From: DMHC Licensing eFiling

Subject: APL 18 - 003 (OPL) – Plan Year 2019 QHP/QDP Filing Requirements

Date: Friday, January 19, 2018 2:18:05 PM

Attachments: 2019 Qualified Dental Plan Checklist.pdf
2019 Qualified Health Plans Checklist.pdf
QDP Attachment.pdf
QHP Attachment Filing Worksheet.pdf
QHP Attachment Prescription Drug Attestation.pdf
QHP Attachment Subcontractor Worksheet.pdf

Dear Health Plan Representative,

The DMHC offers the attached checklists, worksheets, and forms to assist health plans with preparing Individual and Covered California for Small Business Qualified Health and Dental Plan filings for the Plan Year 2019, in compliance with the Knox- Keene Act at California Health and Safety Code Sections 1340 et seq. (Act) and regulations promulgated by the DMHC at California Code of Regulations, title 28 (Rules).

For Qualified Health Plans (QHPs) and Qualified Dental Plans (QDPs) licensed pursuant to the Act, the DMHC has primary responsibility for regulatory review and preliminary recommendations with respect to certain selection criteria identified by the California Health Benefit Exchange (Exchange) in evaluation of whether an applicant is in “good standing.” All licensure, regulatory and product requirements of the Act and Rules apply to QHPs and QDPs offered through the Exchange.
If you have questions regarding the attached documents, please contact your OPL assigned reviewer.

Thank you

2019 CHECKLIST and ATTACHMENT
FOR QUALIFIED DENTAL PLANS IN THE
CALIFORNIA HEALTH BENEFIT EXCHANGE

In anticipation of Qualified Dental Plans ("QDP") filings in relation to the Qualified Dental Plan Certification Application for Plan Year 2019, for Individual and Covered California for Small Business ("CCSB") issued by the California Health Benefit Exchange ("Exchange" or "Covered California"), the Department of Managed Health Care ("Department") offers the following checklist with some helpful hints to expedite approval based on the last couple of years of working with Covered California and QDP filings. The checklist takes into account the Knox-Keene Act ("Act" or "Sections") and implementing regulations at California Health & Safety Code Sections 1351 and 1352, and California Code of Regulations ("Rules") Section 1300.51 and 1300.52.

This checklist is not intended to be all-inclusive. Additional information, as needed, may be requested by the Department within the course of review. The information gathered here is based on lessons learned from previous filing years. This checklist applies to both dental plans that contract directly with Covered California and embedded dental plans that contract with Full Service Qualified Health Plans ("QHP") which contract with Covered California. ***Information specific to only standalone or embedded filings is noted in brackets throughout the checklist.***

This checklist is provided to the plan's e-Filing designated contact. If the plan would like its Covered California contact to be someone else, please contact the the plan's assigned reviewer in the Office of Plan Licensing ("OPL") as soon as possible.

I. Filing Timeframes

Prior to certification, plans must have regulatory approval of necessary filings including, but not limited to networks and products. **Please note, the Department's filing due date is before the date Covered California is requiring its' application materials to be filed.**

II.	**New Applicant; QDP Proposing New: Rating Region, Service Area Expansion and/or Line of Business**	**Recertification**
All Other Exhibits as Necessary	No later than April 1	No later than April 1
Provider Network	No later than April 1	No later than April 1
Product Designs	No later than April 1	

III. General Filing Information

a. For dental plans licensed pursuant to the Act, the Department has primary responsibility for regulatory review and issuing preliminary recommendations with respect to certain selection criteria identified by the Exchange in evaluating whether an applicant is in "good standing," in addition to applying the minimum licensure requirements.

b. ***[Only Embedded Filings]*** Contractual relationships with QHP(s) for embedded Essential Health Benefits ("EHB") pediatric dental benefits are to be **filed separately** from the plan's QDP filing(s).[1]

c. Network Filings for embedded EHBs and Standalone products are to be **filed separately** in a separate filing from the plan's QDP filing(s). In the Exhibit E-1, reference the benefits QDP Filing Number.

IV. Filing Process

a. Filing Process: Prepare and submit an **Amendment or Material Modification[2]** pursuant to Sections 1351 and 1352, to a health plan's license in regard to a QDP Application(s) to address compliance with the Act, Rules, California Patient Protection and Affordable Care Act ("CA-ACA") and Federal Patient Protection and Affordable Care Act of 2010 ("ACA") laws and regulations relative to QDP certification.

   i. When submitting your filing, please:
      1. **Use the subject title "HBEX QDP Application 2019" and**
      2. **Select "QDP" under "Product & Issues - Issues" in the e-Filing system.** This selection will allow the Department to effectively track QDP-related filings.

V. ***[Only Embedded Filing]*** Plan to Plan Agreements

a. If the Plan to Plan Agreement needs to be revised or updated, i.e. includes the Plan Year 2019 benefits, the Plan to Plan Agreement(s) are to be **filed separately**. In the Exhibit E-1, reference the benefits QDP Filing Number.

b. If the Plan to Plan Agreement does **not** need to be revised or updated, include within the Exhibit E-1 the previously approved Filing Number for the Plan to Plan Agreement. *See* Section VII.

[1] For additional information regarding QHP filing requirements, please request the 2019 Qualified Health Plan Filing Checklist from the Plan's assigned attorney in OPL.

[2] In the event that the QDP is revising its products such that the revisions result in a new "product," please submit such product revision as a Material Modification.

VI. Helpful Hints based on the Department's Review of Plan Year 2018

a. **Naming Convention:** Please refer back to Covered California and adhere to Covered California's naming convention for on-exchange plans and off-exchange mirror products pursuant to Government Code section 100503(f).

b. Benchmark Plan:

i. Note that 2015 Senate Bill 43 (Hernandez) modified Section 1367.005(a)(5). The Benchmark Plan is the 2014 Medi-Cal Dental Program.

ii. The Benchmark Plan is the same Benchmark Plan used for Plan Year 2017 and Plan Year 2018.

iii. Please note, the Benchmark Plan (based on the 2014 Medi-Cal Program) uses *outdated* CDT codes. However, Covered California's Standard Benefit Design (SBD) reflects the most recent CDT codes. Thus, please utilize the SBD provided by Covered California for Plan Year 2019. *See* Section I(ii).

iv. If you need a copy of the Benchmark Plan, please reach out to your OPL assigned reviewer as soon as possible.

VII. **Exhibit E-1**[3]**:** Please include the following information in the narrative:

a. Explain the **types of products** the plan is anticipating offering in 2019. The options for products on the Exchange are: Individual Family, Individual Child-only, CCSB Family, or CSSB Child-Only.

b. Identify if any of the products being offered in 2019 are a new offering for the plan.

c. Specify the regions, by regional number or county, where each identified product will be offered for 2019, highlighting any new region for 2019.

d. ***[Only Embedded Filing]*** Identify the full service plan(s) to which this filing pertains.

e. ***[Only Embedded Filing]*** Identify the type of network(s) to which the filing pertains.

i. Examples of types of networks are: HMO, PPO, EPO

[3] Pursuant to Sections 1351 and 1352, the Exhibits and information listed below may need to be included in the Plan's QDP Filing. If applicable, please file.

ii. In the Exhibit E-1, provide an affirmation that the plan is licensed for the type of network utilized for the QHP filing. *See* Affirmation Section in Section E-1.

1. For example, if the QHP is offering an EPO, affirm the QDP is licensed to operate as an EPO.

f. Provide a brief overview of any changes to the plan's network previously approved for use on the Exchange. **Note:** File any network revisions in a separate Amendment or Material Modification.

g. ***[Only Embedded Filing]*** Provide a brief explanation of the nature of the contractual relationship, include:

i. Explanation of the type of contractual relationship (i.e., renting/leasing (no risk) of the network through a provider contract or an ASA or through a plan-to-plan (risk arrangement) contract.)

1. Explain whether this is a new or previously approved contractual relationship. If previously approved, provide the filing number.

ii. Explanation of whether the plan will be performing functions, such as utilization management, grievances, and appeals, etc., on behalf of the QHP.

h. **Evidence of Coverage (EOC):** Provide the filing number for the EOC previously approved for use on the Exchange. If no changes to the previously approved EOC, please indicate in the Exhibit E-1.

i. Any changes made to the EOC previously approved for use on the Exchange needs to be identified by the page(s) and section number(s) within the EOC where changes are located. *See* Exhibit S, T, U Section for more information.

i. **Schedule of Benefits (SOB):** Note whether there are any redlined changes made to the SOB previously approved for use on the Exchange. Please provide the filing number of the previously approved SOB.

i. Please note, it is anticipated that there will be changes to the plan's SOB as Covered California modeled its 2019 SBD from changes made to CDT-18 by the American Dental Association. *See* Exhibit S, T, U Section for more information.

ii. **CDT codes**: Last year, Covered California allowed Plans to use 2017 CDT codes as they appeared in the Standard Benefit Design or the updated 2018 CDT codes with a request for the plans to remain

consistent in their use of one of the years. *See* August 1, 2017 Standard Benefit Design (2018 Dental Benefit Plan Designs – Summary of Benefits and Coverage). If Covered California takes a similar approach for Plan Year 2019, list any 2019 CDT codes that deviate from the SBD.

j. Endnotes:

i. Endnotes are not required to be duplicated word for word. However, the information contained in the SBD endnotes needs to be easily accessible for the plan's enrollees.

ii. Provide the exhibit, page and section number in the SOB where the Covered California SBD endnotes are located within the QDP filing.

iii. ***[Only Embedded Filing]*** Provide the page(s) and section(s) where the Covered California SBD endnotes are located within the QDP SOB or QHP SOB. *See* Exhibit S, T, U Section for more information.

k. Note any changes to the plan's organizational chart, administrative capacity, delegation of functions, utilization management, quality assurances, marketing, broker/solicitor agreements, fiscal solvency and/or grievance and appeals. Note the page and section number where the changes were made and file the applicable exhibit(s). Provide the filing number(s) of previously approved exhibits.

l. As much as the SBD allows for deviation for non-essential health benefits, please identify the adult dental benefits by CDT code(s) the plan will offer in the Exhibit E-1.

m. Affirmation Section:

i. Please file the affirmation section within the plan's Exhibit E-1.

ii. For any differences from the Benchmark Plan for a SBD product in **a) CDT codes, b) limitations and exclusions and/or c) endnotes**, please include an affirmation that the differences lead the plan to offer a benefit that is identical or better than the benefits provided in the Benchmark Plan.

1. The Department will accept a general affirmation from the plan (versus an affirmation per CDT code or per limitation or per endnote).

2. If the Department identifies additional revisions needed to the plan's a) CDT codes, b) limitations and exclusions and/or c) endnotes, during the course of the Department's review, the

plan may need to provide a specific affirmation per a) CDT code, b) limitation and exclusion, and/or c) endnote.

iii. The affirmation should make it clear that the plan's description of benefits and cost share have an identical or better effect for the enrollee than the Benchmark Plan.

iv. ***[Only Embedded Filings]*** Only one EOC and one SOB for each filing type (i.e. HMO, PPO, and/or EPO) that is an SBD are required to be filed for embedded filings. If SBD, include an affirmation that the filed EOC and SOB will apply to all metal levels. If filed as an alternative, file all alternatives.

n. **Confidentiality:** Note whether the plan will be applying for confidential treatment of any exhibits. If applicable, file a Request for Confidentiality and comply with Rule 1007.

VIII. Product Design Exhibits: Exhibits S, T, U[4]:

a. General Instructions for ***Embedded Filings***:

i. If plan's SBD dental benefits (EOC, CDT Codes, limitations and exclusions, SOB, and endnotes) are filed in a separate addendum from the contracted QHP, file only one addendum for each filing type (i.e. HMO, PPO, and/or EPO). Include an affirmation that the filed EOC will apply to all metal levels. *See* Affirmation Section in Section Exhibit E-1.

1. For example, if the plan has six HMO products and three PPO products, the plan will only need to file two EOCs. The two filed will be: a) one for the HMO products and b) one for the PPO products.

ii. If plan's SBD dental benefits (EOC, CDT Codes, limitations and exclusions, SOB, and endnotes) are filed within a QHP's EOC (not a separate addendum), follow all information of embedded filing and additionally file an affirmation in the plan's QDP Exhibit E-1, stating that the dental benefits (EOC, limitations and exclusions, SOB, and endnotes) are identical across all metal levels for each filing type (HMO, PPO, EPO). *See* Affirmation Section in Section Exhibit E-1.

1. If the plan's SBD dental benefits (EOC, CDT Codes, limitations and exclusions, SOB, and endnotes) are not identical across all metal levels per product, please contact your assigned OPL reviewer.

[4] Id.

iii. If the QDP SBD dental benefits are embedded in a QHP in two markets (Individual Family, CSSB Family, or CSSB Child-Only), file an affirmation for both markets. *See* Affirmation Section in Section Exhibit E-1.

iv. If the dental benefits (EOC, CDT codes, limitations and exclusions, SOB, and endnotes) are not SBD, but rather an alternative benefit design, please contact your assigned OPL reviewer.

b. Exhibit S, Exhibit T: (individual and group health care service plan contracts) These exhibits may be required to be filed or revised. The plan is not required to file these exhibits unless changes have been made to the previously approved documents utilized by the plan for its Covered California filings. Please provide the filing number of previously approved contracts.

c. Exhibit U: (EOC) All QDPs must comply with Covered California's SBDs, alternative benefit designs and Covered California's naming convention pursuant to Government Code Section 100503(f) (if applicable). New and revised product designs must be filed (e.g., cost-sharing, EOCs, etc.).

i. Schedule of Benefits (SOB)

1. ***Copayment:*** For efficiency and review of the Copay SOB, the Department recommends the plan follow the same order and text of CDT codes as listed in the 2019 Covered California Dental SBD.

2. ***Coinsurance:*** Plans are not required to file the list of CDT codes with associated text. However, following the CDT list and text, and inserting the plan's coinsurance amounts will expedite review.

3. **CDT codes**: The Benchmark Plan does not reflect the most current CDT codes used in practice. If the plan is utilizing current CDT codes, note any deviations from the Benchmark Plan. Identify the deviation by each specific CDT code.

    a. If the CDT codes deviate, in order to be in compliance with the Act, the plan must ***affirm*** the CDT codes have the identical or better effect than the Benchmark Plan. *See* Affirmation Section in Section Exhibit E-1.

    b. If the Plan is utilizing 2019 CDT codes when the SBD is developed using 2018 CDT codes, please identify the 2019 CDT codes.

4. Include the top portion of the Covered California SBD matrix (i.e., waiting periods, out of pocket max, etc.) at the top of the plan's SOB.

ii. **Limitations and Exclusions:** Please ensure that the QDP's limitations and exclusions mirror the Benchmark Plan.

1. If plan's limitations and exclusions deviate from the Benchmark Plan, to ensure compliance with the Act, the plan must ***affirm*** the limitations and exclusions have an identical or better effect upon the enrollee's coverage than the Benchmark Plan. *See* Affirmation Section in Section Exhibit E-1.

2. The format in the Benchmark Plan lists the limitation and exclusions by CDT codes.

a. For each limitation and exclusion, be sure to include the corresponding CDT code.

b. Many plans have chosen to add the limitation and exclusions to the copay schedule by developing a chart. *See* Attachment.

c. If the plan chooses not to utilize a limitation and exclusion chart, but instead lists the limitations and exclusions in another format, the plan will still need to include the corresponding CDT codes for Departmental review.

d. If the plan wishes to not include the CDT codes in its published documents, include the corresponding CDT code in parentheses or brackets for Departmental review.

iii. **Endnotes:** Incorporate the endnotes provided by Covered California into the plan's SOB.

1. Endnotes do not need to be word for word, but in order to be in compliance with the Act, the plan must ***affirm*** that the plan's endnotes are identical or a better effect for enrollee's coverage as Covered California's endnotes. *See* Affirmation Section in Section Exhibit E-1.

iv. ***[Only Embedded Filings]*** File a separate SOB for AI/AN benefits and catastrophic benefits. The eligibility section and description of the cost share for these two benefit designs should be contained in the full service health plan disclosure documents. Please work with your

contracting full service plan to ensure this eligibility and cost sharing information is disclosed to the enrollees.

IX. **Other Relevant Exhibits[5]:** These exhibits may be required to be filed or revised. The plan is not required to file these exhibits unless changes have been made to the ***previously approved documents utilized by the plan for its Covered California filings***.

a. ***[Only Standalone Filing]*** Exhibit FF-4: *See* Actuarial Value Verification Section.

b. Exhibit H and Exhibit I: *See* Network Section.

c. Exhibit K: (Provider contracts) If there are no changes to the provider contracts, please indicate in Exhibit E-1.

d. Exhibit L: Organizational chart(s).

e. ***[Only Embedded Filing]*** Exhibit N: Administrative service agreements (ASA) for administrative services **related to Covered California products**. If no change to the previously approved administrative service contract, please indicate in Exhibit E-1. Provide the filing numbers for the previously approved ASA. If there are changes to the Exhibit N-1, please file in a separate filing referencing the benefit filing.

i. ***[Only Embedded Filing]*** File as a P-5 a plan-to-plan contract where the dental plan is at financial risk.

ii. ***[Only Embedded Filing]*** File an Exhibit N-1 when the dental plan is not at financial risk, i.e. renting the network.

f. Exhibit P and Exhibit Q: individual or group dental plan contracts. ***[Only Embedded Filing]*** **Dental plans that contract with QHPs to offer EHB dental benefits should file the Off-Exchange mirror filing separate from the plan's QDP filing(s)**. If there are no changes to the plan-to-plan agreements or ASA with full service plans, please indicate in Exhibit E-1. Specialized health plans are required to submit a mirror filing for new or amended plan-to-plan agreements and administrative service agreements with full service plans. If changes are made, please file separately referencing the benefit filing.

i. ***[Only Embedded Filing]*** File as a P-5 a plan-to-plan contract where the dental plan is at financial risk. To facilitate review, please file all Plan to Plan agreements in a separate filing referencing the benefits filings. *See* Section VII.

[5] Id.

ii. ***[Only Embedded Filing]*** File an Exhibit N-1 when the dental plan is not at financial risk, i.e. renting the network.

g. Exhibit W: Please file for review new or revised enrollee/subscriber grievance procedures.

h. Exhibit V, Exhibit Y, Exhibit Z, Exhibit AA, Exhibit BB: Please file for review all new or amended advertising and marketing materials related to QDP products.

i. Exhibit Y, Exhibit Z: The plan should describe its marketing plan for individual and small group products being sold on the Exchange. Redline any changes to the plan's previously approved filing.

j. Exhibit BB: Include all new or revised solicitation contracts that the plan intends on entering into with brokers and/or marketers. If the using a previously approved solicitor/broker contract, please indicate the filing number.

k. Exhibit CC, Exhibit DD, Exhibit EE: By region, please file enrollment projections for all individual and small group contracts, and summary enrollment projections for the QDP.

l. ***[Only Embedded Filing]*** Summary of Benefits and Coverage (SBC): The Individual Silver SBC will be filed in the QHP Filing. Do not file a SBC in the dental filing.

m. Networks: Provider Services Geographic Access/Availability:Exhibits H and I

i. Please report information related to each provider network that is connected to a QDP product, as described below. All plans must provide the e-Filing number identifying the last time the network was reviewed by the Department, even if the network was reviewed under a different name or connected to a different product. A plan need only submit a complete provider network filing for any of its QDP provider networks if the plan is required to submit network information pursuant to the Act. When submitting a network for review, please be sure to identify the name of the network and which products utilize that network in an Exhibit E-1.
ii. As a reminder, the Act requires plans to submit a complete network filing for review under the following circumstances:

1. The plan is applying for a new license to operate as a health care service plan under the Knox Keene Act. (*See* Section 1351, Rule 1300.51.) Plans are strongly encouraged to contact the Department and schedule a pre-filing conference before

filing a new license application. Any new license applicants for the 2019 benefit year must file a network with the Department as soon as practicable, but **no later than April 1, 2018**. Please refer to the Checklist for New Networks and Service Area Expansions, available in the "Downloads" section of the e-File webportal, and be sure to include the following Exhibits with your network filing:

a. Provider Network Rosters (Exhibits I-1, I-2 and I-3, utilizing the Department's templates available for download on e-File)
b. Provider-to-Enrollee Ratios (Exhibit I-4)
c. Description of Service Area, by zip code (Exhibit H-1, utilizing the Department's templates available for download on e-File)
d. Standards of Accessibility (Exhibit I-5)
e. Enrollment Projections (Exhibit EE-1, utilizing the Department's templates available for download on e-File)

2. <u>The plan is expanding its existing, approved network into a new service area or withdrawing from a service area</u>. (*See* Section 1351; Rule 1300.52.4(d).) A network filing proposing a service area expansion or withdrawal must be submitted as a material modification to the plan's license in the e-File system. Plans are strongly encouraged to contact the Department and schedule a pre-filing conference before filing a service area expansion or withdrawal. Any service area expansions or withdrawals for the 2019 benefit year must be filed as soon as practicable, but **no later than April 1, 2018.** Please refer to the Checklist for New Networks and Service Area Expansions, available in the "Downloads" section of the e-File webportal, and be sure to include the following Exhibits with your filing:

a. Provider Network Rosters (Exhibits I-1, I-2 and I-3, utilizing the Department's templates available for download on e-File)
b. Provider-to-Enrollee Ratios (Exhibit I-4)
c. Description of Service Area, by zip code (Exhibit H-1, utilizing the Department's templates available for download on e-File)
d. Standards of Accessibility (Exhibit I-5)
e. Enrollment Projections (Exhibit EE-1, utilizing the Department's templates available for download on e-File)

iii. Under certain circumstances, a plan may be required to file an amendment to its license identifying a major network change. (See Rule 1300.52(f), Section 1367.27, (r).) If the health plan has determined that its QDP network meets those circumstances, please submit an amendment to the plan's license in the e-File system **no later than May 1, 2018**. Please visit the "Downloads" section of the efiling webportal to locate and utilize the Checklist for Network Amendment Filings and the DMHC templates for filing provider roster information.

iv. If the health plan experienced greater enrollment in 2018 than was projected in the prior year's QDP filing, or if the plan projects a significant increase in enrollment in 2019 beyond what was previously projected for 2019, please submit the following:

    1. Enrollment Projections (projected over two years) (Exhibit EE-1, utilizing the DMHC template available for download on e-File)
    2. Provider-to-Enrollee Ratios (Exhibit I-4)

v. ***[Only Embedded Filings]*** If the embedded dental plan intends to enter into a new plan-to-plan arrangement with a QHP to provide some or all of its network providers, the Department will require information from both the QHP and the embedded dental plan as follows:

    1. The QHP must file:

        a. A statement within the Exhibit E-1 identifying the portion of the service area in which the QHP plan intends to utilize the embedded dental plan's network and affirming that the embedded dental plan has been approved to operate a network in that portion of the service area.

        b. In some cases, Exhibits I-1, I-2, and/or I-3, as applicable, and Exhibit H-1. These need only be filed if the change in embedded dental plan arrangement will result in a significant change to the QHP's network, as described in Rule 1300.52, subd. (f) and Section 1367.27, subd. (r).

    2. The embedded dental plan must file:

        a. Provider-to-enrollee Ratios (Exhibit I-4) demonstrating that the embedded dental plan has the capacity to take on the enrollment from the QHP plan.

b. A statement within the Exhibit E-1 indicating the filing number of the most recent network review conducted by the Department and the filing in which the embedded dental plan was approved to operate in the service area covered by the QHP.

c. An Exhibit H-1 demonstrating that the embedded dental plan is approved for the service area in which the QHP plan intends to utilize the embedded dental plan's network.

n. ***[Only Standalone Filing]*** Actuarial Value Calculation: Please file the following documentation. The documents can be found in the Justifications/Supporting Documents section under the Application Resources.

i. Chapter 15a: Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification

1. SADP Actuarial Value Supporting Documentation and Justification – https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits

2. File as an Exhibit FF-4.

ii. Chapter 15b: Stand-Alone Dental Plan—Description of EHB Allocation

1. SADP - Description of EHB Allocation - https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits

2. File as an Exhibit FF-4.

2019 CHECKLIST and WORKSHEET
FOR QUALIFIED HEALTH PLANS IN THE
CALIFORNIA HEALTH BENEFIT EXCHANGE

The Department of Managed Health Care (DMHC) offers the following information to assist Individual and Covered California for Small Business (CCSB) Qualified Health Plans (QHP) filings for the Plan Year 2019, for compliance with the Knox-Keene Act at California Health and Safety Code Sections 1340 et seq. (the Act). References herein to "Section" are to Sections of the Act. References to "Rule" are to the regulations promulgated by the DMHC at California Code of Regulations, title 28.

This checklist and worksheet are not intended to be all-inclusive and represent only what issues, at a minimum, are required to be addressed by a health plan for compliance with the Act and Rules. Additional information as needed may be requested by the DMHC within the course of review of a health plan filing. For health plans licensed pursuant to the Act, the DMHC has primary responsibility for regulatory review and preliminary recommendations with respect to certain selection criteria identified by the California Health Benefit Exchange (Exchange) in evaluation of whether an applicant is in "good standing." All licensure, regulatory and product requirements of the Act and Rules apply to QHPs offered through the Exchange.

Filing Timeframes

Prior to certification, health plans must have DMHC approval of necessary filings, including, but not limited to, licensure, networks, product, benefit plan design, and rate filings. Complete filings are due as follows:

	New Applicant; QHP Proposing New: Rating Region, and/or Line of Business	**QHP proposing no changes to Rating Region or Line of Business**
All Other Exhibits as Necessary	No later than March 1	No later than April 1
Provider Network	No later than March 1	No later than June 1
Benefit Plan Designs	No later than April 1	
Rates Individual and CCSB	Individual: July 6, 2018 (tentative)[1] Small Group: July 25, 2018	

[1] Deadline is tentatively based on the federal *DRAFT Bulletin: Proposed Timing of Submission of Rate Filing Justifications for the 2018 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2019*. The filingdeadline is subject to change based on future federal guidance.

Filing Checklist

- Prepare and submit an Amendment or Material Modification pursuant to Sections 1351 and 1352 to a health plan's license to address compliance with the Act, Rules, CA-ACA and ACA laws and regulations related to QHP certification. When submitting your filing in the e-File system, please use the subject title "HBEX QHP Application 2019."
- Benefit plan design or product revisions that do not meet the federal Uniform Modification standards should be submitted as a Notice of Material Modification filing.[2]
- Health plans that are not required to file a network pursuant to the Act are not required to file a network for the sole purpose of QHP recertification (see below under "Provider Network.")
- Complete and file the attached QHP DMHC Filing Worksheet(s) as Exhibit E-1. Please provide a narrative and ensure that the description corresponds to the summary provided in the QHP DMHC Filing Worksheet.
- Complete and file the attached QHP Subcontractor Worksheet as Exhibit E-1.
- For each formulary utilized in connection with product(s) required to comply with the 2019 Patient-Centered Benefit Plan Designs, submit: (i) an Exhibit T-3 that contains a copy of the formulary, and (ii) an Exhibit T-5 that contains a signed 2019 Prescription Drug Compliance Affidavit, which is attached.
- Changes and updates to previously approved exhibits should be indicated with clearly visible redlined changes.

Narrative: Exhibit E-1

Describe the background and purpose of the filing, including, but not limited to:

- Whether the health plan's QHP Application with the Exchange is for individual and/or small group, and identify the region(s) included in the application.
- Whether the benefit plan designs being proposed have been previously approved by the DMHC including e-File numbers of previously approved benefit plan designs.
- The provider network(s) that will be used to provide health care services to enrollees in the health plan's proposed QHP, including all necessary documentation and filing numbers of all previously approved provider networks, and plan-to-plan contracts. For this purpose, it is not sufficient to reference the filing made pursuant to Annual Network Review.
- A list of each benefit plan design (specifying each metal level, market, region and network) offered by the health plan that is required to comply with 2019 Patient-Centered Benefit Plan Designs and an explanation of whether the health plan utilizes the same or different formularies for different benefit plan designs or product(s).

[2] 45 C.F.R. § 147.106(e).

- ❑ Identify the page numbers of the EOC that demonstrate compliance and/or have been revised to demonstrate compliance with statutes enacted in 2017, including but not limited to:
  - AB 1048 (Arambula, Ch. 616, Stats. 2017)—Pain Management and Schedule II Drug Prescriptions
  - AB 1074 (Maienschein, ch. 385, Stats. 2017)—Pervasive Developmental Disorder or Autism
  - SB 133 (Hernandez, ch. 481, Stats. 2017)—Continuity of Care
  - SB 223 (Atkins, ch. 771, Stats. 2017)—Health Care Language Assistance Services
  - Any other newly enacted statute(s) or regulation(s) for which the health plan deems revision is appropriate.
- ❑ Identify the page numbers of the EOC revised for compliance with newly-enacted or revised Endnotes in the 2019 Patient-Centered Benefit Plan Designs. If revision is not required, the health plan must provide a confirmatory statement which states no revisions are required.
- ❑ If the health plan is proposing to offer non-standard plan(s) on the Exchange, explain whether it has submitted the proposal to the Exchange for approval.
- ❑ An affirmation that the health plan discloses coverage of pediatric vision benefits that are the same benefits as contained in the BCBS Association, 2014 FEP Blue Vision – High Option, including, but not limited to, low vision benefits, and that the Plan discloses coverage of the aphakia benefit without age limitations as required by Section 1367.005(a)(2). Please also identify the page nos. of the EOC which disclose the pediatric vision and aphakia benefits.

For Small Group benefit plan designs only, affirm that for every contract it is offering coverage for:

- ❑ The treatment of infertility, except in vitro fertilization. The term “infertility” is as defined in Section 1374.55; and
- ❑ Orthotic and prosthetic and special footwear benefits, as set forth in Sections 1367.18 and 1367.19.

Contracts with Specialized Health Plans:

- ❑ Full service health plans that contract with specialized health plans for the provision of Essential Health Benefits[3] (EHB), such as acupuncture, pediatric dental or vision benefits, should include in Exhibit E-1 a brief explanation of the contractual relationship.
- ❑ Specialized health plans are required to submit a mirror filing in coordination with a contracted full service health plan for new or amended plan-to-plan contracts. Plan-to-Plan contracts, where the specialized health plan is at risk, should be filed as an Exhibit P-5. Plan-to-Plan contracts where the specialized health plan is not at risk (i.e. rental of network) should be filed as an Exhibit N-1.
- ❑ If the full service health plans is not providing its own specialized services list the plans or other entities providing specialized services on behalf of the full service health plan.
- ❑ Full service health plans should include the filing number for the specialized health plan’s mirrored filing. In addition, the full service health plan should ensure that the plan-to plan contract specifies which health plan will be performing Utilization Management, and Grievance and Appeals functions. Please ensure that this information is set forth in the

[3] Section 1367.005; Rule 1300.67.005.

plan- to-plan contract. See 2019 CHECKLIST FOR QUALIFIED DENTAL PLANS IN THE CALIFORNIA HEALTH BENEFIT EXCHANGE which encompasses dental plans contracting directly with a) the Exchange and b) QHPs.

- Specialized health plans that contract to provide EHB may also need to submit Evidence of Coverages, disclosure forms, and provider network information on behalf of the full service health plan. QHP's should share this checklist with contracted specialized health plans to ensure that the specialized health plan's mirror filings include all DMHC requirements.
- Specialized health plans are not required to provide eligibility information in connection with catastrophic or AI/AN benefit plan designs within their Evidence of Coverage. Specialized health plans must file catastrophic and AI/AN Schedule of Benefits. Note, full service health plans must also include the information regarding those benefit plan designs in the full service health plan's disclosure documents.

All Other Exhibits as Necessary

If the health plan will be relying on existing contracts, policies, or procedures previously approved by the DMHC, and there are no changes, the health plan should indicate this in Exhibit E-1, and is not required to submit these exhibits unless requested.

- Quality of Care (Exhibit J): Internal quality of care system(s) the health plan intends on implementing to serve Exchange enrollees, and address how it meets state and applicable federal requirements.
- Provider and Administrative Services Contract(s) (Exhibits K and N): New or revised provider or administrative service contract(s) related to Exchange product(s).
- Plan Organization (Exhibit L): New or revised organizational chart(s).
- Plan-to-Plan Contracts (Exhibit P-5): New or revised plan-to-plan contract(s) related to the delivery of services to Exchange enrollees.
- Grievance & Appeals (Exhibit W): New or revised grievance and appeal procedures.
- Marketing (Exhibits V, Y, Z, AA, and BB): Advertising and marketing materials related to Exchange product(s).

Benefit Plan Designs: Exhibits S, T, and U

- Evidence of Coverage (EOC) or combined EOC and Disclosure Form (Exhibit T or U): EOC(s) for each benefit plan design and/or product(s) proposed. Ensure that all Essential Health Benefits are included in these exhibits, including those provided by a contracted specialized health plan.[4]
- Schedule/Summary of Benefit (Exhibit S,T, or U): For each benefit plan design proposed.[5]
- Federal Summary of Benefits and Coverage (Exhibit S-3): A federal Summary of Benefits and Coverage (SBC) disclosure form in connection with the Exchange's Individual Silver benefit plan design only. This SBC will be reviewed as a representative sample for all benefit plan designs offered in the Individual and Small Group markets. Health plans are

[4] Please see the 2019 QDP Checklist which has specific instructions for SBD dental benefits.
[5] Id.

reminded to utilize the SBC instructions, materials and supporting documents authorized for use on and after April 1, 2017.[6] If the health plan has already received approval of its representative SBC(s) pursuant to a separate filing, please provide the e-File number in lieu of submitting the exhibit.

- EHB Filing Worksheet (Exhibit T-2): A new EHB worksheet, as promulgated in Rule 1300.67.005 (effective as of June 27, 2017). Note, if the health plan has previously submitted a complete worksheet consistent with the Emergency Rule, effective on November 28, 2016, and received approval, it is not required to submit a new worksheet unless the previously-approved worksheet is being amended.
- Prescription Drug EHB Benchmark Plan Benefits Chart (Exhibit T-4): A new Prescription Drug EHB Chart, as promulgated in 1300.67.005 (effective as of June, 27, 2017). Note, if the health plan has previously submitted a complete worksheet consistent with the Emergency Rule, effective on November 28, 2016, it is not required to submit a new worksheet unless the previously-submitted worksheet is being amended. As part of the submission of the chart disclose the following in the Exhibit E-1:
  - If EHB Count Chart includes generics
  - A summary of any category/class variations from what is shown in the health plan's EHB Count Chart
  - For each variation, a justification and basis for the health plan's determination of compliance with Rule 1300.67.005

Renewal Notices: Exhibit I-9

- Renewal notices must comply with federal requirements including the Updated Federal Standard Renewal and Product Discontinuation Notices Bulletin (September 2, 2016) issued by the Centers of Medicare & Medicaid Services (CMS), Form and Manner of Notices When Discontinuing a Product in the Group or Individual Market (September 2, 2014) issued by CMS, and Draft Standard Notices When Discontinuing or Renewing a Product in the Small Group or Individual Market (June 26, 2014) issued by CMS. Submit representative renewal notices which comply with the requirements above. If the health plan has previously received approval of its representative renewal notices pursuant to a separate filing and revisions are required, provide the e-File number in lieu of submitting the exhibit.

Provider Network: Exhibits H and I

- Please report information related to each provider network that is connected to a QHP, as described below. All health plans must provide the e-File number identifying the last time the network was reviewed by the DMHC, even if the network was reviewed under a different name or connected to a different product. For this purpose, it is not sufficient to reference the filing made pursuant to Annual Network Review.

  A health plan need only submit a complete provider network filing for any of its QHP provider networks if the health plan is required to submit network information pursuant to the Act. If necessary, this filing should be made in a separate Amendment or Notice of Material

[6] Template instructions, materials and supporting documents authorized for use on and after April 1, 2017, may be located at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/

Modification. When submitting a network for review, please be sure to identify the name of the network and which products utilize that network in an Exhibit E-1.

As a reminder, the Act requires health plans to submit a complete network filing for review under the following circumstances:

- An applicant is applying for a new license to operate as a health care service plan under the Act. (*See* Section 1351, Rule 1300.51.) Applicants are strongly encouraged to contact the DMHC and schedule a pre-filing conference before filing a new license application. Any new license applicants for the 2019 benefit year must file a network with the DMHC as soon as practicable, but no later than March 1, 2018. Please refer to the Checklist for New Networks and Service Area Expansions, available in the "Downloads" section of the e-File webportal, and be sure to include the following Exhibits with your filing:
  - Provider Network Rosters (Exhibits I-1, I-2, and I-3, utilizing the DMHC templates available for download on e-File)
  - Provider-to-enrollee Ratios (Exhibit I-4)
  - Description of Service Area, by zip code (Exhibit H-1, utilizing the DMHC template available for download on e-File)
  - Standards of Accessibility (Exhibit I-5)
  - Enrollment Projections (Exhibit EE-1, utilizing the DMHC template available for download on e-File)
- The health plan is expanding its existing, approved network into a new service area or withdrawing from a service area. (*See* Section 1351; Rule 1300.52.4(d).) A network filing proposing a service area expansion or withdrawal must be submitted as a Notice of Material Modification to the health plan's license in the e-File system. Health plans are strongly encouraged to contact the DMHC and schedule a pre-filing conference before filing a service area expansion or withdrawal. Any service area expansions or withdrawals for the 2019 benefit year must be filed as soon as practicable, but no later than March 1, 2018. Please refer to the Checklist for New Networks and Service Area Expansions, available in the "Downloads" section of the e-File webportal, and be sure to include the following exhibits with your filing:
  - Provider Network Rosters (Exhibits I-1, I-2, and I-3, utilizing DMHC templates available for download on e-File)
  - Provider-to-enrollee Ratios (Exhibit I-4)
  - Description of Service Area, by zip code (Exhibit H-1, utilizing DMHC template available for download on e-File)
  - Standards of Accessibility (Exhibit I-5)
  - Enrollment Projections (Exhibit EE-1, utilizing DMHC template available for download on e-File)
- Under certain circumstances, a health plan may be required to file an amendment to its license identifying a major network change. (See Rule 1300.52, subd. (f), Section 1367.27, subd. (r).) If the health plan has determined that its QHP network meets those circumstances, please submit an amendment to the health plan's license in the e-File system no later than June 1, 2018. Please visit the "Downloads" section of the e-File webportal to locate and utilize the Checklist for Network Amendment Filings and the DMHC templates for filing provider roster information.

- If the health plan experienced greater enrollment in 2018 than was projected in the prior year's QHP filing, or if the health plan projects a significant increase in enrollment in 2019 beyond what was previously projected for 2019, please submit the following:
  - Enrollment Projections (projected over two years) (Exhibit EE-1, utilizing DMHC template available for download on e-File)
  - Provider-to-enrollee Ratios (Exhibit I-4)

- If the health plan intends to enter into a new plan-to-plan contract with a Knox-Keene licensed health plan, or change the plan with which it currently has a plan-to-plan contract to another Knox-Keene licensed health plan, to provide some or all of its network providers, the DMHC will require information from both the QHP and the Knox- Keene licensed subcontracting health plan as follows:
  - The QHP must file:
    - A statement within the Exhibit E-1 identifying the portion of the service area in which the QHP plan intends to utilize the subcontracting plan's network and affirmation that the subcontracting health plan has been approved to operate a network in that portion of the service area. For this purpose, it is not sufficient to reference filings made pursuant to Annual Network Review.
    - In some cases, Exhibits I-1, I-2, and/or I-3, as applicable, and Exhibit H-1. These need only be filed if the change in subcontracting arrangement will result in a significant change to the QHP's network, as described in Rule 1300.52, subd. (f) and Section 1367.27, subd. (r). (The DMHC Checklist for Network Amendment Filings and templates for these exhibits are available for download in the e-File webportal).
  - The subcontracting health plan must file:
    - Provider-to-enrollee Ratios (Exhibit I-4) demonstrating that the plan has the capacity to take on the enrollment from the QHP plan.
    - A statement within the Exhibit E-1 indicating the filing number of the most recent network review conducted by the DMHC and the filing in which the plan was approved to operate in the service area covered by the QHP. For this purpose, it is not sufficient to reference the filing made pursuant to Annual Network Review.
    - An Exhibit H-1 demonstrating that the subcontracting plan is approved for the service area in which the QHP plan intends to utilize the subcontracting plan's network. (The DMHC template for this exhibit is available for download in the e-File webportal).
- If the health plan intends to enter into a new plan-to-plan arrangement with a plan that is not licensed by the DMHC, or change the plan with which it currently has a plan-to-plan arrangement to a plan that is not licensed by the DMHC, to provide some or all of its network providers, the QHP will be responsible for providing all network information as follows:
  - A statement within the Exhibit E-1 identifying the plan with which the QHP intends to contract.
  - In some cases, Exhibits I-1, I-2, and/or I-3, as applicable, and Exhibit H-1. These need only be filed if the change in subcontracting plan will result in a significant change to the QHP's network, as described in Rule 1300.52, subd. (f) and Section 1367.27, subd. (r).

(DMHC templates for these exhibits are available for download in the e-File webportal).

Actuarial Value Calculation: Exhibit FF-4

- Actuarial Value – Full service health plans proposing to offer 9.5 and/or 10.0 EHB should submit through the e-File portal the following supporting documentation under Exhibit FF-4:
  - If the benefit plan design is compatible with the federal AV calculator submit the following:
    - A screenshot of the AV calculator with inputs used for each benefit plan design.
    - The Excel tab from the AV calculator entitled "User Inputs for Plan Parameters."
  - If the benefit plan design is not compatible with the AV calculator, then
    - Submit an actuarial certification on the methodology chosen from the options specified in 45 CFR §156.135(b).
    - The certification must be prepared by a member of the American Academy of Actuaries.
    - Calculate the benefit plan designs' s AV by estimating a fit of the benefit plan design into the parameters of the AV calculator; or
    - Partial use of AV calculator for plan provisions that fit within the calculator parameters and with appropriate adjustments to the AV identified by the calculator for benefit plan design features that deviate substantially from the parameters of the AV calculator.

For either methodology, provide the following:

- A screenshot of the AV calculator with inputs used for each benefit plan design.
- A complete description of the data, assumptions, factors, rating models, and methods used to determine the adjustments.
- The certification must describe the methodology with sufficient clarity and detail that another qualified health actuary can make an objective appraisal of the reasonableness of the data, assumptions, factors, models, and methods.

Enrollment Projections: Exhibits CC, DD, and EE

- Enrollment projections and summary for all individual and small group contracts. The first year of projections should be prepared on a monthly basis and the second year on a quarterly basis. The projections should include a balance sheet, income statement and statement of cash flows.

Financial Projections: Exhibit HH

- Financial projections may be requested by the Office of Financial Review, depending upon the financial position of the health plan. If projections are requested, they should mirror the format of the enrollment projections noted above.

Rate Review

- Instructions regarding SERFF filing(s) different than non-QHP rate filings will be forthcoming.

2019 ATTACHMENT FOR QUALIFIED DENTAL PLANS IN THE CALIFORNIA HEALTH BENEFIT EXCHANGE

CDT Code	Description	Pediatric Copay	Adult Copay	Limitation/Exclusion for Pediatric enrollee
*D0120**	*Periodic Oral Evaluation – established patient*	*No cost*	*No Cost*	*1 in 6 months per dentist*

**example*

QHP DMHC FILING WORKSHEET

INSTRUCTIONS

- Complete and file both a narrative description (see Checklist) and attached QHP DMHC Filing Worksheet(s) as Exhibit E-1.
- Ensure that the description corresponds to the plan summary provided in the QHP DMHC Filing Worksheet. Please indicate what plan compliance changes are attached. Plans submitting multiple Worksheets (e.g., by region or market segment) should further subdivide the Exhibit E-1 narrative to correspond with the compliance details for each Worksheet submitted.
- Plans with multiple small group, individual, and region QHPs should complete separate Worksheets for each market segment and region as necessary to record the DMHC filing status of each QHP proposed. For example, a plan that proposes individual and small group contracts, and variations by region, product type, market segment, or benefit design, might organize its Worksheets as follows:
    - ✓ Worksheet #1 of 4: Individual plan contracts for Regions 1, 2 and 3. On this Worksheet, the plan might indicate what license amendments/material modifications are proposed in the attached exhibits, and indicate which QHP certification elements apply from those listed in the “Category” column. Where no change is proposed in a Category, plan should affirmatively answer “no change from prior approval.”
    - ✓ Worksheet #2 of 4: Small Group contracts for Region 4. On this Worksheet, the plan might indicate what license amendments/material modifications are proposed in the attached exhibits, indicate which QHP certification elements apply from those listed in the “Category” column, and whether any components of the change(s) were previously approved, noting previous eFiling number(s).
    - ✓ Worksheet #3 of 4: Individual PPO plan contracts in Regions 5 - 15. On this Worksheet, the plan might indicate changes in the Network Category, no changes to any other category except Benefit Design where plan indicates that it is “Pending with plan, to be addressed in future filing on or about June 2018.”
    - ✓ Worksheet #4 of 4: Individual HMO plan contracts in Regions 5 - 15. On this Worksheet, the plan might indicate changes in the Network Category, no changes to any other category except Benefit Design (open filing) where plan indicates that it is “Pending with plan, response to be filed on or about June 2018.”
- If the plan has the same revisions for multiple documents under the same exhibit, it may file a sample template by listing the exhibit name on the Worksheet and in the Exhibit E-1 narrative description, include a representation that it has filed a sample, and that the same revisions shall be made to all other applicable plan documents per market segments and product types.

PLAN INFORMATION FOR WORKSHEET #__ OF __

[Specify this Worksheet number out of total number of Worksheets submitted in this filing]

Type	Region(s)	Category [Check all that apply]	License Status [Check all that apply]
Sm Group ☐ Indiv. ☐	☐ Region(s):	**Provider Networks** ☐ New Licenses Application ☐ Service Area Expansion ☐ Service Area Withdrawal ☐ Network Change Amendment	☐ No change from prior approval: (Insert eFile Number(s) for previous-approval) ☐ Revised (Insert eFile no.) ☐ Pending with Plan, anticipate initial filing/completion of filing on or about:
Sm Group ☐ Indiv. ☐	☐ Region(s):	**Benefit Design** ☐ Standard Benefit Design ☐ Alternate Benefit Design ☐ Metal Level/Actuarial Value ☐ Essential Health Benefits ☐ Plan-to-Plan Contracts ☐ Evidence of Coverage (EOC) ☐ Summary of Benefits and Coverage (Federal SBC) ☐ Narrow Network (Plan Documents)	☐ No change from prior approval: (Insert e-Filing Number(s) for previous-approval) ☐ Revised (Insert eFile no.) ☐ Pending with Plan, anticipate initial filing/completion of open filing on or about:
Sm Group ☐ Indiv. ☐	☐ Region(s):	**Market Reforms** ☐ Guarantee Issue ☐ Rating Factors ☐ Segregation of Funds for Abortion (QHP Individual Market only)	☐ No change from prior approval: (Insert e-Filing Number(s) for previous-approval) ☐ Revised (Insert eFile no.) ☐ Pending with Plan, anticipate initial filing/completion of open filing on or about:
Sm Group ☐ Indiv. ☐	☐ Region(s):	**Fiscal Solvency** ☐ Enrollment Projections ☐ Tangible Net Equity ☐ Projected Financial Viability	☐ No change from prior approval: (Insert e-Filing Number(s) for previous-approval) ☐ Revised (Insert eFile no.) ☐ Pending with Plan, anticipate initial filing/completion of open filing on or about:

The Plan hereby certifies that the Plan's prescription drug formulary meets the following requirements specified in the 2019 Covered California Patient-Centered Benefit Plan Designs:

1. Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
	3) Any other drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Drugs that are biologics;
	2) Drugs that the FDA or the manufacturer requires to be distributed through a specialty pharmacy;
	3) Drugs that require the enrollee to have special training or clinical monitoring for self-administration or;
	4) Drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates for a one-month supply.

2. Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.
3. A plan’s formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan’s formulary.
4. The Plan’s prescription drug list meets or exceeds the prescription drug formulary requirements set forth in 45 CFR 156.122(a)(1).

The undersigned attests to this certification on_____.

Name:

Signature:

QHP SUBCONTRACTOR WORKSHEET

INSTRUCTIONS

☐ Complete and file the QHP SUBCONTRACTOR WORKSHEET as Exhibit E-1.

☐ Network Arrangement: Select "Direct Contract" where the Plan directly contracts with providers and/or medical groups for the provision of services indicated. Select "Subcontract" where the Plan arranges for the delivery of services indicated through a plan-to-plan agreement, administrative services agreement, orother type of agreement. If the Plan selects "Direct Contract" it is not necessary to complete the remaining columns with respect to that service.

☐ Risk Types are defined as follows:

KKA Risk: An agreement where a full service health plan ("FSHP") contracts with a specialized health plan ("SHP") for the provision of specific health care services, and where the SHP assumes fullfinancial risk on a capitated basis for the delivery of delegated services. Such agreements should be filed as Exhibit P-5.

KKA Lease: An agreement between a FSHP and a SHP where the FSHP utilizes the SHP's providernetwork for the provision of specific health care services, and for which the FSHP retains full financialrisk for the delivery of health care services (i.e. no capitation). Such contracts should be filed as Exhibit N-1. Please note, a FSHP licensed to offer EPO products may desire to enter into an agreement with a SHP for the delivery of health care services under an EPO product. If the SHP isnot licensed to offer an EPO product, the parties may enter into an agreement whereby the SHP provides access to its network of providers.

NON KKA: An agreement between a FSHP and a non-licensed entity where the FSHP utilized the entity's provider network for the provision of specific health care service, and for which the FSHP retains full financial risk for the delivery for health care services (i.e. no capitation). Such contracts should be filed as Exhibit N-1.

Service	Network Arrangement	Name of Entity (If subcontract)	Risk Type	Exhibit	New or Existing Contract	Utilization Management	Grievance and Appeals
Acupuncture	☐ Direct Contract ☐ Sub Contract		☐ KKA Risk ☐ KKA Lease ☐ Non-KKA	☐ P-5 ☐ N-1	☐ New ☐ Existing	☐ Plan ☐ Subcontractor	☐ Plan ☐ Subcontractor
Pediatric Dental	☐ Direct Contract ☐ Sub Contract		☐ KKA Risk ☐ KKA Lease ☐ Non-KKA	☐ P-5 ☐ N-1	☐ New ☐ Existing	☐ Plan ☐ Subcontractor	☐ Plan ☐ Subcontractor
Pediatric Vision	☐ Direct Contract ☐ Sub Contract		☐ KKA Risk ☐ KKA Lease ☐ Non-KKA	☐ P-5 ☐ N-1	☐ New ☐ Existing	☐ Plan ☐ Subcontractor	☐ Plan ☐ Subcontractor
Mental Health/Substance Use Disorder	☐ Direct Contract ☐ Sub Contract		☐ KKA Risk ☐ KKA Lease ☐ Non-KKA	☐ P-5 ☐ N-1	☐ New ☐ Existing	☐ Plan ☐ Subcontractor	☐ Plan ☐ Subcontractor
Pharmacy	☐ Direct Contract ☐ Sub Contract		☐ KKA Risk ☐ KKA Lease ☐ Non-KKA	☐ P-5 ☐ N-1	☐ New ☐ Existing	☐ Plan ☐ Subcontractor	☐ Plan ☐ Subcontractor