIP AER

1. The Contractor shall accept the CalHEERS annual redetermination for continued eligibility for each CCHIP subscriber in accordance with the statutory and regulatory requirements specified in Exhibit A, Section I of this Agreement.

2. The Contractor shall establish and maintain an AER process. The process shall include requesting that subscribers complete their annual redetermination using CalHEERS, and the Contractor shall assist the subscriber with that process if requested.

   a. The Contractor shall enter the information into CalHEERS to redetermine if the person(s) for whom application is being made qualify for continued coverage through the CCHIP if necessary.

3. If the Contractor has not received a CalHEERS annual redetermination for continued eligibility for each CCHIP subscriber within thirty (30) calendar days prior to anniversary date, the Contractor shall send out a reminder postcard informing the subscriber that failure to respond by the subscriber's anniversary date will result in subscriber disenrollment and indicating the disenrollment date.

4. The Contractor shall establish procedures for the AER process, including procedures for processing complete (or made complete) CalHEERS annual redeterminations. The Contractor shall prioritize annual redetermination package processing based on subscribers' anniversary dates and pending disenrollment dates in order to maintain CCHIP eligibility.

5. The CalHEERS shall notify the subscriber in writing of the results of the eligibility determination for each person whose eligibility is being re-determined at AER. The notice shall include, for each person eligible, the eligibility determination.

6. The Contractor shall notify the subscriber of the plans the listed subscriber(s) are enrolled in, the current family contribution, and the twelve (12) month time period for the eligibility determination.

7. For those subscribers determined ineligible, the CalHEERS shall send a notice that shall include the eligibility determination, disenrollment date, and an explanation of the appeal process, including the option for the subscriber to request continued coverage during the appeal process.

8. The Contractor shall establish and maintain AER appeals procedures with established appeal time periods, including the subscriber's ability to request continued coverage during the appeal process.

G. CCHIP Appeals

1. The Contractor shall require that the Contractor's plans establish and maintain appeal procedures related to health care benefits and enrollment. The Contractor's plans will be informing applicants/subscribers of their benefit and enrollment related appeal rights. CalHEERS will be informing applicants/subscribers of their right to appeal eligibility

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determinations to the California Department of Social Services (CDSS) for Fair Hearings. All inquiries not meeting the requirements of a formal appeal shall be responded to as a correspondence, as specified in Exhibit A, Provision III, Subsection F of this Agreement.

2. The CalHEERS and the Contractor shall provide notice of appeal rights in all appropriate appeals correspondence to applicants/subscribers and shall assure compliance with all established timeframes, including the subscriber's right to request continuing eligibility in the CCHIP while the appeal determination is pending.

3. The Contractor shall maintain all business records of written and oral contacts with applicants, subscribers, and their representatives in a manner that will enable such records to be introduced as evidence, pursuant to Evidence Code Section 1271. The Contractor shall have the ability to respond directly to an applicant's/subscriber's authorized representative or other third party for whom the applicant/subscriber has a signed authorization on file with the Contractor. The Contractor shall forward all information necessary to determine an appeal to CDSS after being notified that an appeal has been filed. The Contractor shall work with DHCS and CDSS to ensure that all necessary information has been forwarded to CDSS for an administrative hearing.

4. The Contractor shall forward all eligibility determination appeals received to CDSS as detailed in the NOD01 (Notification Letter) received by the applicant/subscriber. Using established protocols for communications and relaying of private health information, and in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Contractor shall:

    a. For First Level Appeals- The Contractor shall assist in researching and informally resolving appeals as directed by DHCS. If necessary, the Contractor shall contact the appellant to get clarifications and additional information, as needed for research for informal resolution. "Informal resolution" means outreach to the appellant by the Contractor to resolve the issue prior to an administrative hearing. If the appellant requests enrollment/continued enrollment in the CCHIP, the Contractor shall evaluate and determine whether the appellant is entitled to receive CCHIP enrollment/continued enrollment, and if the Contractor determines that enrollment/continued enrollment is appropriate, enroll the appellant in CCHIP, respond to the appellant in writing regarding enrollment/continued enrollment in CCHIP, and notify DHCS and CDSS that the appeal has been informally resolved.

    b. For Second Level Appeals- If the Contractor is unable to informally resolve the appeal, the Contractor shall notify DHCS and CDSS that the appeal could not be informally resolved and assist the appellant by referring his or her request for an administrative hearing on the unsuccessful resolution of the first level appeal to CDSS.

5. The Contractor shall be held harmless for paying medical expenses incurred by an applicant due to the Contractor's action or inaction that delayed or prevented health coverage for which the applicant was subsequently determined to be eligible through the appeal process.

6. The Contractor shall establish and maintain a CCHIP appeals tracking system which has the ability to identify, list, track and report all CCHIP appeals Contractor has forwarded

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or referred to CDSS, as well as requests for continued enrollment, including the date on which appeal was forwarded and the continued enrollment request was received; whether or not each subscriber was granted continued enrollment; the beginning and end date of continued enrollment.

H. Transmission of CCHIP Enrollment Data

1. The Contractor shall assure DHCS that it shall transmit enrollment, subscriber data updates, reinstatement and disenrollment information to each participating plan using Electronic Data Interchange (EDI). All EDI transmissions to participating plans shall be in compliance with the HIPAA of 1996 and any other applicable privacy statutes or regulations.

2. The Contractor shall establish and maintain a secured EDI transmission process to provide participating plan with enrollment data. The process must use industry standard password protection and encryption procedures to maintain CCHIP security and integrity of the data.

3. The Contractor shall transmit enrollment and financial data to DHCS in accordance with Exhibit B of this Agreement.

4. The Contractor acknowledges that all Contractors and its designees/subcontractors must be HIPAA compliant and agrees to conduct all operations, and requires all designees and subcontractors to be, in compliance with HIPAA.

5. The Contractor shall provide EDI instructions and data mapping formats to participating plans upon request. The Contractor shall provide additional technical assistance, by telephone, by email, or in person at the Contractor's site, to Contractor's plans new to EDI data transmission as the plans establish EDI electronic capabilities.

I. CCHIP Applications and Program Materials

1. The Contractor shall establish and maintain CCHIP necessary Program materials in order to administer the Program, in accordance with the statutory and regulatory requirements specified in Exhibit A, Provision I of this Agreement.

2. The Contractor shall translate the necessary Program materials into the same languages spoken by the eligible populations that are served in the Contractor's county. To assure translation accuracy, the Contractor shall retain certified translation services to conduct initial English to non-English translation.

3. The Contractor shall establish and maintain an adequate inventory of the CCHIP necessary Program materials in the appropriate languages to serve the eligible population in the Contractor's county. The Contractor shall have the ability to replenish its inventory of the CCHIP applications and necessary Program materials, whenever the supply is depleted.

4. The Contractor shall assure that all written materials are understandable by low reading level applicants and subscribers, no higher than a sixth grade reading level.

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J. CCHIP Telephone and Customer Service

1. The Contractor shall establish and maintain a toll-free telephone number for CCHIP applicants and subscribers; the toll-free line shall be available during normal business hours, Monday-Friday 8:30 am to 5:00 pm.

2. The Contractor shall have sufficient number of trained bilingual staff to provide customer service to the eligible population in the Contractor's county. The Contractor shall also have the capability to provide telephone services via a translation service in any other languages and TDD service for the hearing impaired.

3. The Contractor's toll-free line shall be staffed with personnel trained to:

   a. Answer application status questions regarding CCHIP;

   b. Answer eligibility questions regarding CCHIP;

   c. Assist applicants in completing the SSA;

   d. Refer callers to the appropriate County Social Services Department for Medi-Cal coverage;

   e. Answer CCHIP AER questions and status questions;

   f. Answer CCHIP appeal questions and follow-ups;

   g. Answer CCHIP billing questions; and,

   h. Answer other CCHIP related questions.

K. CCHIP System Requirements

1. The Contractor shall establish and maintain data systems that support fully integrated CCHIP eligibility, enrollment and financial/accounting systems. The systems shall have the ability to track application eligibility determinations, and shall include an inventory control process for tracking disposition and aging of all applications received. The systems shall also maintain an eligibility determination record for each initial determination and each subsequent determination for additional eligibility periods.

2. The Contractor's systems shall maintain a CCHIP family contribution income accounting subsystem with documented internal controls to track all family contribution activity for each applicant and for each eligible and enrolled subscriber for CCHIP. The system shall have the ability to track initial and ongoing payments by payment type and source, such as check, cash, credit card, and any other payment source. The Contractor's system shall maintain the family contribution historical payment activity for auditing purposes.

3. The Contractor shall establish and maintain a family contribution refund system for the CCHIP, with documented internal controls that shall ensure timely, complete and accurate processing and payment of both automated and manual refunds of family contributions. The Contractor shall ensure that a family contribution payment is verified for validity of funds prior to issuing any refund.

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4. The Contractor shall have sufficient dedicated systems, operations and maintenance staff whose sole purpose shall be to assure that the Contractor's system is fully functional and complies with all the administrative requirements within this Agreement.

L. CCHIP Family Contributions

1. The Contractor shall collect CCHIP family contributions as specified in the statutory and regulatory requirements in Exhibit A, Section I of this Agreement, the Contractor's County requirements and as approved by CMS in the 7th California SPA, Title XXI.

2. The Contractor shall calculate the amount of CCHIP family contribution, including any rate changes, balances due, and payments made, and shall notify applicants of their required family contributions.

3. The Contractor shall refund, by check to the applicants/subscribers, family contributions from applicants/subscribers determined to be ineligible for CCHIP within six (6) weeks. Net adjustments to family contributions that result in overpayment shall be refunded to the applicant/subscriber, except when the applicant/subscriber requests a credit to his or her account.

4. The Contractor shall establish and maintain an American Indian/Alaskan Native (AI/AN) family contribution exemption in accordance with the statutory and regulatory requirement specified in Exhibit A, Section l of this Agreement.

IV. CONTRACTOR RESPONSIBILITIES-HEALTH CARE COVERED SERVICES AND BENEFITS

The Contractor is responsible for all aspects of the administration and provision of covered health care services including health, dental, and vision benefits as specified in the HFP regulations. The Contractor shall purchase the covered health care services required in Exhibit A, Section V through subcontracted DMHC or DOI licensed HCSPs. These responsibilities include maintaining privacy and security of applicant information and subscriber information; enrollment of eligible subscribers; disenrollment of ineligible subscribers; receipt of enrollment data from Contractor's plans transmission of enrollment data to healthcare providers; assigning primary care providers when applicable; providing plan ID cards, plan provider directories and plan evidence of coverage booklets; administering plan grievance procedures; administering cultural and linguistic services; administering Serious Emotional Disturbance (SED) benefits; administering subscriber co-payments; administering clinical quality measures and management practices; development and maintenance of plan data systems; maintaining plan toll-free telephone line; and providing plan customer service. The operational requirements are detailed in this Section IV of Exhibit A, of this Agreement.

A. HCSP

This Agreement is entered into by the Contractor and DHCS for the purpose of purchasing and providing health coverage for subscribers determined to be eligible for CCHIP. The Contractor shall purchase covered health care services from DMHC or DOI licensed HCSPs that includes a County Organized Health System. The method of delivery of the insured health benefits shall be a health maintenance organization and/or a preferred provider organization. The Contractor, through its subcontracted plan, agrees to utilize the health maintenance organization and/or the preferred provider organization.

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B. Dental Care Service Plan

This Agreement is entered into by the Contractor and DHCS for the purpose of purchasing and providing dental coverage for subscribers determined to be eligible for CCHIP. The Contractor shall purchase health covered services from DMHC or DOI licensed HCSPs. The method of delivery of the insured dental benefits shall be a dental maintenance organization and/or a preferred provider organization. The Contractor, through its subcontracted plan, agrees to utilize the dental maintenance organization and/or the preferred provider organization.

C. Specialized HCSP

This Agreement is entered into by the Contractor and DHCS for the purpose of purchasing and providing vision coverage for subscribers determined to be eligible for CCHIP. The Contractor shall purchase health covered services from DMHC or DOI licensed HCSPs. The method of delivery of the insured vision benefits shall be a specialized HCSP. The Contractor, through its subcontracted plan, agrees to utilize the specialized HCSP.

D. Geographic Areas Covered

1. The Contractor's plans' participation in the Program is limited to enrollment of Program subscribers who reside in the Contractor's plans' CCHIP licensed service area accepted by DHCS. The geographic area is San Mateo County, California.

2. The Contractor shall ensure that the Contractor's plans CCHIP geographic coverage shall be the same geographic coverage as was provided for the HFP.

E. Changing Health Care Providers

1. The Contractor shall ensure that the Contractor's plans have an adequate network of providers to provide services to CCHIP subscribers and shall establish a mechanism to ensure adequate access to the providers. These providers (institutional and professional) are listed in the Contractor's plans' Provider Directories. The Contractor agrees to provide copies of the Provider Directories to DHCS upon request.

2. Health, dental, and specialized (vision) care providers shall be deemed added to or deleted from the Contractor's plans Provider Directories as contracts between the Contractor's plans and health, dental, and specialized (vision) care providers begin or end.

3. The Contractor agrees to maintain the availability of those providers listed at any time during the benefit year in the Contractor's plans' Provider Directories until the end of the benefit year, if elimination of the provider would impact twenty-five (25) or more subscribers enrolled with the Contractor's plans through CCHIP. For the purpose of this section, the term "provider" may refer to a solo practitioner, a provider group or a clinic.

4. Provision IV, Subsection E.3 above shall not apply if the withdrawal of a provider from the Contractor's plan's network was done at the request of the provider or is part of the Contractor's plan's activities to obtain or retain National Committee for Quality Assurance (NCQA)/Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) accreditation, or is initiated by the Contractor's plan for cause.

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F. Eligibility

All subscribers who are determined CCHIP eligible are eligible to enroll in a health, dental, and specialized (vision) plan. The Contractor certifies that its enrollment process will not be prejudicial to the participating health, dental, and specialized (vision) plans.

G. Conditions of Enrollment

The Contractor shall ensure that the Contractor's health, dental, and specialized (vision) plans shall enroll all CCHIP eligible subscribers on the effective date of coverage specified by the Contractor.

1. In accordance with the statutory and regulatory requirements specified in Exhibit A, Provision I of this Agreement, the Contractor shall complete the enrollment process within ten (10) calendar days of receipt of the DEF or Add-a-Person Form, unless the Contractor is waiting for necessary information pursuant to Subsection 2699.6606(b)(1) and (2) or is requesting information pursuant to Subsection 2699.6600(c)(1)(BB)(1). For those affected applications, the Contractor shall complete the application review process within twenty (20) calendar days of receipt of the DEF or Add-a-Person Form.

H. Disenrollment

1. The Contractor shall ensure that the Contractor's health, dental, and specialized (vision) plans shall disenroll subscribers when notified to do so by the Contractor on the date specified by the Contractor.

2. In no event shall any individual subscriber be entitled to the payment of any benefits with respect to health, dental, and specialized (vision) care services rendered, supplies or drugs received or expense incurred following termination of coverage consistent with state and federal law. For the purposes of this Agreement, a charge shall be considered incurred on the date the service or supply giving rise to the charge is rendered or received.

I. Commencement of Coverage

Coverage shall commence for a subscriber at 12:01 a.m. on the day designated by the Contractor as the effective date of coverage.

J. Identification Cards, Provider Directory, and Evidence of Coverage

1. The Contractor shall ensure that the Contractor's health, dental, and specialized (vision) plans, no later than the effective date of coverage, issue to the parent(s) or guardian(s) of the newly eligible subscriber(s), an Identification Card, Provider Directory, and Evidence of Coverage booklet setting forth a statement of the services, benefits, and grievance procedure to which the subscriber is entitled. The Contractor agrees that the materials sent to the parent(s) or guardian(s) of the newly eligible subscriber(s) shall also include information regarding how subscribers are to access services. The information shall be in addition to the description provided in the Evidence of Coverage booklet. Examples of acceptable forms of information include, but are not limited to: a brochure on How to Access Services, inclusion in a cover letter of the specific pages in the Evidence of Coverage booklets relating to accessing services, or a magnet listing the telephone numbers to call to schedule an appointment with providers.

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2. The Contractor through its subcontracted plans shall ensure that fifteen (15) calendar days prior to the start of a new benefit year the parent(s) or guardian(s) of the subscribers enrolled in the Contractor's plan shall be issued an updated Evidence of Coverage booklet setting forth a statement of the services and benefits to which the subscriber is entitled in the next benefit year.

3. The Contractor shall ensure that the Contractor's plans' Provider Directories are updated and distributed by the Contractor's plans to parent(s) or guardian(s) on behalf of subscribers whenever there is a material change in the Contractor's plans' provider networks.

4. The Contractor's plans' Provider Directories shall indicate the language capabilities of the providers.

5. The Contractor shall provide copies of the Contractor's plans' Evidence of Coverage booklets and Provider Directories to any person requesting such materials, by telephone or in writing, within ten (10) calendar days of the request.

6. The Contractor shall send DHCS, upon request; copies of the Contractor's plans updated Evidence of Coverage Booklets and updated Provider Directories.

7. Written informational material provided to parent(s) or guardian(s) of subscribers shall be no higher than a sixth grade reading level and that is approved by DHCS, to the extent that compliance with this provision does not conflict with regulatory agency directives or other legal requirements.

K. Primary Care Provider Assignment **(HMOs and DMOs only)**

1. The Contractor, through its subcontracted plans, agrees to ensure that all subscribers shall be enrolled with a primary care physician within thirty (30) days of the effective date of coverage in the plan. The Contractor shall provide the Contractor's health and dental plans with the name of each subscriber's chosen primary care provider, if the name of the primary care provider is listed on the CCHIP application. If the Contractor assigns a primary care provider to a subscriber, the Contractor shall use a fair and equitable method of assignment from the Contractor's plans' provider networks and shall promptly notify subscribers of the selection and of the opportunity to change the assigned primary care providers. The method of assignment shall take into account the geographic accessibility and language capabilities of providers. The Contractor shall ensure that the Contractor's plans notify the primary care providers promptly that they have been chosen by the subscriber or assigned by the Contractor's plan.

2. Whenever the Contractor's plans assign a subscriber to a group or clinic, the Contractor shall ensure that the Contractor's plans notify the subscriber of his or her right to select a new primary care provider immediately or at any future time, including such time as the selected primary care provider is no longer affiliated with the clinic. The Contractor shall ensure that the Contractor's plans notify the subscriber of his or her rights immediately after the assignment to the clinic has been made.

L. Right to Services

Possession of the Contractor's Plan Identification Cards confers no right to services or other benefits of the CCHIP. To be entitled to services or benefits, the holder of the card must, in fact,

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be a subscriber enrolled in the CCHIP. Therefore, any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Agreement, including the law specified in Exhibit A, Provision I, is personally responsible for the cost of all health care services.

M. Enrollment Data

DHCS and the Contractor agree to the following regarding the transmission, receipt, and maintenance of enrollment data.

1. The Contractor shall ensure that the Contractor's plans transmit subscriber enrollment and disenrollment information, subscriber data updates, as well as transfer and reinstatement information, to the Contractor using EDI. The Contractor shall ensure that the Contractor's plans accept the information via EDI. The Contractor shall receive the transmitted information, data and file sent through the EDI in a manner and format that comply with HIPAA standards for electronic transactions and code sets.

2. The Contractor shall ensure that the Contractor's plans accept written confirmation of enrollments from the Contractor, in the event that system errors cause enrollment transactions to be delayed. The Contractor agrees that the written confirmations are valid and acceptable alternative notifications to the Contractor's plans until the failed or delayed enrollment transaction can be generated and sent to the Contractor's plans.

3. The Contractor shall ensure that the Contractor's plans provide EDI instructions and data mapping formats to the Contractor upon request. The Contractor shall provide additional technical assistance to Contractor's plans in order to establish electronic capability.

N. Traditional and Safety Net Providers

The Contractor shall ensure that the Contractor's plans establish, with traditional and safety net providers as described in Article 4 of the HFP regulations, network membership and payment policies that are no less favorable than its policies with other providers.

O. Public Awareness

1. The Contractor shall ensure that all public awareness efforts by the Contractor's plans have been approved by the Contractor before being released in public and must be in compliance with the requirements of the Knox-Keene HCSP Act of 1975, including amendments and applicable regulations.

2. The Contractor shall ensure that the Contractor's plans do not directly, indirectly, or through its agents, conduct in person, door to door, mail or telephone solicitation of applicants for enrollment and that the Contractor's plans are prohibited from these activities.

3. The Contractor shall ensure that the Contractor's plans' marketing shall be in compliance with all applicable statutes and regulations as specified in Exhibit A, Provision I of this Agreement.

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P. Telephone Customer Service for Plan Subscribers

The Contractor shall ensure that the Contractor's plans provide a toll free telephone number for applicant and subscriber plan inquiries and provide all of their subscribers with this telephone number. This telephone service shall be available on regular business days from the hours of 8:30 a.m. to 5:00 p.m. Pacific Standard Time. The Contractor's plans shall provide staff bilingual in English and Spanish during all hours of telephone service. The Contractor's plans shall have the capability to provide telephone services via an interpretive service for all limited English proficient (LEP) persons.

Q. Grievance Procedures

1. DMHC Licensees:

a. The Contractor shall ensure that the Contractor's plans establish grievance procedures to resolve issues arising between themselves and subscribers or parent(s) or guardian(s) acting on behalf of subscribers. The Contractor's plans processes shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by Contractor's plans licensing statute, the Knox-Keene HCSP Act of 1975, as amended. These procedures shall be described in the Contractor's plans Evidence of Coverage booklet.

b. The Contractor shall ensure that the Contractor's plans report to the Contractor and DHCS by February 1 of each year, in a format determined by DHCS, the number and types of benefit grievances filed by subscribers and by parent(s) or guardian(s) acting on behalf of subscribers in the previous calendar year in the CCHIP. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of health care benefits in the CCHIP

2. DOI Licensees:

a. The Contractor shall ensure that the Contractor's plans establish grievance procedures to resolve issues arising between themselves and subscribers or parent(s) or guardian(s) acting on behalf of subscribers. The Contractor's plans processes shall include all features required for health care, dental, and/or specialized service plans pursuant to the Knox-Keene HCSP Act of 1975, as amended, and shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by the Knox-Keene Act. These procedures shall be described in the Contractor's plans' Certificate of Insurance booklet.

b. The Contractor shall ensure that the Contractor's plan report to the Contractor and DHCS by February 1 of each year, in a format determined by DHCS, the number and types of benefit grievances filed by subscribers and by parent(s) or guardian(s) on behalf of subscribers in the previous calendar year in the Program. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of health care benefits in the CCHIP.

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R. Cultural and Linguistic Services

1. Linguistic Services

a. The Contractor shall ensure that the Contractor's plans and their providers comply with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80), which prohibits recipients of federal financial assistance from discriminating against persons based on race, color or national origin. This is interpreted to mean that a LEP individual is entitled to equal access and participation in federally funded programs through the provision of bilingual services.

b. The Contractor shall ensure that the Contractor's plans provide twenty-four (24) hour access to interpreter services for all LEP subscribers seeking health services within the Contractor's plans provider networks. The Contractor's plans shall use face-to-face interpreter services, if feasible. If face-to-face interpreter services are not feasible, the Contractor's plans may use telephone language lines for interpreter services. The Contractor shall ensure that the Contractor's plans develop and implement policies and procedures for ensuring access to interpreter services for all LEP subscribers, including, but not limited to, assessing the cultural and linguistic needs of its subscribers, training of staff on the policies and procedures, and monitoring its language assistance program. The Contractor shall ensure that the Contractor's plans' procedures include ensuring compliance of any subcontracted providers with these requirements.

c. The Contractor shall ensure that when the need for an interpreter has been identified by the provider or requested by a subscriber, the Contractor's plans provide a competent interpreter for scheduled appointments. The Contractor shall ensure that the Contractor's plans avoid unreasonable delays in the delivery of health care services to persons of limited English proficiency. The Contractor shall ensure that the Contractor's plans instruct the providers within the plan's provider networks to record the language needs of subscribers in the medical record.

d. The Contractor shall ensure that the Contractor's plans and their providers do not require or encourage subscribers to utilize family members or friends as interpreters. After being informed of his or her right to use free interpreter services provided by the Contractor's plan, a subscriber may use an alternative interpreter of his or her choice at his or her cost. The Contractor shall ensure that the Contractor's plans encourage the use of qualified interpreters. Minors shall not be used as interpreters except in the most extraordinary circumstances, such as medical emergencies. The Contractor shall ensure that the Contractor's plans document the request or refusal of language or interpreter services in the medical records of providers in the Contractor's plans' provider networks.

e. The Contractor shall ensure that the Contractor's plan inform subscribers of the availability of linguistic services. Information provided to subscribers regarding interpreter services shall include but not be limited to: the availability of interpreter services to subscribers at no charge; the right not to use family members or friends as interpreters; the right to request an interpreter during discussions of medical information such as diagnoses of medical conditions and proposed treatment options and during explanations of plans of care or other

discussions with providers; the right to receive subscriber materials; and the right to file a complaint or grievance if linguistic needs are not met.

f. The Contractor shall ensure that the Contractor's plans have appropriate bilingual proficiency at medical and non-medical points of contact for providers who list their bilingual capabilities in provider directories. Medical points of contact include advice and urgent care telephone lines and face-to-face encounters with providers who provide medical or health care advice to members. Non-medical points of contact include member/customer service, plan or provider office reception, appointment services, and member orientation sessions.

g. The Contractor shall ensure that the Contractor's plans identify and report the on-site linguistic capability of providers and provider office staff through the plans provider directories.

2. Translation of Written Materials

a. The Contractor shall ensure that the Contractor's plans translate written informing materials for subscribers including, but not limited to: the Evidence of Coverage booklet; form letters; notice of action letters; consent forms; letters containing important information regarding participation in the health plan; notices pertaining to the reduction, denial, modification, or termination of services; notices of the right to appeal such actions or that require a response from subscribers; notices advising LEP subscribers of the availability of free language assistance services; other outreach materials; and medical care reminders. Written informing materials for subscribers shall be provided a no higher than a sixth grade reading level, to the extent that compliance with this requirement does not conflict with regulatory agency directives or other legal requirements. Translation of these materials shall be in the same languages that serve the eligible population in the Contractor's county". The Contractor shall ensure that the Contractor's plans that have members who are unable to read the written materials that have been translated into non-English languages have an alternate form of access to the contents of the written materials.

b. The Contractor shall ensure that the Contractor's plans validate the quality of the translated material. The Contractor shall ensure that the Contractor's plans use different qualified translators during sequential levels of the translation process to ensure accuracy, completeness, and reliability of translated materials. The Contractor shall ensure that the Contractor's plans include in the translation process the use of qualified translators for translating and editing, proofreading, and professional review.

c. Upon request, the Contractor shall ensure that the Contractor's plans submit to the Contractor and DHCS one copy of all materials routinely provided to new subscribers pursuant to this Agreement for each language in which the materials are translated.

3. Operationalizing Cultural and Linguistic Competency

a. The Contractor shall ensure that the Contractor's plans develop internal systems that meet the cultural and linguistic needs of its CCHIP subscribers. The

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Contractor shall ensure that the Contractor's plans provide initial and continuing training on cultural competency to staff and providers. Ongoing evaluation and feedback on cultural competency training shall include, but not be limited to, feedback from subscriber surveys, staff, providers, and encounter/claims data.

b. The Contractor shall ensure that the Contractor's plans report to the Contractor and DHCS upon request, the linguistically and culturally appropriate services provided and proposed to be provided to meet the needs of limited-English proficient CCHIP applicants and subscribers. This report shall address types of services including, but not limited to, linguistically and culturally appropriate providers and clinics available; interpreters; marketing materials; information packets; translated written materials; referrals to culturally and linguistically appropriate community services and programs; and training and education activities for providers. The Contractor shall ensure that the Contractor's plans also report their efforts to evaluate cultural and linguistic services and outcomes of cultural and linguistic activities as part of the Contractor's plans ongoing quality improvement efforts. Reported information may include member complaints and grievances, results from membership satisfaction surveys, and utilization and other clinical data that may reveal health disparities as a result of cultural and linguistic barriers.

S. Covered and Excluded Benefits

1. Except as required by any provision of applicable law, only those benefits described in Article 3, Sections 2699.6700 through 2699.6723, of the HFP regulations shall be covered benefits under the terms of this Agreement. Except as required by any provision of applicable law, those benefits excluded in Article 3 of the HFP regulations shall not be covered benefits. The Contractor shall ensure that the Contractor's plans shall set out the plan of coverage in an Evidence of Coverage booklet.

2. The parties understand that terms of coverage under this Agreement are to be set forth in the Contractor's plans' Evidence of Coverage booklets. In the case of conflicts, terms of coverage set forth in the Evidence of Coverage booklets shall be binding only when they are more favorable to the subscriber notwithstanding any provisions in this Agreement that are less favorable to the subscriber.

3. The Contractor shall ensure that the Contractor's plans make benefit and coverage determinations. All such determinations shall be subject to the Contractor's plans' grievance procedures.

T. CCS

1. The Contractor shall ensure that the Contractor's plans identify subscribers with a suspected California Children's Services (CCS) condition and shall refer them to the local CCS Program for a full determination of residential, medical, and financial eligibility. Once CCS eligibility is determined as defined in Title 22, CCR, Division 2, Subdivision 7, Chapter 3, medically necessary services to treat a CCHIP subscriber for a CCS eligible condition shall be provided by the local CCS Program. The Contractor shall ensure that the Contractor's plans provide all medically necessary services including the treatment of CCS conditions when the CCHIP subscriber does not meet the CCS eligibility requirements to the extent that they are covered services under the Optional Targeted Low-Income Children's Program. The Contractor shall ensure that the Contractor's

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plans provide the parent(s) or guardian(s) acting on behalf of the subscriber referred to CCS with a CCS one page (double sided) informational flyer. DHCS agrees to provide the Contractor and the Contractor's plans with camera-ready copies of the CCS informational flyer.

2. The Contractor shall ensure that the Contractor's plans implement written policies and procedures for identifying and referring subscribers with suspected CCS eligible conditions to the local CCS Program. The policies and procedures shall include, but not be limited to:

   a. Procedures for ensuring that the Contractor's plans' providers are informed of the identity of CCS paneled providers and CCS approved hospitals within the Contractor's plans' entire network.

   b. Policies and operational controls that ensure that the Contractor's plans providers perform appropriate baseline health assessment and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a subscriber has a CCS eligible medical condition.

   c. Policies and procedures to assure that the Contractor's plans providers refer potentially eligible children to the CCS Program.

   d. Procedures that provide for continuity of care between the Contractor's plans providers and CCS providers.

3. The Contractor shall ensure that the Contractor's plans annually report to DHCS and Contractor the number of CCHIP subscribers who were referred to the local CCS Program. The first report is due thirty (30) calendar days following the end of the first year of CCHIP implementation under this Agreement.

4. Until eligibility for the CCS Program is established, the Contractor shall ensure that the Contractor's plans continue to be responsible for arranging for the delivery of all covered medically necessary health care and case management services for a subscriber referred to CCS. Services that are provided by a CCS paneled provider or approved facility on the date of referral, or afterwards, and that are authorized by the CCS Program for a CCS eligible child, shall be paid through the CCS Program at the CCS reimbursement rate retroactively to the provider of the services.

5. Once eligibility for the CCS Program is established for a subscriber:

   a. The Contractor shall ensure that the Contractor's plans continue to provide covered primary care and all other medically necessary covered services other than those provided through the CCS Program for the CCS eligible condition and shall ensure the coordination of services between its primary care providers, the CCS specialty providers, and the local CCS Program.

   b. The CCS Program shall authorize and pay for the delivery of medically necessary health care services to treat a subscriber's CCS eligible condition. The CCS authorization, on determination of eligibility, shall be to CCS paneled providers and approved facilities, some of which may also be members of the Contractor's plans' network. Authorization normally cannot predate the initial referral to the local CCS Program in accordance with Title 22, CCR, Section

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41770. Claims for authorized services shall be submitted to the appropriate CCS office for approval of payment.

c. For the purposes of Provision IV, Subsection T.5.b, above, initial referral means referral by a Contractor's plans' network physician, or by any other entity permissible under CCS regulations.

U. Mental Health: Family Members

The Contractor agrees to involve appropriate family members in the mental health and/or substance abuse services provided to a subscriber who has experienced family dysfunction and/or trauma to the extent it is required as a course of treatment for the health and recovery of the child.

V. Mental Health: Services for Subscriber Children

The Contractor shall ensure that the Contractor's health plans provide covered benefits that include mental health services in accordance with Section 1374.72 of the California Health and Safety Code, which include the provision of mental health services for children with SED or with a serious mental disorder.

W. Other Public Linkages

The Contractor shall, to the extent feasible, create viable protocols for screening and referring subscribers needing supplemental services outside of the scope of benefits described in Article 3 of the HFP regulations to public programs providing such supplemental services for which they may be eligible, as well as for coordination of care between the Contractor and the public programs. Public programs may include but not be limited to: regional centers, Women, Infants and Children Supplemental Food Program, lead poisoning prevention, and programs administered by local education agencies.

X. Pre-existing Condition Coverage Exclusion Prohibition

No pre-existing condition exclusion period or post-enrollment waiting period shall apply to subscribers.

Y. Exercise of Cost Control

The Contractor shall enforce all contractual agreements for price and administer all existing utilization control mechanisms for the purpose of containing and reducing costs.

Z. Co-Payments

1. The Contractor shall ensure that the Contractor's plans impose co-payments for subscribers as described in Article 3 of the HFP regulations. The Contractor agrees that co-payment maximums as described in Article 3 of the HFP regulations shall be applied for each benefit year and shall be renewed on July 1 of each year. The Contractor shall ensure that the Contractor's plans' Evidence of Coverage or Certificate of Insurance document describe the process to be used by parent(s) or guardian(s) acting on behalf of subscribers to document that the annual two hundred and fifty dollar ($250) out-of-pocket family maximum has been reached.

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2. The Contractor shall ensure that the Contractor's plans' shall work with its provider networks to provide for extended payment plans for subscribers utilizing a significant number of health services for which co-payments are required. When feasible, the Contractor shall ensure that the Contractor's plans instruct its provider network to offer extended payment plans whenever a family's co-payments exceed twenty-five dollars ($25) in one month.

3. The Contractor shall ensure that the Contractor's plans report the number of subscribers who meet the co-payment maximum in the previous benefit year by October 1 of each year.

4. The Contractor shall ensure that the Contractor's plans implement an administrative process that waives all co-payments for AI and AN subscribers in the Program.

AA. Coordination of Benefits

The Contractor agrees to coordinate benefits with other group health plans or insurance policies for subscribers in the Program. The Contractor shall ensure that the Contractor's plans agree to work with other plans or insurers to provide no more than one-hundred percent (100%) of subscribers' covered medical expenses. The Contractor shall coordinate such that coverage provided pursuant to this Agreement is secondary to all other coverage except for Medicaid (Medi-Cal) and Medi-Cal Access Program.

BB. Acts of Third Parties

If a subscriber is injured through the wrongful act or omission of another person, the Contractor shall provide the benefits of this Agreement and the subscriber or parent(s) or guardian(s) acting on behalf of a subscriber shall be deemed:

1. To have agreed to reimburse the Contractor's plans to the extent of the reasonable value of services allowed by Civil Code Section 3040, immediately upon collection of damages by him or her, whether by action at law, settlement or otherwise, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement; and

2. To have provided the Contractor's plans with a lien to the extent of the reasonable value of services provided by the Contractor's plans and allowable under Civil Code Section 3040, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement. The lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

CC. Workers' Compensation Insurance

If, pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of health services provided by the Contractor's plans, then the Contractor shall ensure that the Contractor's plans' provide the benefits of this Agreement and the subscriber shall be deemed to have provided the Contractor's plans with a lien on such Workers' Compensation medical benefits to the extent of the reasonable value of the services provided by the Contractor's plans. The lien may be filed with the responsible third party, his or her agency, or the court. For purposes of this subsection, reasonable value shall be determined to be the usual, customary or reasonable charge for services in the geographic area where the services are rendered.

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DD. Use of Subcontractors

The Contractor may, in its discretion, use the services of subcontractors to recover on the liens provided for under Provision IV, Subsections BB and CC of this Exhibit. The subcontractor's compensation may be paid out of any lien recoveries obtained. DHCS understands and agrees that lien recoveries are chargeable with a prorata contribution toward the injured person's attorney fees under the Common Fund Doctrine. The Contractor may compromise liens as may be reasonable and appropriately consistent with normal business practices.

EE. Health Insurance Portability and Accountability Act of 1996 Conformity

DHCS and the Contractor understand that the coverage provided pursuant to this Agreement constitute creditable coverage pursuant to the federal Health Insurance Portability and Accountability Act of 1996. The Contractor shall issue the Certificates of Coverage for disenrolled subscribers.

FF. Interpretation of Coverage

The Contractor shall ensure that the Contractor's plans' Evidence of Coverage booklet provides clear and complete notice of terms of coverage to CCHIP subscribers. In the event of ambiguity regarding terms of coverage, the Contractor shall ensure that the Contractor's plans interpret those terms in the interest of the subscriber. In the event of ambiguity regarding an exclusion from coverage, the Contractor shall ensure that the Contractor's plans interpret the language of the exclusion in the interest of the subscriber. Nothing in this provision shall supersede the common law rules for interpretation of insurance contracts.

GG. Measuring Consumer Satisfaction

To the extent that the Contractor and the Contractor's plans elect to conduct consumer satisfaction surveys, the results of the surveys shall be made available to DHCS for informational purposes.

HH. Standards Designed to Improve the Quality of Care

1. The Contractor assures DHCS that the Contractor's plans' providers shall use, and the Contractor's plans shall monitor, the most recent recommendations of the American Academy of Pediatrics with regard to Recommendations For Preventative Pediatric Health Care and the most recent version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices.

2. The Contractor shall ensure that the Contractor's plans notify the parent(s) or guardian(s) of all subscriber children enrolled in Contractor's plans through the CCHIP, on an annual basis, of the recommended schedule of preventive care visits.

II. Quality Management Processes

1. The Contractor represents that the Contractor's plans shall maintain a system of accountability for quality improvement activities, including participation of the governing body of the Contractor's plans' organization, the designation of a Quality Improvement Committee, supervision of the activities of the Medical Director, and the inclusion of contracted physicians and other providers in the Contractor's plans' process of Quality

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Improvement development and performance. Evidence of such activities shall be provided to DHCS upon request.

2. The Contractor represents that the Contractor's plans' Quality Management processes have been reviewed and found to be satisfactory by one of the following review organizations: The JCAHO, the NCQA, or the California DMHC.

Exhibit B
Budget Detail and Payment Provisions

1. Invoicing and Payment

A. For services satisfactorily rendered, and upon receipt and approval of the invoices, DHCS agrees to compensate the Contractor for actual expenditures incurred in accordance with the rates and/or allowable costs specified herein.

B. Invoices shall include the Agreement Number and shall be submitted in triplicate not more frequently than monthly in arrears to:

Sua Yang
Department of Health Care Services
Contract and Facility Operations Support Unit
MS 4506
P.O. Box 997413
Sacramento, CA 95899-7413

DHCS, at its discretion, may designate an alternate invoice submission address. A change in the invoice address shall be accomplished via a written notice to the Contractor by DHCS and shall not require an amendment to this Agreement.

C. Invoices shall:

1) Be prepared on Contractor letterhead. If invoices are not on produced letterhead invoices must be signed by an authorized official, employee or agent certifying that the expenditures claimed represent actual expenses for the service performed under this Agreement.
2) Bear the Contractor's name as shown on the Agreement.
3) Identify the billing and/or performance period covered by the invoice.
4) Itemize costs for the billing period in the same or greater level of detail as indicated in this Agreement. Subject to the terms of this Agreement, reimbursement may only be sought for those costs and/or cost categories expressly identified as allowable in this Agreement and approved by DHCS.

2. Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, DHCS shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Agreement and Contractor shall not be obligated to perform any provisions of this Agreement.

B. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, DHCS shall have the option to either cancel this Agreement with no liability occurring to DHCS, or offer an agreement amendment to Contractor to reflect the reduced amount.

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3. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Government Code Chapter 4.5, commencing with Section 927.

4. Amounts Payable

A. The amounts payable under this Agreement shall not exceed:

1) $553,841 for the budget period of 07/01/15 through 06/30/16.
2) $2,088,350 for the budget period of 07/01/16 through 06/30/17.
3) $4,508,317 for the budget period of 07/01/17 through 06/30/18.
4) $7,070,343 for the budget period of 07/01/18 through 06/30/19.
5) $2,189,187 for the budget period of 07/01/19 through 09/30/19.

B. Reimbursement shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are performed and/or goods are received.

C. The Contractor must maintain records reflecting actual expenditures for each state fiscal year covered by the term of this Agreement.

5. Timely Submission of Final Invoice

A. A final undisputed invoice shall be submitted for payment no more than ninety (90) calendar days following the expiration or termination date of this Agreement, unless a later or alternate deadline is agreed to in writing by the Program Contract Manager. Said invoice should be clearly marked "Final Invoice", thus indicating that all payment obligations of DHCS under this Agreement have ceased and that no further payments are due or outstanding.

B. DHCS may, at its discretion, choose not to honor any delinquent final invoice if the Contractor fails to obtain prior written DHCS approval of an alternate final invoice submission deadline. Written DHCS approval shall be sought from the Program Contract Manager prior to the expiration or termination date of this Agreement.

C. The Contractor is hereby advised of its obligation to submit, with the final invoice, a **"Contractor's Release (Exhibit G)"** acknowledging submission of the final invoice to DHCS and certifying the approximate percentage amount, if any, of recycled products used in performance of this Agreement.

6. Expense Allowability / Fiscal Documentation

A. Invoices, received from a Contractor and accepted and/or submitted for payment by DHCS, shall not be deemed evidence of allowable agreement costs.

B. Contractor shall maintain for review and audit and supply to DHCS upon request, adequate documentation of all expenses claimed pursuant to this Agreement to permit a determination of expense allowability.

C. If the allowability or appropriateness of an expense cannot be determined by DHCS because invoice detail, fiscal records, or backup documentation is nonexistent or inadequate according to generally accepted accounting principles or practices, all questionable costs may be disallowed

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and payment may be withheld by DHCS. Upon receipt of adequate documentation supporting a disallowed or questionable expense, reimbursement may resume for the amount substantiated and deemed allowable.

D. Costs and/or expenses deemed unallowable are subject to recovery by DHCS. See provision 7 in this exhibit entitled, "Recovery of Overpayments" for more information.

7. Recovery of Overpayments

A. Contractor agrees that claims based upon a contractual agreement or an audit finding and/or an audit finding that is appealed and upheld, will be recovered by DHCS by one of the following options:

1) Contractor's remittance to DHCS of the full amount of the audit exception within 30 days following DHCS' request for repayment;

2) A repayment schedule which is agreeable to the both DHCS and the Contractor.

B. DHCS reserves the right to select which option will be employed and the Contractor will be notified by DHCS in writing of the claim procedure to be utilized.

C. Interest on the unpaid balance of the audit finding or debt will accrue at a rate equal to the monthly average of the rate received on investments in the Pooled Money Investment Fund commencing on the date that an audit or examination finding is mailed to the Contractor, beginning 30 days after Contractor's receipt of DHCS' demand for repayment.

D. If the Contractor has filed a valid appeal regarding the report of audit findings, recovery of the overpayments will be deferred until a final administrative decision on the appeal has been reached. If the Contractor loses the final administrative appeal, Contractor shall repay, to DHCS, the over-claimed or disallowed expenses, plus accrued interest. Interest accrues from the Contractor's first receipt of DHCS' notice requesting reimbursement of questioned audit costs or disallowed expenses.

8. Payment Provisions

A. General

1) The Contractor agrees to arrange for the provision of medical benefits and case management services for eligible and enrolled child and infant subscribers as described in Exhibit A.

2) Contractor has been responsible for paying the non-federal share of the costs incurred, with the State's responsibility being limited to providing to Contractor the available Title XXI federal reimbursement.

a. Effective January 1, 2014, State will provide the non-federal share of the costs incurred by reimbursing in arrears Contractor's allowable expenditures, in addition to providing the available Title XXI federal reimbursement.

Exhibit B
Budget Detail and Payment Provisions

B. Fees Provided to Contractor

1) As specified in Provisions 8, Subsection C and D of this Exhibit, the State shall provide Title XXI federal reimbursement to the Contractor based on a flat fee per month for each child subscriber starting in the first month of the child's coverage and ending in the month of the child's nineteenth birthday or when the child otherwise becomes ineligible. This fee is for health, dental, and vision benefit expenses. This fee is set forth in Attachment I, Confidential Attachment, Rates of Payment.

2) As specified in Provisions 8, Subsection C and D of this Exhibit, the State shall provide Title XXI federal reimbursement to the Contractor based on a flat fee per month for each infant subscriber. This monthly fee shall be paid during the first month of enrollment through the twelfth month of the infant's life or when the infant otherwise becomes ineligible, but shall not exceed twelve payments. This fee is for health, dental, and vision benefit expenses. This fee is set forth in Attachment I., Confidential Attachment, Rates of Payment.

3) In cases of subscriber eligibility and enrollment appeals that result in liability of health care costs by the State, the Contractor shall require its contracted plans to arrange for payment to the provider for services delivered, within thirty (30) days of notification by the State of the appeal findings and claim reimbursement from the State within forty-five (45) days after notification by the State of the appeals findings. The State shall pay the Contractor for the actual costs of services received. However, the Contractor shall reimburse and claim for such services at any discounted rate that the Contractor's plan may have in place with the provider participating in the C-CHIP and that is accepted by the provider as payment in full.

4) Administrative Costs

a. As specified in Provisions 8, Subsection C and D of this Exhibit, the State shall provide Title XXI federal reimbursement to the Contractor based on total administrative costs for the month.

b. For the purposes of this Agreement, Administrative Costs are those related to administering the program that include costs related to application processing, C-CHIP enrollment services, and outreach. Administrative costs shall not include those costs of providing or directly administering medical services that are already included in the benefit rates set forth in the Confidential Attachment, Rates of Payment.

c. Contractor Administrative Costs must be in accordance with 45 CFR, Part 74, Section 74.27, "Allowable Costs" and the provisions of OMB Circular A-87. In accordance with federal law, Title XXI, Sec. 2105 (a), the State is limiting payments of administrative costs to ten percent (10%) of the combined administrative costs and benefit costs reduced by monthly contributions (or net benefits). Benefit costs are defined as a combination of Provision 8, Subsection B.1 through I.B.3.

d. Except as stated in subparagraph i. below, the State shall receive compensation for State administrative services, based on the non-federal share of total State personnel and overhead costs. The State administrative costs shall be equally shared by all contractors currently participating in C-CHIP. The Contractor shall be billed its monthly pro-rata share of total State administrative costs. The Contractor shall pay the applicable non-federal share to the CHIM Fund. These funds shall be retained for the draw of Title

Exhibit B
Budget Detail and Payment Provisions

XXI reimbursement and made available to the State for services provided under the Agreement.

i. Effective January 1, 2014, this paragraph d. shall not apply to State administrative costs incurred on January 1, 2014 and later.

e. The Contractor shall receive federal Title XXI reimbursement for actual, justifiable, allowable Administrative Costs of no more than ten percent (10%) of net benefit costs.

5) Offset of Subscriber Contributions

a. As specified in Exhibit A, Provision III, Subsection N, the Contractor shall collect a subscriber contribution flat fee per month for each subscriber enrolled.

b. The Contractor shall report to the State the monthly subscriber contributions collected by the fifteenth (15th) day after the end of the federal fiscal quarter in a standardized electronic and paper format specified by the State. The monthly subscriber contributions shall be submitted with the corresponding HIPAA compliant enrollment files as specified in Exhibit A, Provision III, SubsectionJ.3.

c. The State shall reduce the amount of benefit fees paid to the contractor for expenditures described in Provision 8, Subsection D of this Exhibit by the amount of subscriber contributions collected on a monthly basis. Reduction of subscriber contributions shall be based on the actual amount of subscriber contributions collected for the billed month.

C. Payment Schedule

1) The State agrees to draw Title XXI federal fund reimbursement for payments incurred in Provision 8, Subsection B.1. through 4. of this Exhibit at the federal matching fund rate of sixty-five percent (65%) for children above two hundred fifty percent (250%) up to three hundred percent (300%) of Federal Poverty Level (FPL).

a. Effective January 1, 2014, with the implementation of the ACA, all previous income deduction methodologies shall not apply. A five percent (5%) income disregard does apply, increasing the above FPL range to two hundred sixty-six percent (266%) up to three hundred twenty-two percent (322%) of the FPL.

b. Effective October 1, 2015, the federal matching fund rate increased from sixty-five percent (65%) to eighty-eight percent (88%) for children above two hundred sixty-one percent (261%) up to three hundred seventeen percent (317%) of the FPL.

2) The State agrees to draw Title XXI federal fund reimbursement for payments incurred in Provision 8, Subsection B.1 through 4 of this Exhibit, monthly in arrears. Payment is contingent on the State approval of the monthly Enrollment Reports described in Provision 8, Subsection D. of this Exhibit.

Exhibit B
Budget Detail and Payment Provisions

D. Financial and Enrollment Reports

1) Monthly Financial Reports

a. The State shall generate a monthly financial report for children above two hundred sixty-six percent (266%) up to three hundred twenty-two percent (322%) of the FPL for each month within the federal fiscal quarter following receipt and review of the monthly enrollment report submitted by the Contractor, due the fifteenth (15th) day after the end of the federal fiscal quarter with supporting documentation and a certificate attesting the validity of costs and services provided in an electronic and paper format specified by the State.

b. The monthly financial reports shall support and request payment for services provided to program subscribers pursuant to Provision 8, Subsection B.1, 2., 3., 4., and 6. of this Exhibit.

i. Effective January 1, 2014, State will provide the non-federal share to be transferred to the CHIM Fund.

c. The monthly financial report, generated by the State following review of the monthly enrollment reports submitted by the Contractor, shall indicate the total funds reimbursable to the county for infants and children above two hundred sixty-six percent (266%) up to three hundred twenty-two percent (322%) of the FPL. Because the period of availability of federal funds is limited to two (2) years, the State shall generate and submit the monthly financial reports no later than ninety (90) days prior to the end of the time limit contained in 45 C.F.R. Section 95.7, to ensure availability of the federal funds for reimbursement.

d. The monthly financial reports shall provide adequate documentation to support State approval of Title XXI reimbursement for allowable county administrative costs, which will not be in excess of the established ten percent (10%) of net benefit costs for contractor administrative costs.

2) Monthly Enrollment Report

a. The Contractor shall submit to the State, monthly enrollment reports by the fifteenth (15th) day after the end of the federal fiscal quarter in a standardized electronic and paper format specified by the State. The monthly enrollment reports shall be submitted with the corresponding HIPAA compliant enrollment files as specified in Exhibit A, Provision III, Subsection J.3.

b. The State shall use the monthly enrollment reports to calculate the total funds reimbursable to the Contractor. Because the period of availability of federal funds is limited to two (2) years, the State shall generate and submit the monthly financial reports no later than ninety (90) days prior to the end of the time limit contained in 45 C.F.R. Section 95.7, to ensure availability of the federal funds for reimbursement.

Exhibit B
Budget Detail and Payment Provisions

3) Retroactive Benefits Payment Report

No later than sixty (60) calendar days after submission of the first set of monthly financial reports, the Contractor shall submit to the State a retroactive benefits payment report covering the periods set forth in Provision 8, Subsection B.5. of this Exhibit, along with the supporting enrollment reports in a standardized electronic and paper format specified by the State. The supporting enrollment reports shall be submitted with the corresponding HIPAA compliant enrollment files as specified in Exhibit A, Provision III, Subsection J.3. The State shall use the enrollment reports to verify eligibility for retroactive payments, as well as the Contractor's calculations of the applicable Title XXI contribution to be transferred to the CHIM Fund. The Contractor retroactive benefits payment report submissions shall be in accordance with submission requirements specified in Exhibit B, Provision 8, Subsection D.2.

4) Quarterly Budget Report

a. The Contractor shall submit to the State a quarterly budget report sixty (60) days prior to the start of each federal quarter in a standardized electronic and paper format specified by the State. The quarterly budget report shall include monthly estimates of enrollment and corresponding expenditures in a two-year State fiscal period. A State fiscal period is defined as the twelve-month period beginning July 1 through June 30. This report is a federal requirement, therefore, the State's ability to pay the Contractor is contingent on the timely submission of the quarterly budget report.

b. Upon approval of SPA 19, the Contractor shall make changes to the Quarterly Budget Report if requested by the State.

5) Quarterly Statistical Enrollment Report

a. The Contractor shall submit to the State a quarterly statistical enrollment report by the tenth (10th) day after the end of the quarter in an electronic and paper format as specified by the State. The quarterly statistical enrollment report shall include actual enrollment for each federal quarter, including statistics on new enrollment, disenrollment and ever-enrolled subscribers. This report is a federal requirement; therefore, the State's ability to pay the Contractor is contingent on the timely submission of the quarterly statistical enrollment report.

b. Upon approval of SPA 19, the Contractor shall make changes to the Quarterly Statistical Enrollment Report if requested by the State.

6) Any enrollment, retroactive payment, budget or statistical enrollment report received not completed in accordance with Provision 8, Subsection D.2. through 5. of this Exhibit shall be considered unacceptable and returned to the Contractor unprocessed with an explanation of any problems with the report. The Contractor may resubmit an acceptable report. The State reserves the right to make minor corrections to the report and process the reports for payment or reporting with the corrections.

7) Any enrollment, and retroactive benefit payment report submitted as described under Provisions 8, Subsection D.2. through 3. of this Exhibit after review and approval by the State shall be considered valid and acceptable for processing of payment for benefit and administrative services provided to program subscribers.

Exhibit B
Budget Detail and Payment Provisions

8) The State will notify the Contractor when it has approved the monthly enrollment report or the retroactive benefits payment report, and has generated the monthly financial report for submission to the State Controller's Office, for payment to the Contractor.

9. Fiscal Control Provisions

A. Cost Controls Provided by Contractor

The Contractor shall ensure that the Contractor's plans provide routine monitoring of the cost, quantity, and quality of benefits provided by participating providers to subscribers, for the purpose of determining whether the level, type, and cost of such benefits are appropriate to the health care needs of the subscribers. The system of monitoring utilization shall include reporting to its providers of the findings of the Contractor's plans' monitoring activity.

B. Payment Limitation

Only eligible subscribers whom the Contractor has enrolled in the program are entitled to health services and benefits provided under this Agreement and only for services rendered or supplies received during the period for which the eligible subscriber is enrolled.

C. Availability of Federal Funds

1) It is mutually understood between the parties that this Agreement may have been written for the mutual benefit of both parties, based on then-existing regulations and federal executive agencies' interpretation and application of relevant regulations and statutes but before ascertaining the availability of Congressional appropriation of funds, in order to avoid program and fiscal delays that would occur if the Agreement were executed after that determination was made.

2) This Agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the purposes of this program for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions made applicable at any time by:

   a. enactments of Congress

   b. regulations promulgated or amended by federal executive agencies, or

   c. the interpretation or application by federal executive agencies of relevant regulations and statutes that may affect the provisions, terms or funding of this Agreement in any manner.

3) The parties mutually agree that, if Congress does not appropriate sufficient funds for the Program or, as described in Exhibit B, Provision 9, Subsection C.2.a., b. and c., restrictions, limitations or conditions affect the provisions, terms or funding of this Agreement, this Agreement shall be amended to reflect any reduction in funds and any restrictions, limitations or conditions that affect the Agreement's provisions, terms or funding.

Exhibit B
Budget Detail and Payment Provisions

4) The State has the option to invalidate this Agreement under the 30-day termination clause in Exhibit E, Provision 2 or to amend the Agreement to reflect any reduction in funds in Exhibit E, Provision 1.

D. Prior to Fiscal Year/Crossing Fiscal Years

It is mutually agreed between the parties that this Agreement may have been signed and executed prior to the start of the 2015-2016 State fiscal year before ascertaining the availability of federal funds allocated through the State budget for the 2015-2016 State fiscal year. This Agreement has also been written with a term that crosses State fiscal years, and therefore before ascertaining the availability of legislative appropriation of federal funds for the 2015-2016 through 2019-2020 State fiscal years. This Agreement is valid and enforceable only if sufficient federal funds are made available through the 2015-2016 through 2019-2020 State budget for the purposes of this program. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted in statute by the State Legislature that may affect the provision, term or funding of this Agreement in any manner. It is mutually agreed that if the State Legislature does not appropriate sufficient funds for this program, the Agreement shall be amended to reflect any reduction in funds.

E. CHIM Fund Encumbrance

There is no specific maximum amount assigned to this Agreement. Rather, the Contractor is paid through a general encumbrance from the CHIM Fund apportioned to the Contractor on an as needed basis. Payments under this Agreement are limited to the provisions of Provision 8, Subsection A and B of this Exhibit.

F. Fiscal Solvency

1) The Contractor warrants that the Contractor's plans licensed by the Department of Managed Health Care shall at all times maintain the reserves required under the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations promulgated thereunder by the Department of Managed Health Care, including the Tangible Net Equity regulations.

Evidence of the above referenced solvency shall be made available to the State upon request.

2) The Contractor warrants that the Contractor's health insurers, licensed by the Department of Insurance, shall at all times comply with all solvency requirements of its licensing statutes and regulations and shall at all time maintain one of the following:

a. A rating of A+ under Best insurance rating, or

b. A surplus capable of paying one month of Contractor's paid claims. The amount of one month of the Contractor's paid claims shall be established by averaging claims paid in each of the previous twelve (12) months.

Evidence of the above referenced solvency shall be made available to the State upon request.

Exhibit B
Budget Detail and Payment Provisions

G. Federally Funded Programs (Medicare & Medicaid)

The Contractor shall ensure that the Contractor's plans or insurers who participate in the federal Medicaid or Medicare programs remain in good standing with the State Department of Health Care Services (DHCS) for services provided to Medicaid (Medi-Cal) subscribers, with the federal Centers for Medicare and Medicaid Services (CMS) for services provided to Medi-Cal or Medicare subscribers, and with the Office of the Inspector General of the Department of Health and Human Services. On request, the Contractor agrees to ensure that the Contractor's plans provide the State immediately with copies of all correspondence received by the plan(s) or insurer(s) from the State, the CMS, and the Office of the Inspector General of the Department of Health and Human Services that pertains to the plans or Insurers standing with the respective departments. In addition, the Contractor shall immediately notify the State of any investigations in which there are allegations related to fraud, including but not limited to: 1) the receipt of an administrative subpoena from any state or federal agency, unless the plan or insurer is advised that it is not the target or subject of the investigation; 2) the receipt of a grand jury subpoena from any state or federal court, unless the plan or insurer is advised that it is not the target or subject of the investigation; 3) the execution of a search and seizure warrant at any of the selected plan's or insurer's offices or locations related to such investigations; and 4) the filing of any charges against the selected plan or insurer in any state or federal court related to such investigations. The Contractor shall ensure that the Contractor's plans immediately notify the State if the plan or insurer receives a letter of pending sanction or formal corrective action (such as corrective action addressing audit findings or systemic problems) from the State, the CMS, or the Office of the Inspector General of the Department of Health and Human Services.

H. Licensure

The Contractor warrants the State that the Contractor's health plan or insurer has a license to provide services under this Agreement from its regulatory agency, the Department of Managed Health Care or the Department of Insurance.

I. Licensing Sanction Notifications

1) The Contractor warrants that the Contractor's plans shall remain in good standing with the Department of Managed Health Care. On request, the Contractor agrees to ensure that the Contractor's plans provide the State with copies of all correspondence from the Department of Managed Health Care that pertains to the plan's standing with its regulatory entity. The Contractor shall immediately notify the State if the Contractor's plans receive a letter of pending sanction or formal corrective action (such as corrective action addressing audit findings or systemic problems) from the Department of Managed Health Care.

2) The Contractor warrants that the Contractor's health insurers shall remain in good standing with the Department of Insurance. The Contractor agrees to ensure that the Contractor's insurers provide the State with copies of all correspondence from the Department of Insurance that pertains to the insurer's standing with their regulatory entity. The Contractor shall ensure that the Contractor's insurers immediately notify the State if the insurer receives a letter of pending significant sanction or corrective action from the Department of Insurance.

Exhibit B
Budget Detail and Payment Provisions

J. Responsibility for Audit, Investigation and Evaluation Findings

The Contractor shall hold the State harmless for any federal disallowances and adjustments resulting from the Contractor's performance under this Agreement.

EXHIBIT B ATTACHMENT I
CONFIDENTIAL RATES OF PAYMENT

This attachment is confidential, and is not open until, at the earliest July 2, 2019. See Exhibit E, Item 8. of this Agreement for the standards governing confidentiality.

CCC 04/2017

CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

Contractor/Bidder Firm Name (Printed)	*Federal ID Number*
County of San Mateo	94-6000532
By (Authorized Signature)	
Printed Name and Title of Person Signing	
Louise Rogers, Health System Chief	
Date Executed	*Executed in the County of*
9/26/2017	San Mateo, CA

CONTRACTOR CERTIFICATION CLAUSES

1. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the nondiscrimination program requirements. (Gov. Code §12990 (a-f) and CCR, Title 2, Section 11102) (Not applicable to public entities.)

2. DRUG-FREE WORKPLACE REQUIREMENTS: Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

b. Establish a Drug-Free Awareness Program to inform employees about:

1) the dangers of drug abuse in the workplace;
2) the person's or organization's policy of maintaining a drug-free workplace;
3) any available counseling, rehabilitation and employee assistance programs; and,
4) penalties that may be imposed upon employees for drug abuse violations.

c. Every employee who works on the proposed Agreement will:

1) receive a copy of the company's drug-free workplace policy statement; and,
2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the

certification by failing to carry out the requirements as noted above. (Gov. Code §8350 et seq.)

3. NATIONAL LABOR RELATIONS BOARD CERTIFICATION: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (Pub. Contract Code §10296) (Not applicable to public entities.)

4. CONTRACTS FOR LEGAL SERVICES $50,000 OR MORE- PRO BONO REQUIREMENT: Contractor hereby certifies that Contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lessor of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

5. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

6. SWEATFREE CODE OF CONDUCT:

a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at www.dir.ca.gov, and Public Contract Code Section 6108.

b. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably required by authorized officials of the contracting agency, the Department of Industrial Relations,

or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

7. DOMESTIC PARTNERS: For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.3.

8. GENDER IDENTITY: For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.35.

DOING BUSINESS WITH THE STATE OF CALIFORNIA

The following laws apply to persons or entities doing business with the State of California.

1. CONFLICT OF INTEREST: Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement, the awarding agency must be contacted immediately for clarification.

Current State Employees (Pub. Contract Code §10410):

1). No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

2). No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

Former State Employees (Pub. Contract Code §10411):

1). For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2). For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (Pub. Contract Code §10420)

Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (Pub. Contract Code §10430 (e))

2. LABOR CODE/WORKERS' COMPENSATION: Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

3. AMERICANS WITH DISABILITIES ACT: Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. CONTRACTOR NAME CHANGE: An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:

a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. RESOLUTION: A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. AIR OR WATER POLLUTION VIOLATION: Under the State laws, the Contractor shall not be*:* (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

8. PAYEE DATA RECORD FORM STD. 204: This form must be completed by all contractors that are not another state agency or other governmental entity.

CALIFORNIA CIVIL RIGHTS LAWS CERTIFICATION

Pursuant to Public Contract Code section 2010, if a bidder or proposer executes or renews a contract over $100,000 on or after January 1, 2017, the bidder or proposer hereby certifies compliance with the following:

1. CALIFORNIA CIVIL RIGHTS LAWS: For contracts over $100,000 executed or renewed after January 1, 2017, the contractor certifies compliance with the Unruh Civil Rights Act (Section 51 of the Civil Code) and the Fair Employment and Housing Act (Section 12960 of the Government Code); and

2. EMPLOYER DISCRIMINATORY POLICIES: For contracts over $100,000 executed or renewed after January 1, 2017, if a Contractor has an internal policy against a sovereign nation or peoples recognized by the United States government, the Contractor certifies that such policies are not used in violation of the Unruh Civil Rights Act (Section 51 of the Civil Code) or the Fair Employment and Housing Act (Section 12960 of the Government Code).

CERTIFICATION

<table>
<tr><td colspan="2">I, the official named below, certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Proposer/Bidder Firm Name (Printed)
County of San Mateo</td><td>Federal ID Number
94-6000532</td></tr>
<tr><td colspan="3">By (Authorized Signature)</td></tr>
<tr><td colspan="3">Printed Name and Title of Person Signing
Louise Rogers, Health System Chief</td></tr>
<tr><td>Date Executed
9/26/2017</td><td colspan="2">Executed in the County and State of
San Mateo, CA</td></tr>
</table>

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

September 20, 2017

Ms. Sosefina Pita
Program Manager
County of San Mateo
225 37th Avenue
San Mateo, CA 94403

Subject: Agreement Number 15-92349

Dear Ms. Pita:

The Department of Health Care Services (DHCS) has standardized its contracting procedures and agreement formats. The enclosed agreement references on-line general terms and conditions (i.e., GTC 610 or 307 or a GIA version) that are not attached to the agreement. The cited terms may be accessed by choosing the Standard Contract Language Tab at this Internet site: http://www.ols.dgs.ca.gov/Standard Language/default.htm. The enclosed agreement is not binding until signed by both parties and approved by the appropriate state control agency (if such approval is required). No services are to be provided prior to receipt of all approvals as DHCS is unable to issue any payment prior to receipt of final approval. Expeditious handling of this agreement is greatly appreciated.

For inquiries regarding this agreement, please contact Sua Yang at (916) 552-9172 and cite the DHCS agreement number identified above. Unless otherwise instructed, do not submit an invoice to DHCS for any services rendered under the referenced agreement until a copy of the fully executed agreement is received.

X Affix a signature to the enclosed agreement copy and each additional face sheet. **Submit two copies with original signatures.** Return **all** items to DHCS for further processing. A copy of the approved agreement will be distributed to you after it is fully executed. Alterations, in general, are not allowed. Alterations and page replacements, if any, must be pre-approved by DHCS and each visible alteration must be initialed by the person who signs the agreement.

____ Complete, sign, and return the Payee Data Record (STD 204). Payments cannot be issued unless a signed form containing current contractor information is on file with DHCS.

X Go to the Standard Contract Language Tab at http://www.ols.dgs.ca.gov/Standard Language/default.htm, review the GTC version referenced on the face of the agreement as Exhibit C. Review Provision 11 of the GTC to identify the Contractor Certification Clause (CCC) number (e.g., 307, etc.) that applies to the enclosed agreement. Read the cited CCC Certification in its entirety. Print-out and sign the first page of the applicable cited CCC Certification. Return the first page of the originally signed CCC Certification to the address noted below. The signed CCC will be kept on file. Failure to return the appropriate signed CCC Certification will prohibit DHCS from doing business with your firm.

____ **Corporations:** If the Contractor is a corporation, either submit a copy of the firm's most current Certificate of Status issued by the State of California, Office of the Secretary of State **or** submit a downloaded copy of the Contractor's on-line status information from the California Business Portal website of California's Office of the Secretary of State.

X **Board Resolution**: If Contractor is a City or County, submit a copy of an approved Board Resolution or meeting minute approval to contract with the State.

X **California Civil Rights Laws Attachment:** Affix a signature to the enclosed California Civil Rights Laws Attachment. Submit the original with the final contract.

Return all designated materials to the following address:

Sua Yang, Contract Analyst
Department of Health Care Services
1501 Capitol Avenue, MS 4506
P.O. Box 997413
Sacramento, CA 95899-7413

Direct questions about this letter to Sua Yang at (916) 552-9172. Be sure to cite the DHCS agreement number (#15-92348) in all future correspondence.

Cordially yours,

Sua Yang, Contract Analyst
Department of Health Care Services

Attachment(s)