EXHIBIT A

Statement of Work – Medical Contract

1. DEFINITIONS

The following are definitions that apply to this Contract:

1.1 "834 Transaction" means the ASC X12 Benefit Enrollment and Maintenance transaction submitted to a Carrier by the FFM.

1.2 "Affordable Care Act" or "ACA" means the provisions of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), together with any interim final or final federal regulations implementing the foregoing statute.

1.3 "American Indian/Alaska Native" or "AI/AN" means a person who is a member of an Indian Tribe.

1.4 "Automated SHOP" means an automated portal by which the Marketplace enrolls Eligible Individuals in Small Employer Plans.

1.5 "Benefit Design Standards" means coverage that provides for all of the following:

1.5.1 Essential Health Benefits (EHBs) as defined by OAR 836-053-0008;

1.5.2 Cost-Sharing as described in 45 CFR 156.130; and

1.5.3 A Level of Coverage as described in paragraph 1.27;

1.6 "Carrier" means the party to this Contract described in the opening paragraph of the Contract.

1.7 "Carrier Intellectual Property" means any intellectual property owned by Carrier.

1.8 "Catastrophic QHP" means a Qualified Health Plan that meets the requirements of 42 U.S. Code § 18022(e).

1.9 "Certification" means the certification of a Health Plan by the Marketplace, authorizing Carrier to sell the Health Plan through the Marketplace as a QHP.

1.10 "CMS" means the United States Department of Health and Human Services, Center for Medicare and Medicaid Services.

1.11 "COFA Member" means a citizen of the Republic of the Marshall Islands, the Federated States of Micronesia, or the Republic of Palau with an income of less than 138% of the federal poverty level who resides in Oregon and who participates in the COFA Premium Assistance Program.

1.12 "COFA Premium Assistance Program" means the program established by Oregon Laws 2016, Chapter 94, Section 3 to provide financial assistance to enable a citizen of the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau with an income of less than 138% of the federal poverty level who resides in Oregon to purchase qualified health plan coverage through the health insurance exchange and to pay out-of-pocket, in-network costs associated with the coverage.

1.13 "Cost-Sharing" means any expenditure required by, or on behalf of, an Enrollee with respect to EHBs; Cost-Sharing includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, visit limits, and non-covered services.

1.14 "Cost-Sharing Reductions" means reductions in Cost-Sharing for an Enrollee in a silver level QHP through the FFM or for an Individual who is an American Indian/Alaska Native enrolled in a QHP through the FFM.

1.15 "DCBS" means the State of Oregon, Department of Consumer and Business Services.

1.16 "Decertification" means the removal of a QHP's Certification, making the Health Plan ineligible for sale through the Marketplace.

1.17 "Division of Financial Regulation" or "DFR" means the Division of Financial Regulation of DCBS.

1.18 "Eligible Employee" has the meaning given to the term in ORS 743B.005.

1.19 "Enrollee" means a person enrolled in a Marketplace QHP.

1.20 "Essential Health Benefits" or "EHBs" has the meaning given that term in OAR 836-053-0008.

1.21 "Federally Facilitated Marketplace" or "FFM" means the entity and health insurance exchange platform operated by CMS through which the Marketplace makes QHPs available for sale to individuals, determines their eligibility, and enrolls them in QHPs.

1.22 "Health Plan" means a "health benefit plan" as defined by ORS 743B.005.

1.23 "High Deductible Health Plan" means a Health Plan as defined by 26 USC § 223(c)(2)(A) that also is a Qualified Health Plan.

1.24 "Indian Tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

1.25 "Individual Plan" means a QHP for Qualified Individuals and their families.

1.26 "Individual Product Line" means Carrier's entire line of Individual Plans.

1.27 "Level of Coverage" means a bronze, silver, gold, or platinum level as determined under 45 CFR 156.140.

1.28 "Manual SHOP" means the processing by the Marketplace of manual forms to enable access to small business tax credits.

1.29 "Marketplace" means the health insurance exchange administered by DCBS in accordance with ORS 741.310.

1.30 "Member" means a person insured under a QHP.

1.31 "Open Enrollment" means the period when all Individuals or eligible Employees may choose to enroll in QHPs for a new Plan or Policy Year.

1.32 "Oregon Insurance Laws" means:

1.32.1 The Oregon Insurance Code as defined in ORS 731.004 and its implementing administrative rules in OAR 836; and

1.32.2 DFR Bulletins implementing or interpreting the laws described in paragraph 1.33.

1.33 "Oregon Marketplace Laws" refers to laws of the state of Oregon pertaining to the establishment and operation of the Marketplace. The term includes, but is not limited to:

1.33.1 Senate Bill 1 enrolled (2015), Chapter 3, 2015 Oregon Laws;

1.33.2 ORS chapter 741as amended through 2015; and

1.33.3 All implementing administrative rules (including OAR chapter 945) related to the Marketplace.

1.34 "Plan Year" means the consecutive 12-month period during which a Small Employer Plan provides coverage for health benefits.

1.35 "Policy Year" means the calendar year for which an Individual QHP provides coverage for health benefits.

1.36 "Producer" means a person who is licensed by DFR to sell, solicit, or negotiate the sale of a QHP.

1.37 "Qualified Employer" means a Small Employer that elects to make, at a minimum, all full-time Eligible Employees eligible for one or more QHPs through the SHOP

1.38 "Qualified Health Plan" or "QHP" means a Health Plan that is certified by the

Marketplace and offered for sale through the FFM or Small Employer Health Options Program (SHOP).

1.39 "Qualified Individual" means a person who has been determined eligible to enroll through the FFM in an Individual Plan.

1.40 "Quality Improvement Reporting" means the enrollee experience and clinical data and other information that Carrier is required to submit to CMS or to the Marketplace.

1.41 "Quality Improvement Strategy (QIS)" means the QHP issuer's strategy to meet state and federal requirements to improve patient care and population health, including strategic payment structures or other incentives to improve health outcomes, reduce hospital readmissions, improve patient safety and reduce medical errors, implement wellness and health promotion activities, and reduce health and health care disparities, as described in 42 USC 18031(g)(1).

1.42 "Quality Rating System" means the CMS system intended to inform consumers about the comparable quality of health care services provided by QHPs based on data reported in the means and manner required for Quality Improvement Reporting.

1.43 "Recertification" means the process of obtaining certification of a QHP for the calendar year immediately following a Certification or Recertification.

1.44 "Records" means all financial records, other records, books, documents, papers, plans, records of shipments and payments and writings of Carrier, whether in paper, electronic or other form, that are pertinent to this Contract.

1.45 "Service Area" means the geographic area or areas described in OAR 836-053-0063 in which Carrier offers a QHP.

1.46 "Small Business Health Options Program" or "SHOP" means a health insurance exchange for small employers as described in 42 U.S.C. 18031.

1.47 "Small Employer" has the meaning given that term under the ORS 743B.005.

1.48 "Small Employer Plan" means a SHOP-certified QHP issued to a Small Employer.

1.49 "Small Employer Product Line" means Carrier's entire line of Small Employer Plans.

1.50 "Subscriber" means the person insured under a SHOP-Certified QHP whose employment status serves as the basis for eligibility for coverage under the SHOP-Certified QHP.

1.51 "Third Party Intellectual Property" means any intellectual property owned by parties other than DCBS or Carrier.

1.52 "Tier" or "Metal Tier" means a level of coverage described in paragraph 1.27.

1.53 "Tribal Premium Sponsorship Program" or "TPSP" means a program, pursuant to 45

CFR 155.240, by which the Marketplace assists Indian tribes, tribal organizations, and urban Indian organizations to remit QHP premiums on behalf of Qualified Individuals subject to the terms and conditions determined by the Marketplace.

1.54 "Work Product" means every invention, discovery, work of authorship, trade secret or other tangible or intangible item and all intellectual property rights therein that Carrier delivers to DCBS pursuant to the work performed under this Contract.

2. STATE AND FEDERAL REQUIREMENTS

2.1 Carrier shall comply with the applicable provisions of the following:

2.1.1 The ACA;

2.1.2 Oregon Marketplace Laws;

2.1.3 Oregon Insurance Laws;

2.1.4 Any state or federal regulations implementing the foregoing laws; and

2.1.5 Any other state and federal laws, regulations, or official agency written guidance applicable to Carrier as the issuer of a QHP.

2.2 Throughout the term of this Contract, Carrier shall be an entity described in ORS 743B.005(5)(a), (b), or (c), holding a Certificate of Authority in good standing from DFR.

2.3 Carrier shall not, with respect to its QHPs, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. Carrier will not have marketing practices or benefit designs that will discourage the enrollment of Individuals or Eligible Employees with significant health needs in its QHPs.

3. BENEFIT DESIGN STANDARDS AND QHPs

3.1 **Benefit Design** – Carrier shall ensure that each of its QHPs complies with the Benefit Design Standards, including the Cost-Sharing limits, EHBs, and, except for Catastrophic QHPs, Level of Coverage requirements.

3.2 **Individual Metal Tier QHPs** –Except as provided in paragraph 3.3, Carrier may offer a combination of the following required and optional QHPs totaling no more than four QHPs per Metal Tier in the Individual Product Line in each Service Area in which it provides coverage:

3.2.1 **Required Plan Offerings** –One or more standard QHPs in the bronze and silver Tiers as required by ORS 743B.130 and OAR 836-053-0013 and one or more standard QHPs in the gold Tier (see Appendix 2 for design), as required by OAR 945-020-0020(3)(b); and

Optional Plan Offerings –

3.2.2.1: One or more QHPs per silver, gold, or platinum Metal Tier, which provide coverage of primary care visits and generic drugs without application of the deductible; and

3.2.2.2: One or more QHPs per bronze Metal Tier.

3.3 High Deductible Health Plan (Optional) – In addition to the QHPs described in paragraph 3.2, Carrier may also offer no more than one QHP that is a High Deductible Health Plan in the Individual Product Line in each Service Area in which Carrier provides coverage.

3.4 Catastrophic Plans (Optional) –Carrier may offer no more than one Catastrophic QHP in each Service Area in which Carrier provides coverage in the Individual Product Line.

3.5 Child-Only Plans – For all QHPs sold through the Marketplace, Carrier must offer identical coverage to children.

3.6 Product Line Participation – Carrier shall adhere to the provisions of this Contract relevant to the product line or lines in which it chooses to provide coverage.

3.7 Cost-Sharing Reductions – Carrier shall reduce an eligible enrollee's cost-sharing according to the standard Cost-Sharing Reductions created for the standard silver QHP as described in Appendix 1: Marketplace Guidelines for Standard Plan Cost Sharing Reductions. Carrier shall file Cost-Sharing variations for each of the following:

3.7.1 Silver QHP variations as described in 45 CFR 156.420;

3.7.2 Zero Cost-Sharing for American Indians/Alaska Natives with household incomes at or below 300% of the federal poverty level; and

3.7.3 Zero Cost-Sharing for items or services furnished directly by the Indian Health Service, an Indian Tribe, a Tribal organization, or an Urban Indian organization or through referral under contract health services for American Indians/Alaska Natives with household incomes above 300% of the federal poverty level.

4. QHP CERTIFICATION

4.1 *QHP Submission Process*

4.1.1 DFR Approval – Carrier shall obtain DFR's approval of rates, forms, and binders for each Health Plan for which Carrier seeks Certification. The Marketplace may not certify a Health Plan as a QHP unless and until DFR has approved the rates, forms, and binders for the Health Plan.

4.1.2 **NCQA or URAC accreditation** – Carrier shall provide initial and subsequent renewal accreditation documentation, including any required corrective actions, within 30 days of receipt from the accrediting agency.

4.1.3 **Rate Adjustments** – Carrier may not adjust Individual Product Line rates during a Policy Year. Carrier may adjust Small Employer Product Line rates on a quarterly basis.

4.1.4 **Rate justification –** Carrier must submit to DFR a justification for a rate change prior to implementation of the changed rate. Carrier shall prominently post the justification on its website.

4.2 ***Marketplace Certification Requirements***

At the request of Carrier, the Marketplace will certify a Health Plan as a QHP if Carrier obtains approval from DFR of the rates, forms, and binder.

4.3 ***QHP Recertification***

Carrier shall follow the QHP Submission Process described in paragraph 4.1 for all QHPs for which it seeks Recertification.

4.4 ***Marketplace Decertification of QHP***

The Marketplace may at any time decertify a QHP if the Marketplace determines that Carrier or QHP is no longer in compliance with the Marketplace's Certification criteria.

4.4.1 Carrier may appeal Decertification of a QHP through the following process. Appeal requests must be submitted within 15 days of the notice from DCBS informing Carrier of the Decertification. Carrier's appeal request must be made in writing, and must provide thorough explanation of the grounds for appeal along with any supporting information. Valid appeal requests will be reviewed and decided upon by the Administrator of the Marketplace, within 14 days of receipt of the request. If Carrier is unsatisfied with the Administrator's decision on its appeal, Carrier may seek additional review through a contested case hearing as provided under ORS 183.411 to 183.471.

4.4.2 Upon Decertification of a QHP, the Marketplace will provide notice of Decertification to:

4.4.2.1 Carrier;

4.4.2.2 Enrollees in the QHP;

4.4.2.3 United States Office of Personnel Management if Carrier is a multi-state plan;

4.4.2.4 CMS; and

4.4.2.5 DFR.

4.4.3 In the event of a Decertification, Carrier shall not terminate coverage before giving notice to Enrollees, including information that displaced Enrollees will be given a special enrollment period to allow them to enroll in new QHPs.

5. STAFFING

5.1 Carrier shall identify key staff as primary Marketplace contact(s) responsible for oversight of Carrier's QHPs and shall provide the Marketplace with the name and contact information of such staff.

5.2 Carrier shall provide and maintain direct communication with Marketplace staff during the pendency of this Contract.

5.3 The Marketplace will identify and provide Carrier with the contact information of key staff.

6. SMALL EMPLOYER PRODUCT LINE OPERATION: SMALL EMPLOYER PRODUCT LINE

SHOP Certification. Carrier may coordinate with the Marketplace to offer Small Employer QHPs to Qualified Employers.

6.1 If Carrier offers a product through the manual SHOP:

6.1.1 Rates will be valid for twelve (12) months from the effective date of coverage;

6.1.2 Carrier shall quote and offer to a Small Employer Small Employer QHPs that are available in the Small Employer's geographic area.

6.1.3 If a Small Employer requests that it be enrolled in a SHOP-Certified QHP, Carrier shall complete the SHOP Certification/Recertification Request Form, attached hereto as Appendix 3. Carrier shall email the rates applicable to the Small Employer's health benefit plan and a completed SHOP Certification/Recertification Request Form to SHOP.marketplace@oregon.gov within 10 days of the Small Employer's request.

6.1.4 The Marketplace will confirm that:

6.1.4.1 The QHP purchased by the Small Employer is SHOP-Certified; and

6.1.4.2 The SHOP Certification/Recertification Request Form provided by Carrier contains the following information:

6.1.4.2.1 The small business has fewer than 51 full-time equivalent employees;

6.1.4.2.2 The employer pays at least 50% of the employee-only premium for each enrolled employee; and

6.1.4.2.3 The employer offers a Marketplace SHOP-certified QHP to all of its full time employees.

6.1.5 If an employer meets the criteria enumerated in paragraph 6.1.4, the Marketplace will notify the employer, the agent of record, and Carrier of the employer's eligibility for SHOP.

6.1.6 Carrier shall provide new member information; Summary of Benefits and Coverage (SBC); and group-level materials, such as contracts and program collateral materials, directly to Subscribers.

6.1.7 Carrier shall provide member materials, such as ID cards, member certificates, and Oregon State Continuation information required by ORS 743B.347, directly to Members.

6.2 If Carrier offers a product through the manual SHOP, carrier is not required to offer a product through an automated SHOP. If Carrier does not offer a product through the manual SHOP, carrier may still offer a product through an automated SHOP.

7. AMERICAN INDIAN AND ALASKA NATIVE REQUIREMENT

7.1 To the extent possible using the FFM platform, Carrier shall comply with all applicable federal laws and regulations and all applicable requirements related to the provision of Health Plan coverage to American Indians/Alaska Natives, including but not limited to the requirement to:

7.1.1 Provide monthly enrollment periods for an American Indian/Alaskan Native enrolled in an Individual Plan;

7.1.2 Provide zero Cost-Sharing for American Indians/Alaska Natives with household incomes at or below 300 percent of the federal poverty level;

7.1.3 Provide zero Cost-Sharing for items or services furnished through Indian health providers;

7.1.4 Treat health programs operated by the Indian Health Services, Indian tribes, tribal organizations, and Urban Indian organizations as the payer of last resort for services provided by such programs notwithstanding any federal, state, or local law to the contrary; and

7.1.5 Comply with the Indian Health Care Improvement Act Sections 206 (25 USC 1621e) and 408 (25 USC 1647a).

7.2 If Carrier contracts with a federally recognized Indian Tribe or Indian health provider, Carrier shall provide a copy of the contract to the Marketplace.

7.3 Carrier shall use the Indian Addendum (OAR 945-020-0040) when contracting with a specified Indian health provider.

7.4 Carrier shall:

7.4.1 Participate in the Marketplace Tribal Premium Sponsorship Program.

7.4.2 Aggregate the payment for all TPSP-Sponsored Individuals for each Tribal Entity.

7.4.3 Accept bank routing information from Tribal Entities on behalf of Sponsored Individuals via a paper form produced by Marketplace.

7.4.4 Accept Tribal Entity billing addresses for Sponsored Individual files.

7.4.5 Send premium billing notices and rate change information to a Tribal Entity paying premium sponsorship, with the expected premium withdrawal for all Sponsored Individuals and the expected bank withdrawal date.

7.4.6 Consolidate TPSP billing and rate change notices so that the Tribal Entity does not receive multiple notices.

7.4.7 Send premium billing notices and rate change information to Sponsored Individuals participating in the TPSP if the individual requests to receive such information.

7.4.8 Send all policy information and notices to the Sponsored Individual.

7.4.9 Notify Tribal Entities of aggregate premium withdrawals prior to each automatic deduction each month.

7.4.10 Consolidate Sponsored Individual's rate notices for each Tribal Entity participating in the program.

7.4.11 Notify the Tribal Entity and Marketplace of the date funds will be withdrawn from the Tribal Entity's bank account to pay for TPSP-sponsored premiums.

7.4.12 Develop alternative procedures for accepting TPSP premium funds in the event the standard automatic premium deduction system does not run on the intended withdraw date, preventing the cancellation of coverage or an undue delay or pending of claims. Carrier shall file this alternative procedure with Marketplace.

7.4.13 Send all cost-sharing charges to any AI/AN individual at or above 300% FPL who incurs cost- sharing charges.

7.4.14 Limit premium rate changes to once in a 12-month plan year, except for a change in plan pursuant to:

7.4.14.1 Special enrollment; or

7.4.14.2 The monthly open enrollment period available to AI/AN individuals.

8. MANDATORY REPORTING AND PERFORMANCE STANDARDS

8.1 Carrier shall report information about QHPs as required by federal law, including 45 CFR 156.220**,** in a form, manner, and time prescribed by CMS.

8.2 Carrier shall make information required for disclosure under 45 CFR 156.220 available to the public in plain language. The term "plain language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing.

8.3 In the manner, form, and timeframe prescribed by CMS, Carrier shall submit to CMS and the Marketplace the quality rating system data required by 45 CFR 156.1120(a) and the enrollee satisfaction survey data required by 45 CFR 156.1125(b).

8.4 Carrier shall submit its quality improvement strategy and evaluation data, as required by 45 CFR 156.1130, to the Marketplace through SERFF.

8.4.1 By June 30, 2017, Carrier shall report in the Implementation Plan and Progress Report on the status of the quality improvement strategy submitted in 2016 as described in section 1311(g)(1) of the Affordable Care Act, 42 U.S. Code § 18031(g)(1), consistent with CCIIO technical guidance, including but not limited to CMS "Quality Improvement Strategy: Technical Guidance and User Guide for the 2017 Coverage Year" (November 2015).

8.4.2 By June 30, 2017, Carrier shall also provide in the Implementation Plan and Progress Report to the Marketplace for approval a description of:

8.4.2.1 How the quality improvement strategy described in paragraph 8.4.1 will address a second topic area, if only one of the five topic areas was addressed in the 2017 quality improvement strategy plan. The five topic areas are: activities intended to improve health outcomes; prevent hospital readmissions; improve patient safety and reduce medical errors; promote health and wellness, and reduce health and health care disparities. Carrier will begin to implement activities addressing the second topic area no later than January 2018; or

8.4.2.2 A second quality improvement strategy that Carrier will begin to implement no later than January 2018 that is in addition to the quality improvement strategy described in paragraph 8.4.1

8.5 Within seven business days of a request by the Marketplace, Carrier shall provide to the Marketplace:

8.5.1 The list of appointed producers maintained by Carrier pursuant to ORS 744.078(2).

8.5.2 The email address and telephone number for each of the producers on the list described in paragraph 8.5.1.

8.5.3 A written explanation of Carrier's policies and procedures pertaining to the appointment of producers.

9. ADMINISTRATIVE CHARGE

9.1 The Marketplace will assess an administrative charge on Carrier on the tenth business day of each month following receipt of enrollment data reported by Carrier and verified by DFR. The Marketplace will calculate the administrative charge as set forth in OAR 945-030-0035(1). Carrier shall pay the administrative charge as billed via electronic funds transfer to the Marketplace no later than the last business day of the month in which Carrier is billed. The Marketplace may offset overpayments against future assessments and may increase future monthly assessments to offset underpayments.

9.2 Carrier may not allocate the Administrative Charge only to those Enrollees who enroll through the Marketplace unless Carrier's Health Plan business is limited to the Marketplace.

10. COFA PREMIUM ASSISTANCE PROGRAM

10.1 For the months of November 2016 through January 2017, Carrier:

10.1.1 Shall complete and submit to the Marketplace the information requested by Appendix 4 by the 23rd of each month.

10.1.2 Shall acknowledge to the Marketplace the receipt of each COFA Member Enrollee's premium payment by the 3rd of the month following the receipt of the payment.

10.1.3 Shall reconcile any data or payment discrepancies with the Marketplace by the 5th of the month following receipt of the premium payment.

10.1.4 Shall complete and submit Appendix 5 to Department of Administrative Services; EGS FBS SFMS/ACH Coordinator; 155 Cottage Street NE U60; Salem, OR 97301-3963 no later than October 11, 2016.

10.1.5 May submit to the Marketplace a single invoice that includes aggregate premium for all COFA Member Enrollees by the 23rd of each month.

10.1.6 Notwithstanding paragraphs 10.1.1, 10.1.2, and 10.1.3:

10.1.6.1 Shall complete and submit to the Marketplace the information requested by Appendix 4 by the first business day preceding the 23rd of the month if the 23rd of the month is a state holiday.

10.1.6.2 Acknowledge to the Marketplace the receipt of each COFA Member Enrollee's premium payment by the first business day preceding the 3rd of the month following the receipt of the payment if the 3rd of the month following the receipt of the payment is a state holiday.

10.1.6.3 Reconcile any data or payment discrepancies with the Marketplace by the first business day preceding the 10th of the month following receipt of the premium payment if the 10th of the month following receipt of the premium payment is a state holiday.

10.2 For the months of February 2017 through November 2017, Carrier:

10.2.1 Shall complete and submit to the Marketplace the information requested by Appendix 4 by the 13th of each month.

10.2.2 Shall acknowledge to the Marketplace the receipt of each COFA Member Enrollee's premium payment by the 1st of the month following the receipt of the payment.

10.2.3 Shall reconcile any data or payment discrepancies with the Marketplace by the 5th of the month following receipt of the premium payment.

10.2.4 May submit to the Marketplace a single invoice that includes aggregate premium for all COFA Member Enrollees by the 13th of each month.

10.2.5 Notwithstanding paragraphs 10.2.1,10.2.2, and 10.2.3:

10.2.5.1 Shall complete and submit to the Marketplace the information requested by Appendix 4 by the next business day following the 13th of the month if the 13th of the month is a state holiday.

10.2.5.2 Acknowledge to the Marketplace the receipt of each COFA Member Enrollee's premium payment by the next business day following the 1st of the month following the receipt of the payment if the 1st of the month following the receipt of the payment is a state holiday.

10.2.5.3 Reconcile any data or payment discrepancies with the Marketplace by the next business day following the 5th of the month following receipt of the premium payment if the 5th of the month following receipt of the premium payment is a

state holiday.

10.3 For the period between November 1, 2016 and December 31, 2017, Carrier shall report to the Marketplace for the preceding month by the 13th of each month:

10.3.1 The number of COFA Member Enrollees whose QHP coverage is terminated or whose application for QHP coverage is denied.

10.3.2 The 834 Transaction code for each termination of coverage or application denial described in paragraph 10.3.1.

10.4 For the coverage period between January 1, 2017 and June 30, 2017, Carrier shall report to the Marketplace by September 1, 2017:

10.4.1 The number of COFA Member Enrollees whose QHP coverage is terminated or whose application for QHP coverage is denied.

10.4.2 The 834 Transaction code for each termination of coverage or application denial described in paragraph 10.4.1.

10.4.3 The total number of in-network claims submitted by COFA Member Enrollees.

10.4.4 The total dollar amount of:

10.4.4.1 The claims described in paragraph 10.4.3.

10.4.4.2 The claims described in paragraph 10.4.3 that Carrier paid.

10.4.4.3 The claims described in paragraph 10.4.3 that Carrier denied.

10.4.5 The total number of out-of-network claims submitted by COFA Member Enrollees.

10.4.6 The total dollar amount of:

10.4.6.1 The claims described in paragraph 10.4.5.

10.4.6.2 The claims described in paragraph 10.4.5 that Carrier paid.

10.4.6.3 The claims described in paragraph 10.4.5 that Carrier denied.

10.5 For the coverage period between July 1, 2017 and December 31, 2017, Carrier shall report to the Marketplace by April 1, 2018:

10.5.1 The number of COFA Member Enrollees whose QHP coverage is terminated or whose application for QHP coverage is denied.

10.5.2 The 834 Transaction code for each termination of coverage or application denial described in paragraph 10.5.1.

10.5.3 The total number of in-network claims submitted by COFA Member Enrollees.

10.5.4 The total dollar amount of:

10.5.4.1 The claims described in paragraph 10.5.3.

10.5.4.2 The claims described in paragraph 10.5.3 that Carrier paid.

10.5.4.3 The claims described in paragraph 10.5.3 that Carrier denied.

10.5.5 The total number of out-of-network claims submitted by COFA Member Enrollees.

10.5.6 The total dollar amount of:

10.5.6.1 The claims described in paragraph 10.5.5.

10.5.6.2 The claims described in paragraph 10.5.5 that Carrier paid.

10.5.6.3 The claims described in paragraph 10.5.5 that Carrier denied.

11. Producer Commissions

Carrier will not unlawfully vary the Producer commission rate or rates paid to a Producer for the sale of QHPs from the commission rate or rates underlying the QHP premium rate approved by DFR.

EXHIBIT A

Statement of Work – Dental Contract

1. DEFINITIONS

The following are definitions that apply to this Contract:

1.1. "Affordable Care Act" or "ACA" means the provisions of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), together with any interim final or final federal regulations implementing the foregoing statute.

1.2. "American Indian/Alaska Native" means a person who is a member of an Indian Tribe.

1.3. "Benefit Design Standards" means coverage that provides for all of the following:

1.3.1. Essential Health Benefits as defined by OAR 836-053-0008; and

1.3.2. Cost-Sharing as described in 45 CFR 156.150.

1.4. "Carrier" means the party to this Contract described in the opening paragraph of the Contract.

1.5. "Carrier Intellectual Property" means any intellectual property owned by Carrier.

1.6. "Certification" means the certification of a Dental Plan by the Marketplace as an SADP.

1.7. "CMS" means the United States Department of Health and Human Services, Center for Medicare and Medicaid Services.

1.8. "Cost-Sharing" means any expenditure required by, or on behalf of, an Enrollee with respect to EHBs; Cost-Sharing includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, visit limits, and non-covered services.

1.9. "DCBS" means the State of Oregon, Department of Consumer and Business Services.

1.10. "Decertification" means the removal of an SADP's Certification, making the Dental Plan ineligible for sale through the Marketplace.

1.11. "Dental Plan" means a Health Plan offered in Oregon that offers a limited scope of dental benefits.

1.12. "Division of Financial Regulation" or "DFR" means the Division of Financial Regulation of DCBS.

1.13. "Eligible Employee" has the meaning given to the term in ORS 743B.005.

1.14. "Enrollee" means a person enrolled in an SADP.

1.15. "Essential Health Benefits" or "EHBs"" has the meaning given that term in OAR 836-053-0008.

1.16. "Federally Facilitated Marketplace" or "FFM" means the entity and health insurance exchange platform operated by CMS through which the Marketplace makes SADPs available for sale to Individuals, determines their eligibility, and enrolls them in SADPs.

1.17. "Health Plan" has the meaning given to the term in ORS741.300.

1.18. "Indian Tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

1.19. "Individual Plan" means an SADP for Qualified Individuals including dependents.

1.20. "Individual Product Line" means Carrier's entire line of Individual Plans.

1.21. "Marketplace" means the health insurance exchange administered by DCBS in accordance with ORS 741.310.

1.22. "Oregon Insurance Laws" means:

1.22.1. The Oregon Insurance Code as defined in ORS 731.004 and its implementing administrative rules in OAR 836; and

1.22.2. DFR Bulletins implementing or interpreting the laws described in section 1.23.

1.23. "Oregon Marketplace Laws" refers to laws of the state of Oregon pertaining to the establishment and operation of the Marketplace. The term includes, but is not limited to:

1.23.1. Senate Bill 1 enrolled (2015), Chapter 3, 2015 Oregon Laws;

1.23.2. ORS chapter 741 as amended through 2015; and

1.23.3. All implementing administrative rules (including OAR chapter 945) related to the Marketplace.

1.24. "Plan Year" means the consecutive 12-month period during which a Small Employer Plan provides coverage for dental benefits.

1.25. "Policy Year" means the calendar year for which an Individual SADP provides coverage for dental benefits.

1.26. "Producer" means a person who is licensed by DFR to sell, solicit, or negotiate the sale of an SADP.

1.27. "Qualified Individual" means a person who has been determined eligible to enroll through the FFM in an Individual Plan.

1.28. "Recertification" means the process of obtaining certification of an SADP for the calendar year immediately following a Certification or Recertification.

1.29. "Records" means all financial records, other records, books, documents, papers, plans, records of shipments and payments and writings of Carrier, whether in paper, electronic or other form, that are pertinent to this Contract.

1.30. "Service Area" means the geographic area or areas described in OAR 836-053-0063 in which Carrier offers an SADP.

1.31. "Small Business Health Options Program" or "SHOP" means a health insurance exchange for small employers as described in 42 U.S.C. 18031.

1.32. "Small Employer" has the meaning given that term under the ORS 743B.005.

1.33. "Small Employer Plan" means an SADP issued to a Small Employer.

1.34. "Small Employer Product Line" means Carrier's entire line of SHOP-certified Small Employer Plans

1.35. "Stand-Alone Dental Plan" or "SADP" means a Dental Plan that is certified by the Marketplace and offered for sale through the FFM or Small Employer Health Options Program (SHOP).

1.36. "Third Party Intellectual Property" means any intellectual property owned by parties other than DCBS or Carrier.

1.37. "Work Product" means every invention, discovery, work of authorship, trade secret or other tangible or intangible item and all intellectual property rights therein that Carrier delivers to DCBS pursuant to the work performed under this Contract.

2. STATE AND FEDERAL REQUIREMENTS

2.1. Carrier shall comply with the applicable provisions of the following:

2.1.1. The ACA;

2.1.2. Oregon Marketplace Laws;

2.1.3. Oregon Insurance Laws;

2.1.4. Any state or federal regulations implementing the foregoing laws; and

2.1.5. Any other state and federal laws, regulations, or official agency written guidance applicable to Carrier as the issuer of an SADP.

2.2. Throughout the term of this Contract, Carrier shall hold a Certificate of Authority in good standing from DFR to offer Dental Plans in Oregon.

2.3. Carrier shall not, with respect to its SADPs, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. Carrier will not have marketing practices or benefit designs that will discourage the enrollment of Individuals or Eligible Employees with significant health needs in its SADPs.

3. BENEFIT DESIGN STANDARDS AND SADPs

3.1. **Benefit Design** – Carrier shall ensure that each of its SADPs complies with the Benefit Design Standards, including the actuarial value requirements and the pediatric dental component of federally approved EHBs.

3.2. All SADPs must include, at minimum, coverage of the pediatric dental component of EHBs.

3.3. SADPs must meet an actuarial value of 70% or 85%, plus or minus 2%.

3.4. Cost-sharing for the pediatric dental component of EHBs in an SADP must be held to a separate out of pocket maximum that does not cross-accumulate to an Enrollee's qualified health plan.

3.5. Carrier may offer through the Marketplace up to three SADPs at a 70% Actuarial Value and up to three SADPs at an 85% Actuarial Value per Service Area and Product Line in which it provides coverage.

3.6. Carrier may submit for Certification an unlimited number of Dental Plans to offer outside the Marketplace.

4. SADP CERTIFICATION

4.1. *SADP Submission Process*

4.1.1. **DFR Approval** – Carrier shall obtain DFR's approval of:

4.1.1.1. Rates, forms, and binders for each Individual Dental Plan for which Carrier seeks Certification.

4.1.1.2. Forms and binders for each Small Employer Dental Plan for which Carrier seeks Certification.

4.1.2. **Rate Adjustments** – Carrier may not adjust Individual Product Line rates during a Policy Year. Carrier may adjust Small Employer Product Line rates on a quarterly basis.

4.2. *Marketplace Certification Requirements*

At the request of Carrier, the Marketplace will certify an Individual Dental Plan as an SADP if Carrier obtains approval from DFR of the rates, forms, and binder and will certify a Small Employer Dental Plan as an SADP if Carrier obtains approval from DFR of the forms and binders.

4.3. *SADP Recertification*

Carrier shall follow the SADP Submission Process described in Section 4.1 for all SADPs for which it seeks Recertification.

4.4. *Marketplace Decertification of SADP*

The Marketplace may at any time decertify an SADP if the Marketplace determines that Carrier or SADP is no longer in compliance with the Marketplace's Certification criteria.

4.4.1. Carrier may appeal Decertification of an SADP through the following process. Appeal requests must be submitted within 15 days the notice from DCBS informing Carrier of the Decertification. Carrier's appeal request must be made in writing, and must provide thorough explanation of the grounds for appeal along with any supporting information. Valid appeal requests will be reviewed and decided upon by the Administrator of the Marketplace, within 14 days of receipt of the request. If Carrier is unsatisfied with the Administrator's decision on its appeal, Carrier may seek additional review through a contested case hearing as provided under ORS 183.411 to 183.471.

4.4.2. Upon Decertification of an SADP, the Marketplace will provide notice of Decertification to:

4.4.2.1. Carrier;

4.4.2.2. Enrollees in the SADP;

4.4.2.3. The United States Office of Personnel Management if Carrier offers a multi-state QHP;

4.4.2.4. CMS; and

4.4.2.5 DFR.

4.4.3. In the event of a Decertification, Carrier shall not terminate coverage before giving notice to Enrollees, including information that displaced Enrollees will be given a special enrollment period to allow them to enroll in new SADPs.

5. STAFFING

5.1. Carrier shall identify key staff as primary Marketplace contact(s) responsible for oversight of Carrier's SADPs and shall provide the Marketplace with the name and contact information of such staff.

5.2. Carrier shall provide and maintain direct communication with Marketplace staff during the pendency of this Contract.

5.3. The Marketplace will identify and provide Carrier with the contact information of key staff.

6. AMERICAN INDIAN AND ALASKA NATIVE REQUIREMENT

6.1. Carrier shall comply with all applicable federal laws and regulations and all applicable requirements related to the provision of Dental Plan coverage to American Indians/Alaska Natives, including but not limited to the requirement to:

6.1.1. Provide monthly enrollment periods for an American Indian/Alaskan Native enrolled in an Individual Plan;

6.1.2. Treat health programs operated by the Indian Health Services, Indian tribes, tribal organizations, and Urban Indian organizations as the payer of last resort for services provided by such programs notwithstanding any federal, state, or local law to the contrary; and

6.1.3. Comply with the Indian Health Care Improvement Act Sections 206 (25 USC 1621e) and 408 (25 USC 1647a).

6.2. If Carrier contracts with a federally recognized Indian Tribe or Indian health provider, Carrier shall provide a copy of the contract to the Marketplace.

7. PRODUCERS

Within seven business days of a request by the Marketplace, Carrier shall provide to the Marketplace:

7.1. The list of appointed producers maintained by Carrier pursuant to ORS 744.078(2).

7.2. The email address and telephone number for each of the producers on the list described in subparagraph 7.1.

7.3. A written explanation of Carrier's policies and procedures pertaining to the appointment of producers.

8. ADMINISTRATIVE CHARGE

8.1. The Marketplace will assess an administrative charge on Carrier on the tenth business day of each month following receipt of enrollment data reported by Carrier and verified by DFR. The Marketplace will calculate the administrative charge as set forth in OAR 945-030-0035(1). Carrier shall pay the administrative charge as billed via electronic funds transfer to the Marketplace no later than the last business day of the month in which Carrier is billed. The Marketplace may offset overpayments against future assessments and may increase future monthly assessments to offset underpayments.

8.2. Carrier may not allocate the Administrative Charge only to those Enrollees who enroll through the Marketplace unless Carrier's Dental Plan business is limited to the Marketplace.