Payment to Agency F	Report A Pub	lic Document	t	DAVASTAT TO A COURT			
. Agency Name			Date Stamp	California O			
Covered California			Date Starrip	Form 80'			
Division, Department, or Re	gion (if applicable)			For Official Use Only			
Executive							
Street Address			-				
1601 Exposition Blvd, Sac	ramento, CA 95815						
Area Code/Phone Number	Email						
(916) 228-8608	6) 228-8608 allison.pease@covered.ca.gov			Amendment (explain in comment section)			
Agency Contact (name and title)		Date of Original Filing	Date of Original Filing:				
Allison Pease, Attorney				(month, day, year)			
Donor Name and Addre	ess						
☐ Individual		Ø Other	The Poynter Institu	te			
Last Name 801 Third Street South	First Name			Name			
Address	St. Pete	rsburg	FL	33701			
		ing to incompliant	State	Zip Code			
If "Other" is marked, describe the entity	at provides education and train 's business activity (if business) or its natur	ing to journalism s	students, academics	, and professionals.			
and the second second the charge	o business delivity (ii business) of its natur	e and interests.					
If applicable, i	dentify the name of each source a	and the amount(s) re	eceived by the donor for	or this payment:			
*	\$			c			
Name	. Amount		Name	Amount			
Payment Information (C	Complete Sections 3.1 (a o	or b), 3.2, 3.3)					
3.1 (a) Travel Payment	Washington, D.C.		10/2/	17			
	Location of Trave	el	-	Dates (month, day, year)			
United Airlines	Rail 🛛 Air	☐ Bus ☐ Auto	o □ Other				
Transportation Provider	Check Applie	TO THE RESERVE OF THE PARTY OF	D Clifer	Name of Lodging Facility			
\$	œ.	•		1,000.00			
Lodging Expenses	Meal Expenses Transporta	ation Expenses	Other Expenses	Total Expenses			
3.1 (b) Payment(s) not re	ated to travel:		\$				
		Dates (month, d		Total Expenses			
3.2. Payment Description	. Provide a specific descript	tion of the payme	ent and its agency	purpose and use.			
Reimburse travel to pro	esent at training seminar	for iournalists o	overing health of	ere reform Tonio			
CC's successes as exc	change amidst fed/state p	olicy changes	which is directly	related to its			
functions to operate ex	change & improve health	by assuring ac	ccess to affordab	le high quality care			
	who used the payment in Sec			io, riigii quality care.			
Lee	Peter	Executive D		vocutivo			
Last Name	First Name	_	tion/Title	xecutive			
		, 0310		Department/Division			
Last Name	First Name	Posit	tion/Title	Department/Division			
Verification							
authorized the acceptance	of the reported payment(s) as	in compliance wit	h FPPC regulations				
	Karen Johnson		Deputy Executive D	/ /			
Signature	Print Name		Title	(month, day, year)			
0			- 1755	(month, day, year)			
Comment:			-				
(Use this space or an attachment for	or any additional information)		700 - 200				

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Payment to Agency R	eport	A Public D	ocument		DA	VMENT TO A CENOV DED
1. Agency Name	•			Date Stam		California
Covered California				Date Stain	P	Form 80
Division, Department, or Reg	gion (if applicable)			100	Γ	For Official Use Only
Executive						
Street Address					100	
1601 Exposition Blvd, Sacr	amento, CA 95815					
Area Code/Phone Number	Email					
(916) 228-8608	allison.pease@co	overed.ca.gov		Amenament	(explain in c	omment section)
Agency Contact (name and title)				Date of Original	Filing:	(month day year)
Allison Pease, Attorney						(month, day, year)
2. Donor Name and Addre	ess					
☐ Individual			Other	Patient-Center	ed Prima	ry Care Collaborativ
Last Name	First N		E Calci	AMERICAN STATE STA	Nan	
601 13th Street, NW, Suite	430 North	Washington			D.C.	33701
Nonprofit dedicated to adva	ancing effective and		cyctom prop		tate	Zip Code
If "Other" is marked, describe the entity					ina snarir	ng best practices.
If applicable, i	dentify the name of ea	ach source and the	e amount(s) re	eceived by the do	nor for this	payment:
	\$	100				\$
Name		Amount		Name		Amount
3. Payment Information (C	complete Section	s 3.1 (a or b),	3.2, 3.3)			
3.1 (a) Travel Payment	Washington, D			1	0/11/17 -	10/12/17
United Ataliana	Lo	ocation of Travel			Date	s (month, day, year)
United Airlines Transportation Provider	Rail	✓ Air B Check Applicable B		Other V		ash. D.C. City Center of Lodging Facility
§ 359.00		_e 1,962.38	•		•	2,321.28
Lodging Expenses	Meal Expenses	Transportation Ex	penses Φ_{-}	Other Expenses	Ф	Total Expenses
3.1 (b) Payment(s) not rel	ated to travel:			\$		
			Dates (month, da	1000		Total Expenses
3.2. Payment Description.	. Provide a specifi	c description c	of the payme	ent and its ager	ncy purp	ose and use.
Reimburse travel to pre	esent as keynote	speaker at a	innual educ	cational conf.	Topic:	What can/ shoul
purchasers do to prom-	ote primary care	, which is dire	ectly related	d to Covered	CA's fu	nctions to
operate health ins. exc	hange & improve	e health by as	ssuring acc	ess to afford	able, hi	gh quality care.
3.3. Identify the officials v					1-	
Lee	Peter		Executive Di		Execu	tive
Last Name	First Name	,		ion/Title		Department/Division
						24
Last Name						
Last waitle	First Name	•	Posit	tion/Title		Department/Division
I. Verification						
I authorized the acceptance	of the reported pay	ment(s) as in co	mpliance wit	h FPPC regulat	ions.	1 1
2	Karen Johns	son	Chief	Deputy Executiv	ve Direct	or 1/22/2018
Signature	* F	Print Name		Title		(month, day, year)
Comment:						
(Use this space or an attachment for	or any additional informa	tion)				

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