

**EXHIBIT A  
SCOPE OF WORK  
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## **EXHIBIT A SCOPE OF WORK**

### **I. INTRODUCTION**

#### **A. Act and Regulation**

This Agreement is in accord with and pursuant to Section 12693 et. seq., Part 6.2 of Division 2 of the California Insurance Code, which establishes the Healthy Families Program (hereinafter the Program). The Agreement is also in accord and pursuant to Title XXI of the Social Security Act and its implementing federal regulations, which establish the State Children's Health Insurance Program and provide authorization and federal funding for the Healthy Families Program, and Title 10, Chapter 5.8 of the California Code of Regulations (hereinafter Program Regulations). Terms and conditions used in the Program Regulations shall have the same and identical meanings in this Agreement.

#### **B. Specialized Health Care Service Plan**

This Agreement is entered into by the Contractor and the State for the purpose of providing vision coverage for subscribers determined to be eligible by the State. The method of delivery of the insured vision benefits shall be a specialized health care service plan. The Contractor agrees to provide and maintain the specialized health care service plan.

#### **C. Geographic Areas Covered**

1. The Contractor's participation in the Program is limited to enrollment of Program subscribers who reside in the Contractor's licensed service area accepted by the State. These geographic areas are described in Attachment I: Plan Coverage Area.
2. Geographic coverage in the Program may be changed only upon written approval by the State. The Contractor shall request such approval in writing at least sixty (60) days prior to the date the change will take place and shall include documentation from the state licensing agency that approved the changes to the Contractor's licensed service area.
3. If the change requested is to withdraw from an area due to a plan initiated licensure change or removal, the State shall cease new enrollment of subscribers in the area and the Contractor shall

continue to maintain and provide services to subscribers in the area until the end of the benefit year.

4. If the change requested is to withdraw from an area due to a plan initiated licensure change or removal for a date that is not concurrent with the Program's open enrollment, then the Program will hold a special open enrollment pursuant to Exhibit B, Item I.C.

D. Provider Networks

1. The Contractor's organization shall consist of the list of vision care providers to be provided to the State. These providers are listed in the Contractor's Provider Directory. The Contractor agrees to provide copies of the Provider Directory to the State upon request, and to annotate, on a quarterly basis, the information required in Item II.I with a notation that indicates whether the providers are accepting new Program subscribers.
2. Vision care providers shall be deemed added to or deleted from the Contractor's Provider Directory as contracts between the Contractor and vision care providers begin or end.
  - a. If such contract activity between the Contractor and vision care providers opens a new zip code to the coverage contemplated by this Agreement, the Contractor shall give at least sixty (60) days written notice to the State and, at the time of submission to the state licensing agency, shall provide the State a copy of the documentation referenced in Section I.C.2. and shall implement the change only upon written approval by the State.
  - b. If such contract activity between the Contractor and vision care providers would materially impair the Contractor's capacity to perform under this Agreement, the Contractor shall give at least sixty (60) days written notice to the State and, at the time of submission to the state licensing agency, shall provide the State a copy of the documentation referenced in Section I.C.2.

E. Term of Agreement

The term of this Agreement shall be from July 1, 2005, through September 30, ~~2013~~ 2012. Any renewal or extension of the Agreement is

at the State's sole discretion and is contingent upon successful performance by the Contractor as solely determined by the State.

## II. ENROLLMENT

### A. Eligibility

All subscribers who are determined eligible by the State in accordance with the Act and Program regulations are eligible to enroll in a program vision plan. The State certifies that its enrollment process will not be prejudicial to the Contractor or other participating vision plans. The Contractor may observe the State's eligibility determination and enrollment process. The Contractor agrees that the State conducts all eligibility determinations and shall not attempt to conduct its own eligibility investigations or inquiries.

### B. Conditions of Enrollment

1. The Contractor agrees to enroll all subscribers referred by the State, in writing and electronically when appropriate, on the date specified by the State.
2. The State shall notify the applicant of enrollment with the Contractor and the effective date of coverage by the Contractor. Except for infants born to women enrolled in the AIM Program and as specified in Item II.B.3, the State shall notify the Contractor of new enrollees no later than ten (10) days prior to the subscriber's effective date of coverage.
3. The Contractor agrees that in special circumstances the State may provide less than ten (10) days' notice prior to a subscriber's effective date of coverage. Special circumstances shall be at the discretion of the State, but Contractor shall be notified of the special circumstance, in writing and electronically when appropriate.

### C. Disenrollment

1. The Contractor agrees to disenroll subscribers when notified to do so by the State, in writing and electronically when appropriate, on the date specified by the State.
2. In no event shall any individual subscriber be entitled to the payment of any benefits with respect to vision care services rendered, supplies or drugs received or expense incurred following termination of coverage consistent with state and federal law. For

the purposes of this Agreement, a charge shall be considered incurred on the date the service or supply giving rise to the charge is rendered or received.

D. Commencement of Coverage

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

E. Identification Cards, Provider Directory and Evidence of Coverage (EOC) or Certificate of Insurance (COI) Booklet

1. Except for infants born to women enrolled with the Contractor in the AIM Program and subscribers enrolled with less than ten (10) days' notice pursuant to Item II.C.3, the Contractor shall, no later than the effective date of coverage, issue to applicants on behalf of subscribers an Identification Card, issue or offer a Provider Directory, and issue an Evidence of Coverage or Certificate of Insurance booklet setting forth a statement of the services and benefits to which the subscriber is entitled. The Contractor agrees that the materials sent to applicants on behalf of subscribers shall also include information to subscribers regarding how to access services and the process for resolving a problem or filing a grievance with the plan. The information shall be in addition to the description provided in the Evidence of Coverage or Certificate of Insurance booklet. Examples of acceptable forms of information include but are not limited to: a brochure on How to Access Services, inclusion in a cover letter of the specific pages in the Evidence of Coverage or Certificate of Insurance booklet relating to accessing services, or a magnet listing the telephone number to call to schedule an appointment with a provider. The contractor's Evidence of Coverage or Certificate of Insurance booklet, as approved by the State, is hereby incorporated by reference, as fully set forth within.
2. For infants born to women enrolled in the AIM Program with the Contractor and subscribers enrolled with less than ten days' notice pursuant to Item II.C.3, the Contractor shall provide the Identification Card, issue or offer a Provider Directory, and provide an Evidence of Coverage or Certificate of Insurance booklet and other materials described in Item II.F.1 to applicants on behalf of subscribers no later than ten (10) days from the date the Contractor is notified of the enrollment.

3. a. In addition to the instances described in Items II.F.1 through II.F.2, above, the Contractor shall, by July 1 of each year, issue or offer to each applicant on behalf of the subscribers enrolled in the Contractor's plan an updated Provider Directory, and issue either an updated Evidence of Coverage or Certificate of Insurance booklet setting forth a statement of the services and benefits to which the subscriber is entitled in the next benefit year, or a letter describing any changes to the benefits package that will go into effect at the beginning of the next benefit year.
      - b. In any year in which an updated Evidence of Coverage or Certificate of Insurance booklet is not issued by July 1, the Contractor shall issue an updated Evidence of Coverage or Certificate of Insurance booklet by September 15 to each applicant on behalf of the subscribers enrolled in the Contractor's plan.
      - c. The Contractor shall obtain written approval by the State prior to issuing the updated Evidence of Coverage or Certificate of Insurance booklet and the letter describing changes in the benefit package. The letter shall be submitted to the State by June 1 for review and approval.
      - d. By October 1 of each year, the Contractor shall submit to the State two (2) print copies of the updated Evidence of Coverage or Certificate of Insurance booklet, one (1) electronic copy of the final approved Evidence of Coverage or Certificate of Insurance booklet on compact disk, and one (1) print copy of the updated Provider Directory.
    4. The Contractor's Provider Directory shall be updated and distributed by the Contractor to applicants on behalf of subscribers whenever there is a material change in the Contractor's provider network.
    5. The Contractor's Provider Directory shall indicate the language capabilities of the providers' offices.
    6. The Contractor shall provide a copy of the Contractor's Evidence of Coverage or Certificate of Insurance booklet and Provider Directory to any person requesting such materials, by telephone or in writing, within ten (10) days of the request.

7. Written informing material provided to subscribers shall be at a sixth grade reading level or at a level that the Contractor determines is appropriate for its subscribers and that is approved by the State, to the extent that compliance with this provision does not conflict with regulatory agency directives or other legal requirements.
8. Whenever the Contractor assigns a subscriber to a clinic, the Contractor shall notify the subscriber of his/her right to select a new primary care provider optometrist. If a subscriber selects a primary care provider optometrist who is affiliated with a clinic and the assignment of the subscriber is made to the clinic pursuant to Insurance Code section 12693.515, the Contractor shall inform the subscriber that he/she has been assigned to the clinic and has a right to select a new primary care provider optometrist immediately or at any future time, including such time as the selected primary care provider optometrist is no longer affiliated with the clinic. The Contractor shall promptly notify the subscriber of his/her rights after the assignment to the clinic has been made.

F. Right to Services

Possession of the Contractor's Identification Card confers no right to services or other benefits of the Program. To be entitled to services or benefits, the holder of the card must, in fact, be a subscriber enrolled in the Program.

G. Open Enrollment

The Contractor agrees to participate in an annual open enrollment process during which subscribers may transfer from one vision plan to another.

H. Enrollment Data

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

1. The State shall transmit subscriber enrollment and disenrollment information, subscriber data updates, as well as transfer and reinstatement information, to the Contractor using Electronic Data Interchange (EDI) each business day. The Contractor must accept this information via EDI and update its enrollment system within three (3) calendar days, excluding holidays. The Contractor shall receive the transmitted information, data and file sent through the

EDI in a manner and format that comply with HIPAA standards for electronic transactions and code sets.

2. The Contractor agrees to accept written confirmation of enrollments from the State plan liaisons, in the event system errors cause enrollment transactions to be delayed or under circumstances set forth in Item II.B.3. The State agrees that the written confirmations are valid and acceptable alternative notifications to the Contractor until the enrollment transaction can be generated and sent to the Contractor.
3. The State shall develop an electronic bulletin board system, available twenty-four (24) hours a day, excluding maintenance periods that usually will be held on Sundays, to provide the Contractor with enrollment reports.
4. The State shall establish and manage a plan liaison function for the purpose of enhancing the program operations through the sharing and coordination of information with the Contractor. Common or persistent problems or issues with the Contractor shall be communicated to the State. The State shall provide a separate telephone number for communication between the State and the Contractor.
5. The State shall transmit to the Contractor on a weekly basis (on Saturday or Sunday) a separate confirmation file. This shall consist of a record count of the different record types in the weekly enrollment file. The State shall also transmit to the Contractor enrollment and data files on a weekly basis (on Saturday or Sunday) reflecting the prior week's activity. The Contractor shall use the data files to reconcile and validate weekly activity.
6. The State shall complete weekly transmissions by 4:00 a.m. Pacific Time each Monday or, when Monday is an official State holiday, by 4:00 a.m. Pacific Standard Time Tuesday.
7. The State shall transmit the files described in Items II.H.1 and II.H.5 to the Contractor at no charge.
8. On a monthly basis, the State shall provide audit files for the Contractor, including, but not limited to, currently active subscribers. The audit files shall normally be provided by the third Monday of the month following the month for which data are being reported. If unexpected circumstances cause a delay in the

provision of the audit files, the State, through the administrative vendor's assigned plan liaison, shall notify the Contractor.

9. The State shall provide, at the Contractor's request, retransmission files of the data files set forth in Items II.H.5 and II.H.8. above within six (6) months of the original transmissions. The Contractor agrees to pay for assembly and transmissions costs of the files in Items II.H.5 and II.H.8. above at the rate of \$85 per hour or \$250 per report or file, whichever cost is greater. The State shall waive the assembly and transmission fee if the State determines that the original transmission file was corrupted or unusable.
10. The Contractor agrees to reconcile its enrollment data using the monthly data files sent by the State. The Contractor shall report any enrollment discrepancies to the State, in a format approved by the State, within sixty (60) days from the date the monthly audit file is provided to the Contractor. The State shall not be liable for any discrepancies reported by the Contractor after this 60-day period. The State shall respond to discrepancies timely submitted to the State by the Contractor.
11. With respect to Items II.H.5 and II.H.8. above, the Contractor shall utilize the State's plan liaison personnel as much as possible. There will be no charge for the services of the State's plan liaison.
12. Prior to commencing work requested by the Contractor under Item II.H.9, the State shall provide a cost estimate to the Contractor.
13. The State shall provide EDI instructions and data mapping formats to the Contractor upon request of the Contractor. The State shall provide additional technical assistance, either by telephone or at the Contractor's site, to plans new to EDI data transmission as they establish electronic capability.
14. The State shall conduct at least one meeting for the period of this Agreement for the purpose of providing training and technical assistance to the Contractor regarding EDI and transmission of enrollment data.
15. The Contractor agrees either to use the Program's Family Member Number (FMN) in its data base for subscriber tracking purposes or to maintain a cross reference mechanism between the Contractor's unique identifier and the Program's unique identifier.

I. Network Information Service

1. The Contractor agrees to provide, to the best of the Contractor's ability, complete and accurate data on its provider network in an electronic format to be determined by the State. The information may be expanded by the State with no less than ninety (90) days notice by the State. The Contractor agrees to provide additional data elements, as requested by the State, to the best of its ability. The Contractor understands that the State intends to use information provided pursuant to this section to assist potential and current applicants and subscribers in selecting a vision plan and vision care providers, and that information provided to the State will be shared with the public.
2. The Contractor agrees to provide the provider network information to the State on a quarterly basis, including updated notations on providers accepting new Program subscribers. The Contractor may update its provider network information on a monthly basis. The Contractor is required to provide data for the creation of the database to the State between the 11<sup>th</sup> and 25<sup>th</sup> of any submission month.
3. If the Contractor is unable to provide electronic files in the specified provider network formats, the State agrees to offer the Contractor data capture services at the rate of \$25 per hour.
4. If the Contractor so requests, the State agrees to offer the Contractor an unscheduled update to the provider network information at the rate of \$500 per update.

J. Traditional and Safety Net Providers

The Contractor agrees to establish, with traditional and safety net providers as described in Article 4 of the Program regulations, network membership and payment policies which are no less favorable than its policies with other providers.

K. Public Awareness

1. The Contractor agrees to engage in marketing efforts designed to increase public awareness of and enrollment in the Program. The Contractor shall publicize its participation in the Program through its internal provider communications system and through its general membership communication publications. All public awareness

efforts must be approved by the State before being released in public and must be in compliance with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments and applicable regulations, Insurance Code Sections 12693.31, 12693.32, 12693.325 and 12693.326, as well as be in compliance with the State's marketing guidelines. In the event that the State does not notify the Contractor in writing, with the reasons the marketing materials are not approved, within sixty (60) days of receipt by the State, the materials shall be deemed approved.

2. The Contractor is prohibited from directly, indirectly, or through their agents, conducting in person, door to door, mail or telephone solicitation of applicants for enrollment.
3. By September 1, 2005, the Contractor agrees to submit to the State for its approval, in a format determined by the State, a marketing plan that covers the term of this Agreement.
  - a. The marketing plan shall include the Contractor's mission statement, a written description of proposed marketing activities and locations, a listing of all proposed marketing materials to be used, and proposed locations for distribution, including ancillary components such as scripts. Upon request by the State, the Contractor shall submit other information, such as examples of previously approved marketing materials currently being used.
  - b. The marketing plan shall be in compliance with all applicable statutes and regulations, as well as the Program's marketing guidelines.
4. For each benefit year, the Contractor agrees to submit to the State, in a format determined by the State, any proposed updates or amendments to its then-approved marketing plan.
5. If the Contractor chooses to provide application assistance, the plan must have an approved application assistance plan on file with the State and agrees that its designated staff must successfully complete the State's online application assistance training before beginning any application assistance activity. The Contractor's application assistance activities shall include, but not be limited to, assistance to new applicants to apply for the program; and assistance to their own program subscribers going through the

Annual Eligibility Review (AER) process to maintain their coverage for another year. The State provides the Contractor a monthly AER file that identifies the Contractor's subscribers that are within sixty (60) and thirty (30) days of their anniversary date with the program.

### III. CUSTOMER SERVICE

#### A. Telephone Service for Subscribers

The Contractor agrees to provide a toll free telephone number for applicant and subscriber inquiries. This telephone service shall be available on regular business days, at a minimum, from the hours of 8:30 a.m. to 5:00 p.m. Pacific Time. The Contractor will provide staff bilingual in English and Spanish during all hours of telephone service. The Contractor shall have the capability to provide telephone services via a interpretive service for all Limited English Proficient (LEP) persons.

#### B. Grievance Procedure (DMHC)

Department of Managed Health Care Licensees:

1. The Contractor shall establish a grievance procedure to resolve issues arising between the Contractor and subscribers or applicants acting on behalf of subscribers. The Contractor's process shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by Contractor's licensing statute, and the Knox-Keene Health Care Service Plan Act of 1975, as amended. These procedures shall be described in the Contractor's Evidence of Coverage booklet.
2. The Contractor shall report to the State by February 1 of each year, in a format determined by the State, the number and types of grievances filed by Program subscribers and by applicants on behalf of subscribers for the previous calendar year. "Grievance" means a written or oral expression of dissatisfaction regarding the plan or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. Grievances include, but are not limited to, complaints about waiting times for appointments, timely assignment to a provider, issues related to cultural or linguistic access or sensitivity, difficulty accessing specialists or other

services, delays and denials of care, and the administration and delivery of vision benefits in the Program.

**OR**

**B. Grievance Procedure (CDI)**

California Department of Insurance Licensees:

1. The Contractor shall establish a grievance procedure to resolve issues arising between the Contractor and subscribers or applicants acting on behalf of subscribers. The Contractor's process shall include all features required for health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975, as amended, and shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by the Knox-Keene Act. These procedures shall be described in the Contractor's Certificate of Insurance booklet.
2. The Contractor shall report to the State by February 1 of each year, in a format determined by the State, the number and types of grievances filed by Program subscribers and by applicants on behalf of subscribers in the previous calendar year. "Grievance" means a written or oral expression of dissatisfaction regarding the plan or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. Grievances include, but are not limited to, complaints about waiting times for appointments, timely assignment to a provider, issues related to cultural or linguistic access or sensitivity, difficulty with accessing specialists or other services, delays and denials of care, and the administration and delivery of vision benefits in the Program.

**C. Cultural and Linguistic Services**

1. Linguistic Services
  - a. The Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80) which prohibits recipients of federal financial assistance from discriminating against persons based on race, color or national origin. This is interpreted to

mean that a Limited English Proficient (LEP) individual is entitled to equal access and participation in federally funded programs through the provision of bilingual services.

- b. The Contractor shall also ensure compliance with Health & Safety Code Section 1367.04 and Title 28, California Code of Regulations, Section 1300.67.04 et.seq related to Language Assistance programs.
- c. The Contractor shall provide information to its network providers on the language needs of subscribers.
- d. The Contractor shall provide during the hours of 6:00 a.m. to 6:00 p.m. access to interpreter services for all LEP subscribers seeking vision services from providers within the Contractor's network. The Contractor shall use face-to-face interpreter services, if feasible. If face-to-face interpreter services are not feasible, the Contractor may use telephone language lines for interpreter services.
- e. The Contractor shall develop and implement policies and procedures for ensuring access to interpreter services for all LEP subscribers, including, but not limited to, assessing the cultural and linguistic needs of its subscribers, training of staff on the policies and procedures, and monitoring its language assistance program. The Contractor's procedures shall ensure that subcontracted providers comply with these requirements.
- f. When the need for an interpreter has been identified by a provider or when requested by a subscriber, the Contractor agrees to provide a competent interpreter for scheduled appointments. The Contractor shall ensure timely delivery of language assistance services for emergency, urgent, and routine health care to persons of Limited English Proficiency. The Contractor shall instruct the providers within its provider network to record the language needs of subscribers in the medical record.
- g. The Contractor shall use qualified interpreters. The Contractor agrees that subscribers shall not be required or encouraged to utilize family members or friends as interpreters. After being informed of his or her right to use free interpreter services provided by the Contractor, a

subscriber may use an alternative interpreter of his or her choice at his or her cost. The Contractor agrees that minors shall not be used as interpreters, except for only the most extraordinary circumstances, such as medical emergencies. The Contractor shall ensure that the request or refusal of language or interpreter services is documented in the medical record.

- h. The Contractor shall inform subscribers and its network providers of the availability of, and how to access, linguistic services. Information provided to subscribers and providers regarding interpreter services shall include, but not be limited to, the availability of interpreter services to subscribers at no charge; the right not to use family members or friends as interpreters; the right of a subscriber to request an interpreter during discussions of medical information such as diagnoses of medical conditions and proposed treatment options, and explanations of plans of care or other discussions with procedures; the subscriber's right to receive materials as described in Item III.C.2 of this Exhibit; the subscriber's right to file a complaint or grievance if linguistic needs are not met.
- i. The Contractor shall ensure that there is appropriate bilingual proficiency at medical and non-medical points of contact for providers who list their bilingual capabilities in provider directories. Medical points of contact include advice and urgent care telephone lines and face-to-face encounters with providers who provide medical or health care advice to members. Non-medical points of contact include member/customer service, plan or provider office reception, appointment services, and member orientation sessions.
- j. The Contractor shall identify and report the on-site linguistic capability of providers and provider office staff through the reporting required for the Network Information Service described in Item II.I. of this Exhibit.
- k. If the State finds that the Contractor is deficient in meeting the Cultural and Linguistic requirements specified in Section C, Cultural and Linguistic Services, the Contractor shall submit a corrective action plan that corrects the deficiency within a time period satisfactory to the State.

2. Translation of Written Materials

- a. The Contractor shall translate written informing materials for subscribers including, but not limited to, the Evidence of Coverage or Certificate of Insurance booklet; form letters; notice of action letters; consent forms; letters containing important information regarding participation in the health plan; notices pertaining to the reduction, denial, modification, or termination of services; notices of the right to appeal such actions or that require a response from subscribers; grievance forms; notices pertaining to the right to seek Independent Medical Review; notices advising LEP subscribers of the availability of free language assistance services; other outreach materials; and medical care reminders. Written informing materials for subscribers shall be provided at a sixth grade reading level or as determined appropriate through the Contractor's Cultural and Linguistic Needs Assessment and approved by the State, to the extent that compliance with this requirement does not conflict with regulatory agency directives or other legal requirements.
- b. Translation of subscriber materials shall be in the following languages: Spanish, and any language representing the preferred mode of communication for either five percent (5%) or more of the Contractor's enrollment or 3,000 or more subscribers as of March 1 of the previous year. In addition, if the State includes the subscriber's preferred written language in the enrollment file sent to the Contractor, and that language is Spanish or the preferred mode of communication for either five percent (5%) or more of the Contractor's enrollment or 3,000 or more subscribers, the Contractor shall provide materials in that language. If the Contractor serves both Medi-Cal and Program subscribers, the Contractor is encouraged to translate Program member materials into additional Medi-Cal threshold languages not required by the Program. The Contractor shall ensure that members who are unable to read the written materials that have been translated into non-English languages have an alternate form of access to the contents of the written materials.
- c. The Contractor shall ensure the quality of the translated material. The Contractor is encouraged to use different qualified translators during sequential levels of the

translation process to ensure accuracy, completeness and reliability of translated materials. The Contractor agrees that the translation process shall include the use of qualified translators for translating, editing, proofreading and professional review.

- d. By December 31 of each year, the Contractor shall submit to the State one copy of only those materials that, pursuant to Item II.E, are routinely provided to new subscribers for each language in which the materials are translated.

3. Cultural and Linguistic Competency

- a. The Contractor shall develop internal systems that meet the cultural and linguistic needs of the Contractor's subscribers in the Program. The Contractor shall provide initial and continuing training on cultural competency to staff and providers. Ongoing evaluation and feedback on cultural competency training shall include, but not be limited to, feedback from subscriber surveys, staff, interpreters, providers, and encounter/claims data.
- b. The Contractor shall report, on or before March 10 of each year, the linguistically and culturally appropriate services provided in the prior benefit year and proposed to be provided during the subsequent benefit year to meet the needs of Limited English Proficient applicants and subscribers in the Program.
  - i. This report shall include information about the number and types of services provided by the Contractor including, but not limited to linguistically and culturally appropriate providers and clinics available, interpreters, marketing materials, information packets, translated written materials, and referrals to culturally and linguistically appropriate community services and programs, and training and education activities for providers.
  - ii. The report shall include a description of the Contractor's efforts to evaluate cultural and linguistic services and the outcomes of cultural and linguistic activities as part of the Contractor's ongoing quality improvement efforts. Reported information shall

include member complaints and grievances, results from membership satisfaction surveys, and utilization and other clinical data that may reveal health disparities as a result of cultural and linguistic barriers.

- iii. The report shall also address activities undertaken by the Contractor to develop internal systems, as required in Item III.C.3.a of this Exhibit. The Contractor shall also report on the status of the Contractor's cultural and linguistic activities identified in the Group Needs Assessment. The format for this report shall be determined by the State.

#### IV. COVERED SERVICES AND BENEFITS

##### A. Covered and Excluded Benefits

1. Except as required by any provision of applicable law, the benefits described in Article 3, Sections 2699.6721 and 2699.6723, of the Program regulations shall be covered benefits under the terms of this Agreement. Except as required by any provision of applicable law, those benefits excluded in Article 3 of the Program regulations shall not be covered benefits. The Contractor shall describe all covered and excluded benefits as well as any limitation in benefits, in an Evidence of Coverage or Certificate of Insurance booklet.
2. The parties understand that terms of coverage under this Agreement are set forth in the attached Evidence of Coverage or Certificate of Insurance booklet, hereby incorporated by reference, as fully set forth within. In the case of conflicts, terms of coverage set forth in the Evidence of Coverage or Certificate of Insurance booklet shall be binding notwithstanding any provisions in this Agreement which are less favorable to the subscriber.
3. The Contractor shall make benefit and coverage determinations. All such determinations shall be subject to the Contractor's grievance procedures.

##### B. California Children's Services (CCS)

1. Medically necessary vision services that are authorized by the CCS Program to treat a subscriber for CCS eligible conditions, once

CCS eligibility is determined as defined in Title 22, CCR, Section 41518, are not covered under this Agreement.

2. The Contractor shall identify subscribers with suspected CCS eligible vision conditions and shall refer them to the local CCS Program office or primary care provider (PCP) for determination of medical eligibility by the CCS Program. Upon referral, the Contractor shall provide the applicant on behalf of the subscriber with a CCS one-page (double-sided) informational flyer. The State agrees to provide the Contractor with a camera ready copy of the CCS informational flyer.
3. The Contractor shall implement written policies and procedures for identifying and referring subscriber with suspected CCS eligible vision conditions to the local CCS Program office and shall provide the policies and procedures to the State. The policies and procedures will address early identification and referral. The policies and procedures shall include, but not be limited to:
  - a. Procedures for ensuring that the Contractor's providers are informed of the procedures to make a referral to the local CCS program.
  - b. Policies and operational controls that ensure that the Contractor's providers perform appropriate baseline vision assessment and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a subscriber has a CCS eligible medical condition.
  - c. Procedures for ensuring that the Contractor's providers are able to obtain access to CCS paneled providers and CCS approved facilities within the Contractor's entire network. Policies and procedures will also include identification of CCS approved hospitals.
  - d. Policies and procedures to ensure that the Contractor's providers refer potentially eligible children to the CCS Program.
  - e. Policies and Procedures that ensure continuity of care between the Contractor's providers and CCS providers.

4. The Contractor shall report to the State the subscribers who were referred to the local CCS Program and the subscribers who received services from CCS in the previous benefit year. The report shall include information about the referrals that were accepted, denied and pending with the local CCS Program. The report is due by October 31 of each year. The format for the report shall be determined by the State.
5. The Contractor shall enter into a Memorandum of Understanding (MOU) with each local CCS Program in the Contractor's service area. The CCS Program shall provide a MOU template to the Contractor.
6. The Contractor shall consult and coordinate CCS referral activities with the local CCS Program in accordance with the required MOU between the Contractor and a local CCS Program.
7. Until eligibility for the CCS Program is established by the local CCS Program, and to the extent that otherwise-covered services are not provided by the CCS Program once eligibility is established, the Contractor shall be responsible for the delivery of all covered medically necessary vision care and case management services for a subscriber referred to CCS. Payments paid to the Contractor by the CCS Program shall be made pursuant to the policies contained in the Department of Health Care Services N.L. 02-0203, dated July 11, 2003, and any modification to such policies.
8. Once eligibility for CCS is established by the CCS Program for a subscriber:
  - a. The Contractor shall continue to provide primary vision care unrelated to the CCS eligible condition and shall ensure the coordination of services between its primary care providers, the CCS specialty providers and the local CCS Program.
  - b. The Contractor shall ensure the coordination of services between its primary care providers, the CCS specialty providers and the local CCS Program.
  - c. The CCS Program shall authorize and pay for the delivery of medically necessary vision care services to treat a subscriber's CCS eligible condition. The CCS authorization, on determination of medical eligibility, shall be to CCS paneled providers and approved facilities, some of which

may also be members of the Contractor's network. Authorization normally cannot predate the initial referral to the local CCS Program in accordance with Title 22, CCR, Section 42180. Claims for authorized services shall be submitted to the appropriate CCS office for approval of payment.

- d. For the purpose of Section IV.B.8.c above, initial referral means by a Contractor's network provider, or by any other entity permissible under CCS regulations.

C. Other Public Linkages

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

D. Pre-existing Condition Coverage Exclusion Prohibition

No pre-existing condition exclusion period or post-enrollment waiting period shall be required of subscribers.

E. Exercise of Cost Control

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

F. Copayments

1. The Contractor shall impose copayments for subscribers as described in Article 3 of the Program regulations.
2. The Contractor shall work with its network providers to provide for extended payment plans for subscribers utilizing a significant number of vision services for which copayments are required. When feasible, the Contractor shall instruct its network providers to

offer extended payment plans whenever a family's copayments exceed twenty-five dollars (\$25) in one month.

3. The Contractor shall report the copayments for covered services paid by a list of subscribers provided by the State in the previous benefit year by February 1 of each year. The format for the report shall be determined by the State.
4. The Contractor shall implement an administrative process that assures that all copayments are waived for American Indian and Alaska Native subscribers in the Program, if the State identifies such subscribers as qualifying for the waiver.

G. Coordination of Benefits

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

H. Acts of Third Parties

If a subscriber is injured through the wrongful act or omission of another person, the Contractor shall provide the benefits of this Agreement and the subscriber or applicant on behalf of a subscriber shall be deemed:

1. To have agreed to reimburse the Contractor to the extent of the reasonable value of services allowed by Civil Code Section 3040, immediately upon collection of damages by him or her, whether by action at law, settlement or otherwise, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement; and
2. To have provided the Contractor with a lien to the extent of the reasonable value of services provided by the Contractor and allowable under Civil Code section 3040, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement. The lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

I. Workers' Compensation Insurance

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

J. Use of Subcontractors

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

K. Interpretation of Coverage

The Contractor, in its Evidence of Coverage or Certificate of Insurance booklet (Attachment V), shall provide clear and complete notice of terms of coverage to subscribers. In the event of ambiguity regarding terms of coverage, the Contractor shall interpret those terms in the interest of the subscriber. In the event of ambiguity regarding an exclusion from coverage, the Contractor shall interpret the language of the exclusion in the interest of the subscriber. Nothing in this provision shall supersede the common law rules for interpretation of insurance contracts.

V. DATA REPORTING

A. Electronic Data Transfer

The Contractor agrees to establish and maintain, in a manner and format to be specified by the State and agreed to by the Contractor, the capability to transmit the data specified in Item II.I to the State using electronic

media. The transmission shall be in a manner and form that comply with HIPAA standards for electronic transactions and code sets.

VI. QUALITY MANAGEMENT PROCESSES

A. Group Needs Assessment

The Contractor shall complete a Group Needs Assessment and submit a report to the State by September 30, ~~2012~~<sup>2014</sup>. The purpose of the Group Needs Assessment is to assess the services provided to the Contractor's diverse enrollee population based on race, ethnicity, spoken language, and health status. The Group Needs Assessment report shall include the Contractor's plan to address any disparities identified as a result of the assessment findings, with special attention to addressing cultural and linguistic barriers and reducing health disparities among different racial, ethnic, and Limited-English Proficient groups.