



**Quality Improvement Health Equity  
Committee (QIHEC)**

**April 16, 2025-Qtr. 1 Agenda**

**12:00 P.M.**

**512 W. Aten Rd., Imperial, CA 92251**

**Join the meeting now**

Meeting ID: 248 074 919 271

Passcode: M9nY3Ly7

All supporting documentation is available for public review at <https://chpiv.org>

Committee Members	Representing	Present
<b>Dr. Unnati Sampat</b>	Imperial Valley Family Medical Care Group	
<b>Dr. Masoud Afshar</b>	Masoud Afshar MD	
<b>Dr. Ameen Alshareef</b>	Valley Pediatric Health	
<b>Leticia Plancarte-Garcia</b>	Imperial County Behavioral Health	
<b>Janette Angulo</b>	Imperial County Public Health Department	
<b>Mersedes Martinez</b>	El Centro Regional Medical Center	
<b>Shiloh Williams</b>	San Diego State University	
<b>Dr. Gordon Arakawa</b>	CHAIR-Community Health Plan of Imperial Valley	

**1. CALL TO ORDER**

- a. Roll Call
- b. Approval of Agenda
  - 1. Items to be pulled or added from the Information/Action/Closed Session Calendar
  - 2. Approval of the order of the agenda

*Dr. Gordon Arakawa, Chair  
Donna Ponce, Commission Clerk*

**2. PUBLIC COMMENT**

Public Comment is limited to items NOT listed on the agenda. This is an opportunity for members of the public to address the Committee on any matter within the committee’s jurisdiction. Any action taken as a result of public comment shall be limited to the direction of staff. When addressing the Committee, state your name for the record prior to providing your comments. Please address the Committee as a whole, through the Chair. Individuals will be given three (3) minutes to address the committee.



**3. CONSENT AGENDA**

All items appearing on the consent calendar are recommended for approval and will be acted upon by one motion, without discussion. Should any Committee member or other person express their preference to consider an item separately, that item will be addressed at a time as determined by the Chair.

- a. Approval of Minutes from January 15, 2025..... Pg. 4-13
- b. Q1 HNCS Presentation
- c. Q1 HNCS Packet
- d. Clinical Policies-Program Descriptions and Workplans
  - 1. 2025 Health Equity Program Description
  - 2. 2025 Health Equity Workplan
  - 3. 2024 Health Equity Workplan Complete
  - 4. 2025 Quality Improvement Health Equity Program Description
  - 5. 2025 Quality Improvement Health Equity Workplan
  - 6. 2025 UM Program Description
  - 7. 2025 UM/Care Management Workplan
  - 8. 2024 UM/Care Management Workplan Evaluation
  - 9. 2025 Care Management Program Description
- e. CHPIV Policies
  - 1. UM-004 Appropriate Professionals and Use of Board-Certified Physician Consultants in UM Decision Making..... Pg. 14-18
  - 2. UM-005 Medical Necessity Criteria, Technology Assessment, and Hierarchy of Resources .....Pg. 19-22
  - 3. GA-002 Appeals Process..... Pg. 23-31
- f. Provider Contracts
  - 1. PCP..... Pg. 32-197
  - 2. Specialist..... Pg. 198-240
  - 3. FFS Facility..... Pg. 241-298
  - 4. Ancillary ..... Pg. 299-347



- g. Medical Director Job Descriptions
  - 1. CHPIV CMO.....Pg. 348-349
  - 2. Health Net Physician Staff.....Pg. 350-352

**4. ACTION**

**5. INFORMATION**

- a. QI CHPIV QIHEC Presentation.....Pg. 353-431

**Adjournment**

Next Meeting: **Wednesday, July 16, 2025**



**Quality Improvement & Health Equity (QIHEC) Committee**

<b>Date/Time</b>	January 15, 2025, 12:00pm – 1:30pm
<b>Location / Dial-In #</b>	<a href="#">Microsoft Teams meeting</a> Meeting ID: 260 661 110 12 Passcode: xr3xmf Dial in by phone: +1 469-998-7368,453800447#

Time	Topic	Presenter	Approval Required
12:00 – 12:05	<b>Call to Order</b>	Gordon Arakawa, MD	
	<i>Roll Call</i>	Gordon Arakawa, MD	
12:06 – 12:10	<b>Consent Agenda</b>	Gordon Arakawa, MD	
	<i>a. Approval of previous meeting minutes from Wednesday, October 16, 2024.</i>	Gordon Arakawa, MD	<input checked="" type="checkbox"/>
	<i>b. Approval of meeting agenda for 2024 Quarter 4 QIHEC Presentation.</i>	Gordon Arakawa, MD	<input checked="" type="checkbox"/>
	<i>c. Approval of 2025 QIHEC schedule.</i>	Gordon Arakawa, MD	<input checked="" type="checkbox"/>
12:10 - 12:44	<b>New Business</b>	Gordon Arakawa, MD	
	A. Call Center Metrics	Gordon Arakawa, MD	<input checked="" type="checkbox"/>
	B. Utilization Management Key Metrics <ul style="list-style-type: none"> <li>• UM Prior Authorization TAT</li> <li>• UM Medi-Cal Activities</li> </ul>		
	C. Appeals & Grievances <ul style="list-style-type: none"> <li>• Annual Totals</li> <li>• Top 5 Appeals</li> <li>• Top 5 QOS Grievances</li> <li>• Top 5 QOC Grievances</li> <li>• Top 5 Access to Care Grievances</li> <li>• PQIs</li> </ul>		
	D. Healthcare Effectiveness Data & Information Set (HEDIS)		
	E. Care Management KPI Report		
	F. Enhanced Care Management/Community Supports <ul style="list-style-type: none"> <li>• ECM Enrollment</li> <li>• CS Authorizations/Claims Trends</li> <li>• Barriers to ECM &amp; CS</li> </ul>		
	G. Long Term Support Services (LTSS) <ul style="list-style-type: none"> <li>• Quarterly Totals Report</li> </ul>		
	H. Pharmacy <ul style="list-style-type: none"> <li>• PA Metrics</li> <li>• Top 5 PA Requests</li> <li>• Top 5 Denials</li> <li>• QA/Reliability Results for Q3</li> </ul>		



**Quality Improvement & Health Equity (QIHEC) Committee**

	<ul style="list-style-type: none"> <li>I. Behavioral Health                             <ul style="list-style-type: none"> <li>• CHPIV Members Served (Quarterly)</li> <li>• ABA Services</li> </ul> </li> <li>J. California Children’s Services</li> <li>K. Quality Improvement Projects</li> <li>L. Population Health Management (PHM) Quarterly Report</li> <li>M. Health Equity                             <ul style="list-style-type: none"> <li>• Family Unit HEDIS/Multigap Outreach Calls Project Updates</li> </ul> </li> <li>N. Peer Review Credentialing</li> <li>O. Facility Site Reviews</li> <li>P. Network access &amp; Availability</li> <li>Q. Vendor Management                             <ul style="list-style-type: none"> <li>• Oversight</li> <li>• 2024 Audit &amp; Monitoring Results</li> </ul> </li> </ul>		
12:44 - 12:46	<p><b>Committee Recommendation to the Board of Members and Adjournment</b></p> <p><b>Next Meeting:</b>                  Date: Wednesday, April 16, 2025                  Time: 12:00pm – 1:30pm                  Location: Community Health Plan of Imperial Valley Conference Room/Microsoft Teams</p>	Gordon Arakawa, MD	



## Quality Improvement & Health Equity (QIHEC) Committee

*QIHEC Meeting Minutes: 01/15/2025*

Community Health Plan of Imperial Valley QIHEC Committee convened on 15<sup>th</sup> day of January 2025 at 12:00pm.

Voting Members Attendance Record (Quorum =2) Name / Title	Present	Absent	Designee		Voting Members Attendance Record Name / Title	Present	Absent	Designee
<b>Gordon Arakawa, MD</b> Community Health Plan of Imperial Valley <i>(Committee Chair)</i>	<input checked="" type="checkbox"/>							
<b>Unnati Sampat, MD</b> Imperial Valley Family Medical Group	<input checked="" type="checkbox"/>							
<b>Masoud Afshar, MD</b> Masoud Afshar MD	<input checked="" type="checkbox"/>							
<b>Ameen Alshareef, MD</b> Valley Pediatric Health	<input checked="" type="checkbox"/>							
<b>Leticia Plancarte-Garcia</b> Imperial County Behavioral Health	<input checked="" type="checkbox"/>							
<b>Janette Angulo</b> Imperial County Public Health Dept.	<input checked="" type="checkbox"/>							
<b>Mercedes Martinez</b> El Centro Regional Medical Center		<input checked="" type="checkbox"/>						
<b>Shiloh Williams</b> San Diego State University	<input checked="" type="checkbox"/>							



## Quality Improvement & Health Equity (QIHEC) Committee

Ad Hoc Members and Guests Present	Present	Absent	Designee		Ad Hoc Members and Guests Present	Present	Absent	Designee
<b>Jeanette Crenshaw</b> Executive Director of Healthcare Services, Community Health Plan of Imperial Valley	<input checked="" type="checkbox"/>							
<b>Fernanda Ortega</b> Project Supervisor, Community Health Plan of Imperial Valley	<input checked="" type="checkbox"/>							
<b>Priscilla Carpio</b> Supervisor of Clinical Auditing, Community Health Plan of Imperial Valley	<input checked="" type="checkbox"/>							
<b>Amanda Delgado</b> Project Specialist, Community Health Plan of Imperial Valley	<input checked="" type="checkbox"/>							
<b>Donna Ponce</b> Executive Assistant and Commission Clerk, Community Health Plan of Imperial Valley	<input checked="" type="checkbox"/>							



## Quality Improvement & Health Equity (QIHEC) Committee

Agenda Item	Discussion	Recommendation /Decision/ Action /Date	Responsible Party
<b>I. Call to Order</b> <b>II. Announcements</b>	Dr. Gordon Arakawa called the meeting to order at 12:00 p.m.  Dr. Gordon Arakawa presented no new announcements.		
<b>III. Consent Agenda</b>	<ul style="list-style-type: none"> <li><i>a.</i> Dr. Gordon Arakawa presented the meeting minutes from the CHPIV QIHEC meeting held on Wednesday, October 16, 2024, for Committee review and approval.</li> <li><i>b.</i> Dr. Gordon Arakawa presented the meeting agenda for the CHPIV 2024 Quarter 4 QIHEC Presentation, for Committee review and approval.</li> <li><i>c.</i> Dr. Gordon Arakawa presented the 2025 QIHEC Schedule on Wednesday, January 15, 2025, for Committee review and approval.</li> </ul>	<ul style="list-style-type: none"> <li><i>a.</i> A motion to approve the meeting minutes was made by Dr. Unnati Sampat and seconded by Shiloh Williams.</li> <li><i>b.</i> A motion to approve the 2024 Quarter 4 QIHEC presentation was made by Dr. Unnati Sampat and seconded by Shiloh Williams.</li> <li><i>c.</i> A motion to approve the 2025 QIHEC schedule was made by Dr. Unnati Sampat and seconded by Janette Angulo.</li> </ul>	
<b>IV. New Business</b>			
	Dr. Gordon Arakawa presented New Business for Committee review, approval, and participation.	A motion to approve all New Business reports was made by Dr. Unnati	





## Quality Improvement & Health Equity (QIHEC) Committee

<p><b>D. Healthcare Effectiveness Data &amp; Information Set (HEDIS)</b></p>	<p>Grievances fall into two categories: quality of service (e.g., transportation issues) and quality of care (e.g., delays in referrals). Slight increase in quality-of-care grievances in Quarter 3, 2024.</p> <p>Overall improvement compared to the previous year. Concern raised about data accuracy and the need for more support and training from HealthNet on HEDIS reporting.</p> <p><b>Follow-up items (CHPIV):</b></p> <ol style="list-style-type: none"> <li>1. Request more frequent updates and training from HealthNet on HEDIS reporting, potentially including monthly or quarterly sessions.</li> <li>2. Follow up on the shortened HEDIS data submission deadline.</li> <li>3. CHPIV will inquire with Health Net regarding Health Net Provider access to Coordination of Benefits for members.</li> </ol>	
<p><b>E. Care Management KPI Report</b></p>	<p>Engagement rates are around 50% for physical health, with lower rates for behavioral health. Need to investigate benchmarks and strategies to improve engagement. Good engagement rates for transitional care and first year of life programs.</p>	
<p><b>F. Enhanced Care Management/Community Supports</b></p>	<p>Engagement rates are around 50% for physical health, with lower rates for behavioral health. Need to investigate benchmarks and strategies to improve engagement.</p> <p>Good engagement rates for transitional care and first year of life programs.</p>	



## Quality Improvement & Health Equity (QIHEC) Committee

	<p>Engagement rates are around 50% for physical health, with lower rates for behavioral health. Need to investigate benchmarks and strategies to improve engagement.</p> <p>Good engagement rates for transitional care and first year of life programs.</p> <p>Uptake remains good, the enrollment assignment ratio is still around 40%. The significant utilization of medically tailored meals, which has attracted attention from the state.</p>		
<b>G. Long Term Support Services (LTSS)</b>	Challenges with long-term support services due to capacity issues, we continue to utilize out-of-county resources.		
<b>H. Pharmacy</b>	Turn-around-times for pharmacies are consistent and excellent service from HealthNet pharmacies.		
<b>I. Behavioral Health</b>	Previously discussed a lag in the June data. Roughly 1,000 to 1,500 members served per month.		
<b>J. California Children’s Services</b>	Imperial County is non-CCS, Health Net processes requests and then requests are sent to the state for CCS processing. Approximately 80% of requests are approved.		
<b>K. Quality Improvement Projects</b>	80 projects were undertaken, with 7 focused on health equity. Examples of successful projects include improved rates for initial health appointments and lead screening in children.		
<b>L. Population Health Management</b>	New report provides valuable insights into population stratification and needs.		



## Quality Improvement & Health Equity (QIHEC) Committee

<b>(PHM) Quarterly Report</b>	2024 Segmentation Inputs by program name, eligible population, number of members eligible as of 01/2024, and percentage of members eligible as of 01/2024.		
<b>M. Health Equity</b>	<p>Family Unit HEDIS/Multigap Outreach Calls Project Updates: CVH and CHPIV outreach began in July 2024 through August 2024 with anchor measure WCV (7-13).</p> <p>Phone outreach is being conducted by members who previously had not report/engaged in years.</p> <p>Phone outreach program targeting members with gaps in well-child visits.</p>		
<b>N. Peer Review Credentialing</b>	<p>No cases for PRC in Quarter 4. One case from 2024 will be reviewed in January 2025.</p> <p>Credentialing and re-credentialing data now available from Health Net.</p>		
<b>O. Facility Site Reviews Network access &amp; Availability</b>	<p>For Quarter 3 of 2024, Health Net completed 11 Facility Site Reviews and Medical Records reviews.</p> <p>Dr. Sampat: Were they randomly chosen?</p> <p>Dr. Arakawa: CHPIV will inquire with Health Net in FSR sampling.</p>		
<b>P. Vendor Management</b>	<p>Health Net works directly with transportation and language line. Health Net has its own oversight through their Joint Oversight Committees.</p> <p>Dr. Sampat: This is a great wealth of data. This committee can hopefully do more of a deep dive to see how we can intervene and how to go about doing so.</p> <p>Dr. Arakawa: I agree. We can possibly get this presentation out a little bit earlier and receive feedback from the committee members.</p>		



## Quality Improvement & Health Equity (QIHEC) Committee

	<p>Dr. Alshareef: I already have a couple of recommendations... Regarding the number of calls, as a practicing provider we have to directly connect with the provider line. I would like to bring that number of calls down, a common reason for these calls is that the health network site does not include patient/member specifics. This includes coordination of benefits, insurance information, etc. Previous health plans I have worked with do have this information readily available for providers to view on the health network.</p>		
<p><b>V. Adjournment</b></p>	<p>Dr. Gordon Arakawa asked if there were any recommendations, comments, or questions. There were no recommendations, comments, or questions from the committee.</p> <p><b>Next Meeting:</b>                  Date: Wednesday, April 16, 2025                  Time: 12:00pm – 1:30pm                  Location: Community Health Plan of Imperial Valley Conference Room/Microsoft Teams  <i>Meeting Material Due: Friday April 11, 2025</i></p> <p><b>Meeting adjourned at 12:42 P.M.</b></p>		

	<b>Appropriate Professionals and Use of Board-Certified Physician Consultants in Utilization Management Decision Making</b>		<b>UM-004</b>
	<b>Department</b>	Health Services	
	<b>Functional Area</b>	Utilization Management	
	<b>Impacted Delegate</b>	<input checked="" type="checkbox"/> Subcontractor <input type="checkbox"/> NA	

DATES			
<b>Policy Effective Date</b>	11/12/2024	<b>Reviewed/Revised Date</b>	
<b>Next Annual Review Due</b>	11/13/2025	<b>Regulatory Approval</b>	

APPROVALS			
<b>Internal</b>		<b>Regulator</b>	
<b>Name</b>	Gordon Arakawa, MD	<input type="checkbox"/> DHCS	<input checked="" type="checkbox"/> NA
<b>Title</b>	Chief Medical Officer	<input type="checkbox"/> DMHC	

ATTACHMENTS
N/A

AUTHORITIES/REFERENCES
<ul style="list-style-type: none"> <li>Manual, Rev 105, Issued 04-20-2012, Section 40.1.1 California Knox Keene Act / H&amp;S Code Section 1367.01 (e) (h) and (j)</li> <li>Knox Keene Act/ H&amp;S Code Section 1367.63(b)</li> <li>CIC Section 10123.135(e)</li> <li>NCQA UM Standards UM 4</li> <li>Medicare Managed Care Manual, Chapter 4</li> <li>Title 22 CCR 51340 and 51340.1</li> <li>Title 42 USC Section 1396d (r)(5)</li> <li>NCQA UM Standard 4</li> <li>Medicare Managed Care Manual, Chapter 13,</li> <li>SB 1008 (Statutes of 2012, Chapter 33)</li> <li>DHCS Managed Care Contracts (Two Plan and Geographic Model, Exhibit A, Attachment 5.</li> <li>MMCD All Plan Letter 17- 006 "Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments"</li> <li>California Mental Health Parity Act</li> <li>Section 1374.721 of the Health and Safety Code</li> <li>Section 10144.5 to 10144.52 of the Health and Safety and Insurance Code</li> <li>Section 1374.72 and 1374.73 of the Health and Safety Code</li> </ul>

HISTORY
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	<b>Appropriate Professionals and Use of Board-Certified Physician Consultants in Utilization Management Decision Making</b>	<b>UM-004</b>
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Revision Date	Description of Revision
11/12/2024	Policy Creation

**I. OVERVIEW**

- A.** This policy and related procedures apply to all individuals employed, contracted, or otherwise representing CHPIV and its subsidiaries who are responsible for providing Utilization Management for Plan Members.

**II. POLICY**

- A.** CHPIV will ensure that appropriately licensed professionals to make MEDICAL NECESSITY Utilization Management decisions. To achieve this the following procedures are followed:
  1. Licensed Healthcare Professionals
    - a. CHPIV will ensure that only appropriately licensed professionals make MEDICAL NECESSITY determinations.
    - b. CHPIV will ensure that Qualified licensed healthcare professionals render or supervise all clinical review decisions. Under certain circumstances, non-clinical staff may authorize requests for coverage based on explicit instructions and coverage guidelines.
    - c. CHPIV will ensure that Nurses may review and approve cases that are a covered benefit and meet MEDICAL NECESSITY criteria according to clinical guidelines as outlined in the Medical Policy Hierarchy. Cases not meeting MEDICAL NECESSITY criteria are forwarded to an appropriate physician for final decision. Medical directors provide oversight to nurses for consultation as needed.
    - d. CHPIV will ensure that Nurses, at the discretion of the medical director, may approve requests for an Out of Network (OON) PROVIDER when MEDICAL NECESSITY criteria have been met.
    - e. CHPIV will ensure that Nurses may make administrative denials based on lack of eligibility, or benefit exhaustions.
    - f. CHPIV will ensure that non-clinical associates, under the supervision of appropriately licensed health professionals, collect data for preauthorization and CONCURRENT REVIEW and may approve requests for select services.
    - g. CHPIV will ensure that written job descriptions on the Medical Management Intranet site, with qualifications for all practitioners who review potential denials of covered services based on MEDICAL NECESSITY.
    - h. CHPIV will ensure that Qualifications include education, training, and/or professional experience in a medical or clinical practice, as well as a current license to practice without restriction.
    - i. CHPIV will ensure that a contractual relationship with at least one external review organization. This organization is able to provide timely specialty opinions for all



## Appropriate Professionals and Use of Board-Certified Physician Consultants in Utilization Management Decision Making

UM-004

recognized specialty types in the United States, usually within one business day. The panel of board-certified specialists can be consulted, when appropriate, to aid in the determination of MEDICAL NECESSITY for cases in which clinical judgement is needed for Utilization/Care Management decisions which are sufficiently specialized.

- j. CHPIV will ensure that the Plan has entered into an agreement with a vendor to provide a panel of specialists. Credentialing of specialists included in a vendor panel has been delegated to the vendor in accordance with the Plan's Credentialing DELEGATION policies. The Plan contracted external review organizations are URAC accredited.

### 2. Utilization Management Decision-Making

- a. CHPIV will ensure that Qualified licensed healthcare professionals render or supervise all clinical review decisions. Under certain circumstances, non-clinical staff may authorize requests for coverage based on explicit instructions and coverage guidelines.
- b. These licensed health care professionals:
  - Provide day-to-day supervision of assigned UM staff.
  - Participate in staff training.
  - Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
  - Monitor documentation for adequacy.
  - Are available to UM staff on site or by telephone.
- c. CHPIV will ensure that Pharmacists may review cases for final decision.
- d. CHPIV will ensure that Review of Behavioral health cases for denial of covered services are reviewed by physicians, psychiatrists, doctor-level clinical psychologists or certified addiction medicine specialists.
- e. CHPIV will ensure that all utilization review decisions to deny coverage based on MEDICAL NECESSITY are made by APPROPRIATE PRACTITIONERS with the appropriate clinical expertise. For specialty areas, every effort is made to assure that the physician reviewing the case has the appropriate clinical expertise. Internal Plan Medical Directors, when available for the required specialty, will be the first contact for specialty consultations. When necessary, a same/similar specialist reviewer will evaluate the case and request service/item and provide recommendations regarding the MEDICAL NECESSITY of the requested service in accordance with The Plan's available clinical guidelines and medical policies used in making determinations as to whether a covered service is medically necessary.

### 3. Same/Similar Specialist Review

- a. CHPIV will ensure that Guidelines for requesting same/similar specialist review or consultation include but are not limited to:
  - i. The case and or service/item under review request includes a complex medical procedure, a standard of care review, regulatory requirement, and/or specialist knowledge, or



## Appropriate Professionals and Use of Board-Certified Physician Consultants in Utilization Management Decision Making

UM-004

- ii. No Plan National Medical Advisory Committee Policy is available to clarify the MEDICAL NECESSITY decision-making process, or
  - iii. No INTERQUAL criteria are available, or
  - iv. The service/item under review request is outside the credentialed expertise of the reviewing The Plan's Medical Director.
4. Request for same/similar specialist review or consultation:
- a. CHPIV will ensure that upon request for MEDICAL NECESSITY review, the Plan's Medical Director will either:
    - i. Make the MEDICAL NECESSITY determination, or
    - ii. Refer the case to a board-certified same/similar specialist for clinical review.
  - b. CHPIV will ensure that if the case requires same/similar specialist review or consultation:
    - i. The Plan's Medical Director will contact or arrange for contact of the appropriate same/similar specialist, requesting consultation on the case and service/item under review generally within one (1) working day of receiving the case for review. The Plan's Medical Director will provide appropriate and available medical/clinical information, including the medical records, to the designated same/similar specialist and will request that a written opinion be received within a medically appropriate time frame, generally within one (1) working day.
    - ii. Upon receipt of the Specialist's consultation, the Plan's Medical Director will review the same/similar specialist's written recommendation and will make a final determination. The written review is imaged into the online file.
  - c. CHPIV will ensure that the Plan's Medical Director, or his/her designee, notifies the requesting PROVIDER of the determination, and the determination is documented in the electronic medical management system.

### **III. PROCEDURE**

- A.** CHPIV delegates the Utilization Management process to its Subcontractor, Health Net.
- B.** Delegation Oversight
  - 1. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Health Net. CHPIV ensures Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
    - i. Ongoing monitoring
    - ii. Performance reviews
    - iii. Data analysis
    - iv. Utilization of benchmarks, if available
    - v. Annual desktop and on-site audits

### **IV. DEFINITIONS**



**Appropriate Professionals and Use of Board-Certified  
Physician Consultants in Utilization Management Decision  
Making**

**UM-004**

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

<b>TERM</b>	<b>DEFINITION</b>
<b>Appropriate Practitioners</b>	May include but are not limited to Physicians, behavioral health practitioners, including psychiatrists, doctoral-level clinical psychologists or certified addition medicine specialists, chiropractors, dentists, and pharmacists.
<b>Concurrent Review</b>	Concurrent review is a member centric process that includes 3 essential components: -Medical Necessity Review -Discharge and Transitional Care Planning -Coordination of Care. Medical Management's focus is during the acute hospital event to support a smooth transition across the continuum.
<b>Delegation</b>	A formal process by which an entity is given the authority to perform certain functions on another's behalf.
<b>InterQual</b>	A set of measurable clinical indicators, diagnostic and therapeutic services reflecting the need for hospitalization. Criteria are based on the patient's level of illness and services required rather than on diagnosis.
<b>Medical Necessity</b>	Except where state or federal law or regulation requires a different definition, the Plan defines "Medical Necessary" or comparable term in each agreement with Physicians, Physicians Groups, and Physician Organizations and will not include in any such agreement a definition of Medical Necessity that is different from this definition.
<b>Medically Necessary/Medical Necessity (Medical)</b>	For purposes of this Contract, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5).
<b>National Medical Advisory Council (MAC)</b>	The Medical Advisory Council (MAC) oversees the formal process for medical policy development, including medical necessity criteria, clinical practice guidelines and newly emerging technology.
<b>Provider</b>	The term provider includes providers contracted with the plan sponsor, non-contracted providers, and sub-contractors, including, but not limited to, pharmacists, pharmacies, physicians, hospitals, and long-term care facilities.

	<b>Medical Necessity Criteria, Technology Assessment and Hierarchy of Resources</b>		<b>UM-005</b>
	<b>Department</b>	Health Services	
	<b>Functional Area</b>	Utilization Management	
	<b>Impacted Delegate</b>	<input checked="" type="checkbox"/> Subcontractor <input type="checkbox"/> NA	

DATES			
<b>Policy Effective Date</b>	11/12/2024	<b>Reviewed/Revised Date</b>	
<b>Next Annual Review Due</b>	11/13/2025	<b>Regulator Approval</b>	

APPROVALS			
Internal		Regulator	
<b>Name</b>	Gordon Arakawa, MD	<input type="checkbox"/> DHCS	<input checked="" type="checkbox"/> NA
<b>Title</b>	Chief Medical Officer	<input type="checkbox"/> DMHC	

ATTACHMENTS	
N/A	

AUTHORITIES/REFERENCES	
<ul style="list-style-type: none"> <li>American Medical Association (AMA). Statement of the AMA to the Institute of Medicine’s Committee on Determination of Essential Health Benefits. January 14, 2011.</li> <li><a href="http://www.nationalacademies.org/hmd/~media/8D03963CAEB24450947C1AEC0CAECD85.ashx">http://www.nationalacademies.org/hmd/~media/8D03963CAEB24450947C1AEC0CAECD85.ashx</a></li> <li>Lembitz A, Clarke TJ. Clarifying “never events” and introducing “always events.” Patient Saf Surg. 2009; 3:26.</li> <li>Change Healthcare InterQual® criteria.</li> <li>MCG (formerly Milliman Care Guidelines®) guidelines.</li> <li>National Committee for Quality Assurance. NCOA Standards and Guidelines for the Accreditation of Health Plans 2014.</li> <li>National Quality Forum. Serious reportable events in healthcare 2006 update: A consensus report.</li> <li>Steinberg, EP, Tunis, S, Shapiro, D. Insurance coverage for experimental technologies. Health Affairs, 1995 Vol. 14:4.</li> <li>California Senate Bill (SB) 855 Health Coverage Mental Health or Substance Use Disorders</li> </ul>	

HISTORY	
Revision Date	Description of Revision
11/12/2024	Policy Creation



**I. OVERVIEW**

A. MEDICAL NECESSITY criteria and related definitions.

**II. POLICY**

- A. CHPIV will ensure that the Plan will use the following guidelines and uses criteria for determining medical appropriateness based on sound clinical evidence such as age, comorbidities, complications, progress of treatment, psychosocial situation, home environment, when applicable, are clearly documented, and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.
1. Federal law (e.g., National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Medicare Coverage Articles for Federal programs such as Medicare).
  2. State law/guidelines (e.g., when State requirements trump or exceed federal requirements).
    - a. Note: Per Regulation SB 855, for Mental Health and Substance Abuse (MH/SA) the most recent versions of treatment criteria developed by the nonprofit professional agencies such as Level of Care Utilization System (LOCUS)/Child & Adolescent Level of Care Utilization System (CALOCUS) criteria, American Society of Addiction Medicine (ASAM), and Early Childhood Service Intensity Instrument (ECSII) shall be applied when contractually required. When no nonprofit professional association provides criteria for a clinical specialty, an external vendor such as InterQual or internally developed criteria may be used as long as they meet the “generally accepted standards of mental health and substance use disorder care.”
  3. Plan-specific clinical policy including plan-specific clinical policies in InterQual® as custom content and vendor specific criteria (such as eviCore, NIA).
  4. The Plan’s clinical policy (including The Plan’s or Plan’s delegate’s clinical policies in InterQual as custom content).
  5. If no Plan-specific clinical policy exists, then nationally recognized decision support tools such as Change Healthcare InterQual Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are used.
  6. In the case of no guidance from A-E, additional information that the applicable health plan Medical Director will consider, when available, includes:
    - a. Reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations.
    - b. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment.
    - c. Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
    - d. Medical association publications.
    - e. Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality



(AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health, and Care Excellence (NICE), etc.

- f. Published expert opinions.
  - g. Opinion of health professionals in the area of specialty involved.
  - h. Opinion of attending provider in case at hand.
- B. Availability of Criteria:
1. CHPIV will ensure that Clinical policies are posted internally for the health plan staff and are available to providers and members on the CHPIV website.
  2. CHPIV will ensure Communication of these policies is arranged by the Provider Communications Department through quarterly fast fax distribution.
- C. Annual Review of Criteria:
1. CHPIV will ensure Corporate clinical policies, InterQual criteria updates and health plans specific policies are reviewed on an annual basis or more frequently as clinical literature dictates.
- D. CHPIV will ensure Clinical policies that have been approved by the Compliance and Policy Committee and provided to the Plan for review and adoption.
- E. CHPIV will ensure Clinical policies are reviewed at the Plan's Medical Advisory Council (MAC) (see the Plan's Medical Advisory Council Charter).
- F. The Plan may choose to adopt, not adopt, or develop its own clinical policies based on business need. Clinical policies that developed by the Plan are reflective of current evidence based scientific research and critical thinking as The Plan's clinical policies are reviewed on an annual basis by the MAC.

### **III. PROCEDURE**

- A. CHPIV delegates the Utilization Management process to its Subcontractor, Health Net.
- B. Delegation Oversight
1. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Health Net. CHPIV ensures Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
    - a. Ongoing monitoring
    - b. Performance reviews
    - c. Data analysis
    - d. Utilization of benchmarks, if available
    - e. Annual desktop and on-site audits

### **IV. DEFINITIONS**

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.



**Medical Necessity Criteria, Technology Assessment and Hierarchy of Resources**

**UM-005**

<b>TERM</b>	<b>DEFINITION</b>
<b>Medical Necessity</b>	<p>Means all Covered Services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5).When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W &amp; I Code Section 14132 (v).</p> <p>For individuals under 21 years of age, EPSDT service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services.</p> <p>A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Additional services must be provided if determined to be medically necessary for an individual child.</p>

	<b>Appeals Process</b>		<b>GA-002</b>
	<b>Department</b>	Health Services	
	<b>Functional Area</b>	Grievances & Appeals	
	<b>Impacted Delegate</b>	<input checked="" type="checkbox"/> Subcontractor <input type="checkbox"/> NA	

DATES			
<b>Policy Effective Date</b>	6/12/2023	<b>Reviewed/Revised Date</b>	10/01/2024
<b>Next Annual Review Due</b>	10/02/2025	<b>Regulatory Approval</b>	12/15/2023

APPROVALS			
Internal		Regulator	
<b>Name</b>	Gordon Arakawa, MD	<input type="checkbox"/> DHCS	<input type="checkbox"/> NA
<b>Title</b>	Chief Medical Officer	<input checked="" type="checkbox"/> DMHC	

ATTACHMENTS
NA

AUTHORITIES/REFERENCES
<ul style="list-style-type: none"> <li>• <b>Internal</b> <ul style="list-style-type: none"> <li>○ CHPIV, Delegation Oversight Policy and Procedure, CMP-002</li> </ul> </li> <li>• <b>Federal</b> <ul style="list-style-type: none"> <li>○ 42 CFR Sections 438.3, 438.400, 438.402, 438.406, 438.408, 438.410, 438.416, 438.420, 438.424, 18446</li> </ul> </li> <li>• <b>State</b> <ul style="list-style-type: none"> <li>○ California Health and Safety Code Sections ("H&amp;S Code") 1367.01, 1367.042, 1368, 1368.015, 1368.016, 1368.02, 1368.2, 1370.2, 1374.31, 1374.34</li> <li>○ California Welfare and Institutions Code Sections ("W&amp;I Code") 10950</li> <li>○ Title 22 California Code of Regulations Rules ("CCR") 51014.1, 51014.2, 53858</li> <li>○ Title 28 CCR Rules 1300.68, 1300.68.01, 1300.74.30</li> <li>○ 2024 DHCS Contract Exhibit A, Attachment III, 4.6 Member Grievance and Appeal System</li> <li>○ DHCS All Plan Letters ("APL") 22-002, 21-011, 21-004, 20-020</li> </ul> </li> <li>• <b>Accreditation</b> <ul style="list-style-type: none"> <li>○ NCOA: Utilization Management (UM) 8, Element A, UM 9, Elements A-D, Member Experience (ME) 7, Element B, ME 7, Elements C-F</li> </ul> </li> </ul>

HISTORY	
Revision Date	Description of Revision
6/12/2023	Policy creation
7/10/2023	Revised requirement around IMRs

	<b>Appeals Process</b>	<b>GA-002</b>
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10/01/2024	Annual Review- added requirement HSC 1368.01(b) to immediately notify members of their right to notify DMHC of the appeal

**I. OVERVIEW**

- A. This policy addresses Community Health Plan of Imperial Valley’s (“CHPIV” or the “Plan”) APPEALS requirements, policies, and procedures. The purpose of this policy is to establish an APPEAL Process pursuant to applicable statutory, regulatory, and contractual requirements.

**II. POLICY**

A. Standard APPEALS

1. Pursuant to 42 CFR sections 438.228 and 438.400 - 424, CHPIV has an APPEAL process as required below to attempt to resolve MEMBER APPEALS before the MEMBER requests a STATE FAIR HEARING or an IMR. CHPIV may have only one level of APPEAL for MEMBERS. Upon a MEMBER’s request, CHPIV must assist any MEMBER in preparing their APPEAL which includes assisting the MEMBER with navigating CHPIV’s website, providing all documents that were relied on for its decision and providing the APPEAL form to the MEMBER.
2. Following the receipt of a NOA, a MEMBER has 60 calendar days from the date on the NOA to file a request for an APPEAL either orally or in writing. The MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER and with the MEMBER’s written consent, may request an APPEAL. Unless the MEMBER is requesting an expedited APPEAL, the date of the MEMBER’s oral or written request for an APPEAL establishes the filing date for the APPEAL. The contractor must resolve the APPEAL within 30 calendar days of the MEMBER’s oral or written request for an APPEAL.
3. If CHPIV fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements in 42 CFR sections 438.10, 438.404, 438.408, W&I Code section 14029.91, 22 CCR section 53876 and Exhibit A, Attachment III, Section 5.1.3 (MEMBER Information), the MEMBER is deemed to have exhausted the internal APPEAL process and may request a STATE FAIR HEARING pursuant to 42 CFR section 438.402(c)(1)(i)(A). Deemed Exhaustion means the MEMBER has effectively exhausted Contractor’s internal APPEAL because Contractor failed to timely resolve the APPEAL.
4. CHPIV ensures the NOA informing the MEMBER of its NAR at a minimum, must indicate whether the decision on the APPEAL is upheld and the date of the decision on the APPEAL. For decisions not wholly in the MEMBER’s favor, the NAR at a minimum, must include:
  - a. MEMBER’s right to request a STATE FAIR HEARING.
  - b. How to request a STATE FAIR HEARING.
  - c. That the MEMBER has a right to continuation of benefits during the STATE FAIR HEARING, and that Contractor is obligated to continue benefits as long as the requirements of 42 CFR section 438.420 are met.



- d. The right to request an IMR or a review of the decision by DMHC, if the MEMBER has not presented the disputed health care services for resolution by the Medi-Cal fair hearing process.
    - e. The IMR is not required for final STATE FAIR HEARING decision; and
    - f. The DHCS-approved "Your Rights" Attachment.
  5. The timeframe to resolve an APPEAL may be extended by up to 14 calendar days if the MEMBER requests an extension or Contractor shows that there is a need for additional information. The contractor must maintain documentation to demonstrate to DHCS why the delay is in the MEMBER's interest. If the timeframe extension has not been requested by the MEMBER, CHPIV ensures the following:
    - a. Make reasonable efforts to give the MEMBER prompt oral notice of the delay.
    - b. Give the MEMBER a written notice of the reason to extend the timeframe within two calendar days, including information on the right to file an additional GRIEVANCE for the delay; and
    - c. Resolve the APPEAL as expeditiously as the MEMBER's health condition requires and no later than the date the extension expires.
  6. If the decision is reversed during the APPEAL, it must authorize or provide the disputed services promptly, and as expeditiously as the MEMBER's health condition requires, but no later than 72 hours from the date it reverses the action if the disputed services were not provided during the APPEAL.
  7. CHPIV must pay for disputed services if the MEMBER received the disputed services while the APPEAL was pending.
  8. The MEMBER must be given the opportunity before and during their APPEAL process to examine their case file. CHPIV ensures provision of, sufficiently in advance of the resolution timeframe and free of charge, the MEMBER's case file, including medical records, clinical criteria, guidelines and all documents and records relied on during the APPEAL process for its decision. CHPIV must assist any MEMBER who requires assistance preparing their APPEAL.
- B. Expediated APPEALS
  1. CHPIV ensures implementation and maintenance of a process resolve expedited APPEALS as described below. CHPIV ensures the expedited APPEAL process is followed when it determines or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the MEMBER's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
  2. A MEMBER, or a Provider or an AUTHORIZED REPRESENTATIVE, and with the MEMBER's written consent, may file an expedited APPEAL either orally or in writing. No additional follow-up from the MEMBER is required. CHPIV ensures that punitive action is not taken against a Provider who requests an expedited resolution or supports a MEMBER's APPEAL.
  3. CHPIV must inform the MEMBER of the limited time available for the MEMBER to present evidence and allegations of fact or law, in person, by phone or in writing, sufficiently in advance of the resolution timeframe.



## Appeals Process

GA-002

4. CHPIV ensures that the Member, or a provider or AUTHORIZED REPRESENTATIVES are immediately notified of their right to notify DMHC of the APPEAL.
5. CHPIV must provide a MEMBER notice, as quickly as the MEMBER's health condition requires, but no later than 72 hours from the day Contractor receives the request for an expedited APPEAL.
6. CHPIV may extend the timeframe to resolve an expedited APPEAL by up to 14 calendar days if the MEMBER requests an extension or if there is a need for additional information and how the delay is in the MEMBER's interest. If the extension was not requested by the MEMBER, CHPIV ensures reasonable efforts are made to give the MEMBER prompt oral notice of the delay, and within two calendar days provide the MEMBER with written notice that includes the reason the extension is needed. The notice must include information on the right to file a GRIEVANCE if the MEMBER disagrees that the extension is appropriate. CHPIV ensures that the APPEAL is resolved as expeditiously as the MEMBER's health condition requires and no later than the date the extension expires. CHPIV ensures documentation is maintained to demonstrate to the Department why the extension is necessary.
7. CHPIV ensures reasonable efforts are made to provide oral notice of an expedited APPEAL decision.
8. If a request for an expedited resolution of an APPEAL is denied, the request for an APPEAL must be processed in accordance with the standard APPEAL process timeframes for resolutions and extensions as required in Exhibit A, Attachment III, Subsection 4.6.4 (APPEAL Process).
9. A MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER, and with the MEMBER's written consent, has the right to file an APPEAL in the timeframes set forth in this Policy.
10. CHPIV ensures the APPEAL Process addresses the receipt, handling, and disposition of a MEMBER's APPEAL, in accordance with applicable statutory, regulatory, and contractual requirements.
11. CHPIV ensures assistance is provided to MEMBERS requiring assistance with filing an APPEAL, including, but not limited to, a MEMBER with limited English proficiency (LEP), disabilities, or cultural needs.
12. CHPIV ensures prompt review and investigation of an APPEAL.
13. CHPIV ensures referral of all APPEALS related to medical quality of care issues to the Quality Improvement (QI) Department for review by the Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process.
14. CHPIV ensures MEMBERS are informed during the APPEAL Process of his or her right to request a State Hearing after the internal APPEAL Process has been exhausted or should have been exhausted, and of his or her right to Aid Paid Pending (i.e., continuation of benefits).
15. Continuation of Benefits Pending an APPEAL (i.e., Aid Paid Pending)
  - a. CHPIV ensures MEMBERS are advised and assisted with the provision of Aid Paid Pending, regardless of whether the MEMBER makes a separate request during the APPEAL process, if all of the following conditions are met:





procedural steps, including but not limited to, providing all documents relied on for the decision to the MEMBER, in addition to the following services:

- i. Alternative formats (as set forth in All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, And Language Assistance Services)
  - ii. Providing Auxiliary Aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability; and
  - iii. Assistance in the APPEAL Process, or to provide translation of APPEAL correspondence.
25. A MEMBER may be represented by anyone they choose during the APPEAL Process, including a legal representative.
26. The MEMBER has the right to request an APPEAL in the event a ABD/NOA is not issued within the required time frame, which shall be considered a denial and therefore constitutes an ADVERSE BENEFIT DETERMINATION.
27. CHPIV ensures the provision, upon request by the MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER and with the MEMBER's written consent, before and during the APPEALS Process, the opportunity to examine and/or obtain a copy of the MEMBER's case file, including Medical Records, and any other relevant documents and records considered during the APPEALS Process. CHPIV ensures the provision of records at no cost.
28. CHPIV ensures that the person reviewing the APPEAL was not involved in the initial determination and he or she is not the subordinate of any person involved in the initial determination.
29. CHPIV ensures that for APPEALS, the person making the final decision for the proposed resolution of an APPEAL has not participated in any prior decisions related to the APPEAL and is of the same or similar specialty, has clinical expertise in treating the MEMBER's condition or disease, and is able to treat complications that may result from the service or procedure, if deciding on any of the following:
- a. An APPEAL of a denial based on lack of Medical Necessity or experimental/clinical investigation; and
  - b. Any APPEAL involving clinical issues.
30. Upon notice of the decision to deny an authorization request, a MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER, and with the MEMBER's written consent, may request an expedited APPEAL, when it is determined or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the MEMBER's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
31. All medical APPEALS are referred to the Chief Medical Officer (CMO) or to his or her Designee who has the authority to require CORRECTIVE ACTION and did not make the initial utilization management decision.
32. CHPIV ensures the provision of GRIEVANCE and APPEAL system requirements to subcontractors at the time they enter into a subcontract, on an annual basis, and when the relevant GRIEVANCE and APPEALS policies and procedures are updated.
33. CHPIV ensures language assistance is provided to MEMBERS, by plan staff or language line interpreter services, for Threshold Languages to register and resolve APPEALS.



- 34. In addition to any rights set forth in this Policy, a MEMBER or a MEMBER’s AUTHORIZED REPRESENTATIVE shall also have the right to:
  - a. Request a standard or expedited State Hearing with the Department of Social Services (DSS).
  - b. CHPIV ensures MEMBERS are informed of such State Hearing rights annually, and in every Notice of APPEAL Resolution (NAR) letter.
- 35. If adequate notice is not provided to a MEMBER with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, within applicable federal or state timeframes, then the MEMBER is deemed to have exhausted the internal APPEAL process and may immediately request a State Hearing.
- 36. CHPIV ensures APPEALS processes for pharmacy services rendered or requested before implementation of Medi-Cal Rx.
- 37. CHPIV ensures the maintenance of records of GRIEVANCES and APPEALS and must have policies and procedures in place governing the review of the information as part of its ongoing Quality Improvement System. CHPIV ensures the identification of systemic patterns of wrongful denials and impose CORRECTIVE ACTION as necessary. The records must be accurately maintained in a manner accessible to the State and available to CMS upon request. Records must include all required information set forth in 42 CFR section 438.416. Contractors must ensure that all documents and records, whether in a written or electronic format generated or obtained are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

**III. PROCEDURE**

- A. CHPIV delegates the APPEAL process to its Subcontractor, Health Net.
- B. Delegation Oversight
  - 1. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Health Net. CHPIV ensures Health Net’s compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
    - a. Ongoing monitoring
    - b. Performance reviews
    - c. Data analysis
    - d. Utilization of benchmarks, if available
    - e. Annual desktop and on-site audits

**IV. DEFINITIONS**

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the “Definitions” below.

TERM	DEFINITION
<b>Adverse Benefit Determination (“ABD”)</b>	Means any of the following actions taken by Contractor: <ul style="list-style-type: none"> <li>• The denial or limited authorization of a requested service, including determinations based on the type or level of a Covered Service, Medical Necessity,</li> </ul>



**Appeals Process**

**GA-002**

<b>TERM</b>	<b>DEFINITION</b>
	<p>appropriateness, setting, or effectiveness of a Covered Service.</p> <ul style="list-style-type: none"> <li>• The reduction, suspension, or termination of a previously authorized Covered Service.</li> <li>• The denial, in whole or in part, of payment for a Covered Service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of Clean Claim is not an Adverse Benefit Determination.</li> <li>• The failure to provide Covered Services in a timely manner.</li> <li>• The failure to act within the required timeframes for standard resolution of Grievances and Appeals.</li> <li>• The denial of the Member’s request to obtain services out of Network when a Member is in an area with only one Medi-Cal managed care health plan; or</li> <li>• The denial of a Member’s request to dispute financial liability.</li> </ul>
<b>Member</b>	A beneficiary enrolled in a CHPIV program.
<b>Appeal</b>	<p>Means a review by a Contractor of an ABD, which includes one of the following actions:</p> <ul style="list-style-type: none"> <li>• A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service.</li> <li>• A reduction, suspension, or termination of a previously authorized service.</li> <li>• The denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim.</li> <li>• Failure to provide services in a timely manner; or</li> <li>• Failure to act within the timeframes provided in 42 CFR section 438.408(b).</li> </ul>
<b>Authorized Representative</b>	Means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.
<b>Corrective Action</b>	Means specific identifiable activities or undertakings of Contractor which address Contract deficiencies or noncompliance.

	<b>Appeals Process</b>	<b>GA-002</b>
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<b>TERM</b>	<b>DEFINITION</b>
<b>Grievance</b>	<p>Means an oral or written expression of dissatisfaction about any matter other than an ABD, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor’s employee, failure to respect a Member’s rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision.</p>
<b>State Fair Hearing (SFH)</b>	<p>Means a hearing with a State Administrative Law Judge to resolve a member’s dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors.</p>

**CALIFORNIA  
PROVIDER PARTICIPATION AGREEMENT  
PARTICIPATING PROVIDER GROUP (PPG)**

This Provider Participation Agreement (“Agreement”) is made and entered into as of the \_\_\_\_ day of \_\_\_\_\_, 200\_\_ (the “Effective Date”) by and between [INSERT NAME OF PPG], on behalf of itself and its Professional Providers as that term is defined herein (collectively, “PPG”), and Health Net of California, Inc. on behalf of itself and its subsidiaries and affiliates (collectively, “Health Net”).

**RECITALS**

A. PPG has the legal authority to enter into this Agreement, and to deliver or arrange for the delivery of Covered Services.

B. Health Net has the legal authority to enter into this Agreement, and to perform the obligations of Health Net hereunder with respect to the Benefit Programs.

C. The parties desire to enter into this Agreement to arrange for PPG to participate in one or more of Health Net’s networks of Participating Providers that render Covered Services to Beneficiaries of various Benefit Programs.

D. PPG’s primary consideration shall be the quality of the health care services rendered to Beneficiaries, pursuant to Title 10 CCR 2240.4.

**A G R E E M E N T**

NOW, THEREFORE, in consideration of the above recitals and the covenants contained herein, the parties hereby agree as follows:

**I. DEFINITIONS**

Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Article I.

**1.1 Allowable Charges.** Allowable Charges is defined as PPG’s billed charges for Contracted Services.

**1.2 Beneficiary.** A person who is properly enrolled in and eligible to receive Covered Services under a Benefit Program at the time Covered Services are rendered. The parties acknowledge that the term ‘member’ may be used by Health Net in certain related materials, such as Benefit Program documents covering various products, marketing materials, and Health Net Policies. For purposes of reference in this Agreement, the term Beneficiary includes the term ‘member’ wherever used.

**1.3 Benefit Program.** The group agreement, evidence of coverage, certificate of insurance, summary plan description or similar documents in effect at the time Covered Services are rendered for lines of business offered through Health Net whereby Health Net or a Payor is obligated to provide or arrange for Covered Services or compensation therefore, to Beneficiaries in accordance with the provisions contained in such agreements, plans and documents. The Benefit Programs in which PPG participates and terms and conditions such as payment rates relating to such Benefit Programs are set forth in the Addenda to this Agreement.

**1.4 Capitated Services.** The Covered Services described in and governed by an Addendum to this Agreement for which PPG (i) is responsible to deliver to Beneficiaries or to arrange for the delivery to such Beneficiaries by and through Professional Providers and/or Participating Providers under the terms and condition of this Agreement, and (ii) has accepted all or a portion of financial responsibility, in return for Capitation for the Benefit Programs to which the applicable Addendum applies.

**1.5 Capitation.** The compensation mutually agreed to be paid in exchange for delivery or arranging the delivery of, and the assumption of financial risk for, certain Covered Services as set forth in the applicable Addendum to this Agreement.

**1.6 Coinsurance.** That portion of the cost of Covered Services that a Beneficiary is obligated to pay under a particular Benefit Program which is calculated as a percentage of the contracted reimbursement rate for such services. Coinsurance does not include Copayments or Deductibles.

**1.7 Complete Claim.** A Complete Claim means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides reasonably relevant information as defined by applicable State or federal statutes and regulations, and which is submitted to Health Net or a Payor by PPG for payment of Covered Services that are paid on a FFS basis under this Agreement and that may be processed by Health Net or a Payor without obtaining additional information from PPG or from a third party.

**1.8 Complete Encounter.** A medical service covered by PPG under its capitation and reported to Health Net on a per member, per visit basis. To be considered complete the encounter shall conform to Health Net's Encounter Companion Guide as posted in Health Net Policies and shall include, at a minimum the member-paid cost-share amounts such as copayments, coinsurance, and deductible, as applicable to the member's benefit, as well as the same data elements that would be required on a fee-for-service (FFS) claim form. Additionally, any rejected encounter data must be corrected and resubmitted in order to be considered a Complete Encounter.

**1.9 Coordination of Benefits.** The allocation of financial responsibility between two or more payors of health care services, each with a legal duty to pay for or provide Covered Services to a Beneficiary at the same time.

**1.10 Copayment.** That portion of the cost of Covered Services that a Beneficiary is obligated to pay under a particular Benefit Program, which is a fixed dollar amount paid at the time Covered Services are rendered. Copayments do not include Coinsurance or Deductibles.

**1.11 Covered Services.** All health care services, equipment and supplies that are covered as determined by the Benefit Program and by applicable State and federal law and regulations, including without limitation decisions issued as a result of independent medical review conducted under applicable State or federal law, and without regard to whether they are compensated under this Agreement on a FFS, Capitation or Shared Risk basis.

**1.12 Deductible.** The amount of money that a Beneficiary must pay before the Benefit Program pays certain benefits for Covered Services. Deductibles do not include Coinsurance or Copayments.

**1.13 Dispute.** The term "Dispute", as used in this Agreement, including Sections 7.5 and 7.6, shall mean any controversy or disagreement that may arise out of or relate to this Agreement, or the breach thereof, whether involving a claim in tort, contract, or other applicable area of law.

**1.14 DOFR.** The term "DOFR" means the division of financial responsibility matrix or matrices set forth in the applicable Addendum to this Agreement.

**1.15 Emergency.** The term "Emergency" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Active labor is considered an Emergency. "Active labor" means labor at the time that either of the following could reasonably occur: (1) There is inadequate time to effect safe transfer to another Hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the Enrollee or unborn child.

Certain benefit plans require adherence to the federal and government program standard for defining an Emergency, which defines an Emergency as : a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the patient's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

**1.16 Excluded Services.** Those health care services, equipment and supplies that are determined by Health Net or a Payor to be non-Covered Services under the applicable Benefit Program in effect at the time such services are rendered and for which PPG may bill the Beneficiary.

**1.17 FFS.** The term FFS means “fee for service” and refers to a method of compensation under which Health Net or Payor pays PPG, or Professional Providers for Covered Services based on a negotiated fee paid for each Covered Service delivered to a Beneficiary pursuant to this Agreement.

**1.18 Facility (ies).** All service locations owned, operated, or subcontracted by PPG at which Covered Services are provided under this Agreement.

**1.19 Health Net.** A network of managed health care delivery or indemnity companies, owned, controlled, controlling, under common control with, managed or administered in whole or in part now or hereafter, by Health Net, LLC., its successors and assigns.

**1.20 Health Net Policies.** The policies, procedures and programs established by Health Net and applicable to Participating Providers in effect at the time Covered Services are rendered, including without limitation Health Net’s grievance and appeal procedures, provider dispute and/or appeal process, drug formulary or preferred drug list, fraud detection, recovery procedures, eligibility verification, billing and coding guidelines, payment and review policies, anti-discrimination requirements, medical management programs, continuity of care policies, provider manuals and/or operations manuals. The medical management program includes policies regarding topics such as credentialing, utilization management, quality improvement, catastrophic care management, peer review, medical and other record reviews, outcome rate reviews, Prior Authorization, and Referral.

**1.21 Medically Necessary.** A Medically Necessary service or supply is one that meets the following criteria: it is an otherwise covered category of service, not specifically excluded and is recommended by the treating physician and determined by Health Net’s Medical Director or physician designee to be: (i) for the purpose of treating a medical condition; (ii) the most appropriate supply or level of service, considering potential benefits and harm to the Beneficiary; not furnished primarily for the convenience of the Beneficiary or PPG; not required solely for custodial, comfort or maintenance reasons; consistent with Health Net Policies and furnished in the most appropriate place of service consistent with nationally recognized review criteria and/or guidelines; and (iii) known to be effective and safe in improving health outcomes. For new treatments, services or supplies, effectiveness is determined by scientific evidence. For existing treatments, services or supplies, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. The fact that a physician or other provider may prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary or make it a Covered Service.

**1.22 Out-of-Area.** The geographical area which is outside of the PPG Service Area.

**1.23 Participating Provider.** A facility, physician, physician organization, independent practice association, health care provider, supplier, or other organization which has met applicable credentialing requirements, if any, and has, or is governed by, an effective written agreement directly with Health Net or indirectly through another entity, such as another Participating Provider or a PPG, to provide Covered Services.

**1.24 Payor.** Any public or private entity contracted with Health Net which provides, administers, funds, insures or is responsible for paying Participating Providers for Covered Services rendered to Beneficiaries under a Benefit Program, including without limitation self-funded health plans.

**1.25 PMPM.** The term PMPM means “per assigned Beneficiary per month” and refers to an amount of compensation paid to PPG per assigned Beneficiary per month for Capitated Services.

**1.26 PPG.** The participating physician group and/or the independent practice association that has entered into this Agreement.

**1.27 Primary Care Physician (PCP).** A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who: (1) is duly licensed and qualified under the laws of the relevant jurisdiction to render certain Covered Services; (2) is a Participating Provider; and (3) meets the credentialing standards of Health Net for designation as a PCP; and (4) is responsible for coordinating the provisions of health care services and providing for continuity of care and for twenty-four (24) hours a day, seven (7) days a week availability to Beneficiaries.

**1.28 Prior Authorization.** The written or electronically issued prior approval by Health Net or a Payor or either of their designees (which may include PPG) for the provision of Covered Services which may be required under a Benefit Program or a Health Net Policy.

**1.29 Professional Provider.** The physicians, allied health professionals and other health care providers who contract with PPG, or are employed by PPG, and who provide to Beneficiaries: (i) Covered Services that are billed and paid on a FFS basis, and/or (ii) Capitated Services, both of which are provided under the terms and conditions of this Agreement.

**1.30 PPG Service Area.** The geographic area within a thirty (30) air mile radius of a Beneficiary's PCP's office, and the geographic area within which PPG is financially responsible for providing or arranging for the provision of Capitated Services to certain Beneficiaries as further described in the applicable DOFR and Addendum to this Agreement.

**1.31 Reconciliation Period.** The time period used for the purpose of calculating a Shared Risk Program's payable or receivable amount, which ends on December 31 of the first year during which this Agreement is effective, and which thereafter is a twelve (12) month calendar year period.

**1.32 Records.** Books, documents, and records prepared and/or maintained by a party that relate to this Agreement whether in written or electronic format, including without limitation medical records, Beneficiary billing and payment records, financial records, policies and procedures, and other books and records that may be required by applicable federal and State law.

**1.33 Referral.** The written or electronically issued referral of a Beneficiary by a Participating Provider to another health care provider that may be required under a Benefit Program or a Health Net Policy prior to the rendition of Covered Services, usually for a specified number of visits or type or duration of treatment.

**1.34 Regulatory Requirements.** All applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of governmental contracts and standards, and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Benefit Program addendum.

**1.35 Shared Risk Budget.** The amount allocated PMPM for the cost of Shared Risk Services set forth in the applicable Addendum to this Agreement.

**1.36 Shared Risk Claims.** Claims for Shared Risk Services which are rendered during a Reconciliation Period, minus those amounts in excess of the Shared Risk threshold and amounts received from third parties to offset Health Net's payment of any such claims. Shared Risk Claims include all claims with dates of service within the Reconciliation Period and paid within ninety (90) days after the end of the Reconciliation Period.

**1.37 Shared Risk Program.** A program which rewards PPG for effectively coordinating Shared Risk Services rendered to Beneficiaries.

**1.38 Shared Risk Services.** The Covered Services identified in the column labeled "Shared Risk Services" as set forth in the applicable DOFR.

**1.39 State.** The State of California.

**1.40 Surcharge.** An additional fee which is charged to a Beneficiary for a Covered Service, but which is not approved by the applicable State and federal regulatory authority and is neither disclosed nor provided for in a Benefit Program.

**1.41 Urgently Needed Services.** Covered Services required in order to prevent a serious deterioration of a Beneficiary's health that results from an unforeseen illness or injury if (i) such Beneficiary is temporarily absent from the PPG Service Area, and (ii) receipt of the Covered Service cannot be delayed until the Beneficiary's return to the PPG Service Area.

**1.42 Withhold Fund.** A fund established by withholding from Capitation an amount set forth in the applicable Addendum to this Agreement, the purpose of which is to cover any Shared Risk Deficit.

## II. DUTIES OF PPG

**2.1 General Obligations of PPG, Professional Providers and Facilities.** PPG agrees to the following provisions on behalf of itself, its Professional Providers, and its Facilities:

2.1.1 PPG binds its Facilities and Professional Providers to the terms and conditions of this Agreement, to the extent Covered Services and/or contractual provisions are performed by, or apply to, such Facilities and Professional Providers.

2.1.2 No new satellite shall be added to, or allowed to deliver Covered Services under, this Agreement until Health Net has approved such satellite in a written communication to PPG.

2.1.3 Except as otherwise may be permitted under a delegation agreement between Health Net and PPG, no new Professional Provider shall be added to, or allowed to deliver, Covered Services under this Agreement until Health Net has approved such Professional Provider through an applicable credentialing process.

2.1.4 PPG shall secure adherence by Professional Providers to all the obligations of this Agreement which affect Professional Providers, including but not limited to: (i) accepting Beneficiaries when such Beneficiaries have selected, or are assigned or transferred to PPG, provided that PPG and its Professional Providers have capacity to provide Covered Services under this Agreement and PPG and Professional Providers continue to accept new patients from other health care service plans; (ii) conforming to drug dispensing guidelines and other requirements set forth in Health Net Policies, (iii) conforming to applicable professional liability insurance requirements; (iv) no agreement between PPG and a Professional Provider shall contain any incentive plan that includes a specific payment made, in any type or form, as an inducement to deny, reduce, or limit Covered Services to a Beneficiary, (v) PPG shall comply and shall cause its Professional Providers to comply with State and federal law regarding physician incentives and stop loss insurance requirements, where applicable, (vi) PPG shall assure through written communication that all Professional Providers are aware of the appeals process regarding any decision, policy, or practice of Health Net or PPG that Professional Provider believes is not consistent with the provision of quality medical care to Beneficiaries, (vii) to the extent that PPG maintains economic profiles, as defined in the California Health and Safety Code Section 1367.02(d), of its Professional Providers, it shall, upon request, provide a copy of the individual economic profile information to the Professional Providers who are profiled, and such profile information shall be provided to a Professional Provider upon request until sixty (60) days after the date the contract between PPG and Professional Provider.

2.1.5. If PPG renders services to certain Beneficiaries on behalf of, or as an affiliate, contractor or agent for another healthcare organization, entity or individual that is contracted with Health Net, where that other healthcare organization, entity or individual is to be compensated by Health Net and/or has assumed responsibility for claims payment for such Beneficiaries, PPG agrees that it shall hold Health Net harmless, and will seek payment under the terms of this Agreement for services rendered to those Beneficiaries solely and exclusively from that other healthcare organization, entity or individual, and shall not under any circumstances seek payment directly from Health Net, a Payor, or such Beneficiaries. PPG further agrees that any claims for such services submitted directly to Health Net shall be denied as a duplicate payment. In the event the other healthcare organization fails to pay for Covered Services, except for applicable Copayments, Coinsurance or Deductibles, a Beneficiary shall not be liable to PPG for any sums owed by the other healthcare organization, entity or individual. Neither PPG nor any agent, trustee, or assignee thereof may maintain any action at law against a Beneficiary to collect sums owed to PPG by another healthcare organization, entity or individual.

2.1.6 PPG, Professional Providers and Facilities are licensed without restriction or limitation by the State to provide Covered Services to the extent such licensure is required by the State.

2.1.7 PPG, Professional Providers and Facilities are either certified to participate (if Medicare and/or Medi-Cal are included within the scope of this Agreement) or have not been excluded from participation in Medicare under Title XVIII of the Social Security Act, and in Medicaid/Medi-Cal under Title XIX of the Social Security Act or other applicable State law pertaining to Title XIX of the Social Security Act. PPG shall not subcontract, either directly or indirectly, with any provider that has been excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act (42 U.S.C. 1320a-7) or in the State Medi-Cal Program.

2.1.8 PPG, Professional Providers and Facilities shall deliver Covered Services to Beneficiaries in the same manner and with the same availability, as services are delivered to other patients.

2.1.9 PPG and Professional Providers shall maintain such physical plant, equipment, patient service personnel and allied health personnel as may be necessary to provide Covered Services.

2.1.10 Professional Providers shall be available to Beneficiaries twenty-four (24) hours per day, seven (7) days per week on an Emergency basis.

2.1.11 PPG shall notify Health Net in writing, thirty (30) days in advance, of any changes to PPG, Professional Provider, and Facilities' information, including but not limited to, federal tax identification numbers, practice or billing addresses, office email address, phone numbers, office hours, non-English languages spoken by Professional Provider or their medical office staff, and/or national provider identifier numbers that may apply to Professional Providers and/or Facilities. In addition, PPG shall acknowledge and respond in a timely manner to all Health Net requests for Professional Provider and Facilities practice information updates. PPG shall inform Health Net within five (5) business days when either of the following occurs:

- A) PPG's Professional Provider is not accepting new patients, or
- B) PPG's Professional Provider had previously not accepted new patients but is currently accepting new patients.

2.1.12 PPG shall timely and accurately pay providers delivering Capitated Services under this Agreement and shall perform claims processing in accordance with applicable Benefit Program requirements, Health Net Policies and applicable State and federal law.

2.1.13 PPG shall comply with the terms of Section 2.5 hereof with respect to any subcontracts between PPG and Facilities and/or Professional Providers.

2.1.14 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. PPG agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of Member information and records pursuant to this Agreement; and iii) allow Health Net to use PPG's performance data.

2.1.15 To the extent applicable, PPG warrants and represents that it is in compliance with the Department of Managed Health Care (DMHC)'s general licensure regulation (28 C.C.R. 1300.49) and related DMHC guidance or will apply for an exemption to said requirements within thirty (30) days of execution of this Agreement and any subsequent renewals thereto. In the event PPG fails at any time to obtain and/or maintain such license or exemption, the parties agree to meet within ten (10) business days of Health Net's written notice to PPG to negotiate a resolution to PPG's breach of this Section 2.1.15. If the parties are unable to reach said resolution within thirty (30) days of the date of Health Net's notice, Health Net may but shall not be required to exercise its rights under Article V of this Agreement.

2.1.16 PPGs delivering Telehealth services shall reimburse providers delivering services for the diagnosis, consultation, or treatment of a commercial Beneficiary appropriately delivered through telehealth services, on the same basis and to the same extent as the reimbursement for the same service through in-person diagnosis, consultation, or treatment. Telehealth shall be defined as applicable in California law and regulations, California Health & Safety Code Sections 1374.14 and 1374.141, California Insurance Code Sections 10123.855 and 10123.856, and California Business and Professions Code Section 2290.5.

**2.2 Provision of Services.** PPG agrees to deliver or arrange for the delivery of Covered Services to Beneficiaries of Benefit Programs under the terms and conditions of this Agreement.

PPG shall deliver or arrange for the delivery of preventive care and health education to Beneficiaries during each office visit and document such preventive care and health education in the medical record in accordance with external reporting and accrediting bodies such as the National Committee for Quality Assurance (NCQA), The Joint Commission (TJC), or the Utilization Review Accreditation Commission (URAC). PPG acknowledges that Health Net or a Payor shall not be liable for, nor will exercise control or direction over, the manner or method by which PPG, Professional Providers, and/or Facilities render any Covered Services (or any other medical or healthcare services) to Beneficiaries under this Agreement.

**2.3 Verification of Eligibility.** Except in an Emergency, PPG shall verify the eligibility of Beneficiaries using Health Net's telephonically or electronically available system before providing Covered Services paid on a FFS basis.

**2.4 Non-Discrimination.** PPG shall assure that Beneficiaries are not discriminated against in the provision of Covered Services hereunder, whether on the basis of the Beneficiary's coverage under a Benefit Program, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, source of payment, utilization of medical or mental health services, equipment, pharmaceuticals or supplies, health status (including without limitation, Beneficiaries who are, were, or

may be victims of domestic violence, or have or may have conditions that are caused by domestic violence), genetic information, or other unlawful basis including, without limitation, the filing by such Beneficiary of any complaint, grievance or legal action against PPG, Professional Providers/Facilities, Health Net or Payor. PPG shall assure that reasonable accommodations are made for Beneficiaries with disabilities or handicaps, including but not limited to, providing such auxiliary aides and services to Beneficiaries as are reasonable, necessary, and appropriate for the proper rendering of Covered Services at PPG's expense.

**2.5 Subcontracting.** The following requirements shall survive termination of this Agreement with respect to Covered Services rendered during the term of the Agreement and apply when Covered Services are provided by a subcontractor:

2.5.1 PPG shall furnish Health Net with copies of its subcontracts within ten days of Health Net's written request.

2.5.2 Every subcontract shall comply with all applicable local, State, and federal laws, including privacy/confidentiality and medical record accuracy laws, be consistent with the terms and conditions of this Agreement, and shall not be used by PPG with respect to Beneficiaries, Benefit Programs and/or Covered Services upon the reasonable request of Health Net.

2.5.3 PPG shall not subcontract either directly or indirectly, with any provider that has been excluded from participation in the Medicare Program under Section 1128 or 1128A [42 U.S.C. 1320a-7] of the Social Security Act or in the State Medi-Cal program.

2.5.4 Each such subcontractor shall meet applicable Health Net credentialing requirements, if any, prior to the subcontract becoming effective with respect to Covered Services.

2.5.5 (i) PPG shall be solely responsible to pay the subcontractor and (ii) PPG shall hold Health Net, Payors and Beneficiaries harmless from and against any and all claims which may be made by subcontractors in connection with Covered Services provided to Beneficiaries by the subcontractor; and (iii) PPG shall require that the subcontractor hold Health Net, Payors, and Beneficiaries harmless from and against any and all claims for payment for such services and shall not attempt to collect any sums owed by PPG from Health Net or a Beneficiary.

2.5.6 Subcontracts shall not restrict the rights and obligations of a healthcare provider to communicate freely with Beneficiaries regarding their medical condition and treatment alternatives including medication treatment options, regardless of benefit coverage limitations.

2.5.7 In the event that any of PPG's subcontracts fail to comply with the requirements set forth herein, Health Net or Payor shall not be required to recognize the existence or validity of the subcontract with respect to Beneficiaries, Benefit Programs and/or Covered Services.

**2.6 Participating Providers and Facilities.** PPG shall refer Beneficiaries only to Participating Providers and shall use Participating Providers to provide Covered Services, except in an Emergency, as otherwise permitted in the applicable Benefit Program Requirements, or as otherwise required by applicable State or federal law. Additionally, PPG shall refer to Health Net's designated Participating Providers when required by Health Net. In the event PPG fails to comply with this Section 2.6, Health Net may exercise its rights under Section 4.3 of this Agreement.

Prior to rendering any non-emergency episode of care, PPG shall determine and disclose to EPO and PPO Beneficiaries the out-of-network providers who are likely to be involved in providing care and the estimated cost of that non-participating provider's care (e.g. for a surgery, PPG shall disclose to the Beneficiary prior to the surgery, all non-participating providers, such as anesthesiologists, radiologists, and pathologists, who are anticipated to be involved in the Beneficiary's care, and the estimated cost of such out-of-network services). PPG's disclosure shall be made sufficiently in advance of the scheduled episode of care to afford the Beneficiary a reasonable opportunity to explore alternate arrangements.

Additionally, PPG shall comply with the terms of Section 2.5 hereof with respect to its Facilities and Participating Providers, to the extent Facilities are not owned, and/or Participating Providers are not employed, by Provider.

**2.7 Health Net Policies.** PPG and Professional Providers shall participate in and comply with all Health Net Policies in effect on the effective date of this Agreement, and as modified periodically by Health Net in accordance with Section 3.2 of this Agreement. PPG hereby acknowledges that it has had the opportunity to review Health Net Policies regarding quality improvement and utilization management that pertain to Health Net and PPG's rights and obligations under this Agreement at least 15 business days prior to the date PPG has executed this Agreement.

**2.8 Prior Authorization and Referrals.** When either Prior Authorization and/or a Referral is required for the rendition of a health care service, the receipt of the required Prior Authorization and/or the required Referral, each being separate and distinct requirements, is a prerequisite to payment of Complete Claims for Covered Services in addition to confirming eligibility prior to delivering service as required by this Agreement and Health Net Policies. Health Net (or its designee as applicable) may rescind or modify its Prior Authorization, in a manner consistent with Health Net Policies, based on variety of factors, including but not limited to the eligibility of the Beneficiary and whether the rendered service is a Covered Service. However, when Health Net or its designee issues a Prior Authorization for a specific service under a Benefit Program regulated by the California Department of Managed Health Care or the California Department of Insurance, Health Net (or its designee as applicable) shall not rescind or modify its Prior Authorization after PPG has rendered the specified and authorized service in good faith and pursuant to the terms of the Prior Authorization for any reason, including, but not limited to, Health Net's subsequent rescission, cancellation, or modification of the Beneficiary's contract or Health Net's subsequent determination that it did not make an accurate determination of the Beneficiary's eligibility; provided, however that this section shall not be construed to expand or alter benefits available to a Beneficiary under such Benefit Program.

**2.9 Notification.** PPG agrees to notify Health Net or a Payor and the appropriate PCP as applicable, as soon as possible, but no later than twenty-four (24) hours or by the next working day after providing Covered Services that would otherwise require Prior Authorization. PPG shall notify Health Net prior to or at the time of each admission of a Beneficiary to a hospital or skilled nursing facility whose admission is the financial responsibility of Health Net. In the event of an emergency admission, PPG shall notify Health Net regarding such Beneficiary within twenty-four (24) hours.

**2.10 Credentialing Program.** PPG shall submit to Health Net or its designee any applicable credentials application, which meets minimum requirements of Health Net except as may otherwise be permitted pursuant to credentialing delegation between PPG and Health Net. In no event will this Agreement be executed by Health Net, nor will PPG or any Professional Provider begin performing obligations under this Agreement, until PPG and/or Professional Provider has satisfied applicable credentialing requirements, if any.

**2.11 Insurance.** Prior to the initiation of service, PPG shall deposit with Health Net's designated representative evidence of insurance protection in the form of certificates of insurance (ACCORD). All insurance policies maintained to provide coverage herein shall be issued by insurance companies authorized to do business in the State in which the work is performed, and by companies rated, at a minimum, "A X" by A.M. Best. Coverage afforded under such policies is primary as respects Health Net, and any other insurance maintained by Health Net is excess and non-contributing with the insurance required herein. Notification to Health Net by PPG of cancellation or material modification of the risk protection program shall be made to Health Net at least thirty (30) days prior to any cancellation. PPG shall maintain appropriate insurance programs or policies as follows and in accordance with Health Net Policies.

2.11.1 PPG agrees to maintain professional liability insurance and managed care errors and omissions insurance, in the amounts required by law but no less than One Million Dollars (\$1,000,000) per claim and Three Million Dollars (\$3,000,000) annual aggregate and shall name Health Net as an additional insured. In the event said liability insurance coverage is provided through a "claims made" policy, Health Net shall require PPG to purchase a five (5) year "tail" policy with the same policy limits.

2.11.2 PPG shall maintain a policy or program of comprehensive general liability insurance with minimum coverage including a Combined Single Limit Body Injury and Property Damage Insurance of not less than One Million Dollars (\$1,000,000) per claim and Three Million Dollars (\$3,000,000) annual aggregate and shall name Health Net as an additional insured.

2.11.3 PPG's employees shall be covered by Workers' Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code and shall also maintain Employers Liability coverage in the amount of no less than One Million Dollars (\$1,000,000).

2.11.4 PPG agrees to waive any rights of subrogation that PPG may have against Health Net under insurance policies related to the work performed or arranged by PPG.

Nothing in this Agreement, nor any insurance coverage limitations, shall be deemed to reduce, limit, or nullify PPG's indemnification obligations under the Agreement.

**2.12 Trade names, Trademarks, Directories.** PPG, Professional Providers and Facilities shall not use or display the trade names, trademarks, or other identifying information of Health Net without Health Net's prior written approval of both form and

content, which approval shall not be unreasonably withheld, provided, however, that this provision shall not prohibit PPG from posting a reasonable notice on its website or in its Facilities listing by name those insurance carriers that are accepted by PPG so long as the notice lists each name in substantially similar format. PPG shall supply all printed materials and other information requested by Health Net in connection with the production of provider directories within seven (7) days of Health Net's request. PPG agrees that Health Net may list the name, address, telephone number and other factual information of PPG, each Facility and Professional Provider, in its provider directories, marketing and informational materials, and electronic media.

**2.13 Non-Solicitation.** Neither PPG nor any Professional Provider, employee, agent or subcontractor of PPG shall solicit or attempt to convince or otherwise persuade any Beneficiary to discontinue participation in any Benefit Program or in any other manner interfere with Health Net's contract and/or property rights; provided, however, that this provision does not prohibit PPG from posting a reasonable notice on its website or in its Facilities listing by name those insurance carriers that are accepted by PPG so long as the notice lists each name in substantially similar format. Notwithstanding the foregoing, Health Net in no way restricts PPG or Professional Providers from discussing medical treatment options with Beneficiaries regardless of Benefit Program coverage options. Further, Health Net and PPG, and each of their employees and subcontractors shall portray each other in a positive light to Beneficiaries and the public.

**2.14 Conflict of Interest.** PPG shall not, during the term of this Agreement, acquire, or make any commitment to acquire a proprietary interest in any organization which is licensed as a health care service plan, or which has submitted an application for such licensure except as to a health care service plan with waivers. This restriction shall include any affiliated, subsidiary or parent organizations to which PPG may belong in which thirty percent (30%) or more is under common ownership. "Proprietary Interest", as used herein, shall not be deemed to include: i) participation as a provider of services for any other health care service plan or system of prepaid health care delivery; or ii) ownership of shares having a current value of less than two hundred fifty thousand dollars (\$250,000.00) in a corporation whose shares are regularly traded in a public market.

**2.15 Encounter Submission.** PPG agrees to cooperate with Health Net in the development and maintenance of an electronic transmission system in accordance with Health Net encounter data specifications contained in Health Net Policies. For Capitated Services rendered to Beneficiaries, PPG shall provide Health Net with Complete Encounter information, via electronic transmission in standard form or its successor format, for each encounter with a Beneficiary during a calendar month. Such electronic encounter information shall be complete, accurate and provided to Health Net within 120 days of the date of service. Encounter reporting shall be in accordance with, but not limited to, Health Net's Encounter Companion Guide, guidelines as set forth by CMS, or the Healthcare Effectiveness Data and Information Set (HEDIS) Version 3.0 or its successor. Additionally, PPG shall promptly provide Health Net with all corrections to such encounter data. Any costs associated with the electronic encounter transmission system will be borne solely by PPG. PPG attests to the validity, accuracy and truthfulness of each encounter submission made to Health Net.

**2.16 Delegation.**

2.16.1 Delegation of Certain Functions. If qualified, as determined by Health Net, PPG shall accept delegation of and perform such utilization management, credentialing and re-credentialing, medical record review, Capitation and claims adjudication, complex case management, dispute resolution functions, and any other contractual responsibilities of this Agreement in accordance with the performance standards and criteria set forth in Health Net Policies, the provider manual and the applicable written delegation agreements between the parties. Furthermore, PPG shall a) timely provide Health Net with any reporting, b) participate in data validation, as requested by Health Net, and c) shall attest to the accuracy of submitted reports and/or data to Health Net. Notwithstanding the foregoing, PPG shall notify Health Net no less than ninety (90) days prior to any changes in services delegated to MSOs and/or changes in MSOs. Further, Health Net shall retain the right to approve or deny any change(s) to PPG's MSO. PPG agrees to provide Health Net with a copy of their contract with MSO, any delegation agreement(s) and policies related to the oversight of PPG's MSO.

2.16.1.1 PPG agrees to implement and/or conform to any Corrective Action Plans ("CAP") issued by Health Net, for failure to perform or meet any standards outlined in the Agreement, delegation agreement, or Health Net Policies including the provider manual. Additionally, if PPG, or any Professional Provider, or any Participating Provider fails an audit, or is under a CAP, PPG shall ensure and shall provide evidence to Health Net, that it has properly resourced its operations, improved its processes and systems, appropriately trained its staff and/or Professional Provider and Participating Providers to address and resolve any such deficiencies. Should PPG be under a CAP and has not addressed or resolved such a CAP within one hundred twenty (120) days or deadlines in the CAP, whichever is longer, Health Net may issue a written notice to cure any deficiencies within sixty (60) days. Should PPG not resolve all deficiencies within sixty (60) days following the notice to cure, Health Net may, at its sole discretion, institute a Capitation deduction of up to 5%, until such time that the findings have been remediated by PPG to

Health Net's satisfaction. Repeat findings during the next annual audit will result in a Capitation deduction of 5%, without any cure period, until such time that the findings have been remediated by PPG to Health Net's satisfaction. Health Net's written communications shall indicate to PPG specific reasons for Capitation deduction and effective date of Capitation deduction.

2.16.2 **Termination of Delegation.** Health Net shall have the right to periodically audit PPG's performance of utilization management, credentialing and re-credentialing, medical record review, Capitation and claims adjudication and/or dispute resolution functions as applicable. If Health Net determines that deficiencies exist in PPG's performance, Health Net shall notify PPG of such deficiencies and shall allow PPG a reasonable period of time to correct such deficiencies; such reasonable time period to be delineated in the notice of deficiency. PPG shall accept consulting assistance from Health Net when offered. Failure to cure any identified deficiencies within the time period set forth in the notice of deficiency, or such other reasonable period of time mutually agreed by the parties, or if Health Net determines PPG does not have the ability to perform delegated functions, or is not effectively performing delegated functions, Health Net may impose sanctions up to and including the revoking delegation authority of all or any of these functions in accordance with procedures set forth in Health Net Policies and re-assume the performance of such functions itself. Should it become necessary for Health Net to reassume delegated functions, Health Net shall charge the following administrative fees: utilization management 5% of PPG Capitation; complex case management 5% of PPG Capitation; credentialing 3% of PPG Capitation; and claims processing and dispute resolution 5% of PPG Capitation.

2.16.3 **Termination of Agreement following De-Delegation**

Notwithstanding anything in Article V of this Agreement to the contrary, Health Net may terminate this Agreement upon 90 days written notice to PPG, in the event one or more of the following events occurs:

- (i) PPG fails to cure any identified deficiencies, as described in Section 2.16, within the time period set forth in the notice of deficiency, or such other reasonable period of time mutually agreed by the parties; or
- (ii) Health Net determines PPG does not have the ability to perform one or more delegated functions; or
- (iii) Health Net determines PPG is not effectively performing one or more delegated functions; or
- (iv) Health Net must reassume a delegated function(s) as set forth in Section 2.16.2.

2.16.4 PPG acknowledges that although it will participate in the Value -Based Performance Program, PPG remains delegated for Utilization Management per the Agreement and/or Health Net Policies.

**2.17 Fair Employment Requirements.** During the term of this Agreement, PPG and its subcontractors shall not unlawfully discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military or veteran status. PPG and its subcontractors also shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination. PPG and its subcontractors shall comply with the provisions of the Fair Employment and Housing Act (California Government Code, Section 12990 *et seq.*) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0 *et seq.*). The applicable regulations of the Fair Employment & Housing Council implementing Government Code, Section 12990, set forth in Subchapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. PPG and its subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreements.

**2.18 Out-of-Area Services.** PPG shall cooperate fully with Health Net and shall provide any information necessary to transfer Beneficiaries back into the PPG Service Area, including but not limited to, notification to Health Net of Out-of-Area services. PPG shall accept the prompt transfer of Beneficiary to the care of PPG and its Professional Providers following the receipt of Out-of-Area services when medically appropriate.

**2.19 Language Assistance Program.** PPG shall comply with Health Net's ongoing language assistance program to ensure Limited English Proficient ("LEP") Beneficiaries have appropriate access to language assistance while accessing PPG services, pursuant to Health and Safety Code §§ 1367(e)(3), 1367.04 and 1367.07 and Insurance Code §§ 10133.8 and 10133.9.

**2.20 Additional Rights and Obligations.** Any additional rights or obligations of PPG or Health Net shall be set forth in the Addenda to this Agreement.

**2.21 Federal Lobbying Restriction.** Health Net is obligated under 31 U.S.C. § 1352 to obtain certain information from subcontractors engaged to fulfill part or all of Health Net's obligations under its health maintenance contracts with state and local

governments, the proceeds of which are funded by federal grants or federal appropriations. To that end, PPG certifies and agrees as follows:

**Certification:** PPG certifies that it has not and will not use any funds received from Health Net under this Agreement to lobby Congress or any employee or member of Congress, or any federal agency or federal government employee or official (hereinafter “the federal government”) for the award of any federal contract, grant, appropriation or loan (or the continuation, extension, renewal, amendment, or modification of the same) or for the ability to participate in any federal cooperative agreement.

**Required Disclosures:** PPG also agrees that if it engages any person to lobby the federal government for the award to Health Net of a federal contract, grant, appropriation, or loan (or the continuation, extension, renewal, amendment, or modification of the same) or for the ability to participate in any federal cooperative agreement involving Health Net, the undersigned will fully and truthfully execute Standard Form LLL as set forth in Health Net Policies, and will provide such executed form to Health Net. PPG understands that Health Net is legally obligated to provide such information to certain federal grant and contract recipients with which it contracts, and further understands that all executed Standard Form LLLs will be supplied to the federal government. PPG agrees to supplement its disclosure under this paragraph promptly if there is a change in any of the information therein.

**Subcontracting Obligation:** If PPG engages any subcontractor to perform all or part of its obligations under this Agreement, it will require the subcontractor (1) to sign a certification stating that it will not use funds earned under the subcontract to lobby for the award of a federal contract, grant, appropriation or loan (or the continuation, extension, renewal, amendment, or modification of the same) or for the ability to participate in any federal cooperative agreement, and (2) to execute Standard Form LLL, in the event that it engages any person to lobby the federal government for such purposes. PPG will promptly provide to Health Net any Standard Form LLLs executed by its subcontractor(s).

**2.22 Data Sharing.** PPG agrees to cooperate and implement the California Health and Human Services Data Exchange Framework data sharing that requires the real time exchange of health information for members as outlined in California Assembly Bill 133 and Health Net Policies.

### III. DUTIES OF HEALTH NET

**3.1 Payment.** Health Net shall, or Health Net shall require Payor to, make payment to PPG for Covered Services in accordance with Article IV and the applicable addenda, schedules and exhibits of this Agreement. Any overpayment, inaccurate payment or other payment error made by Health Net or Payor shall not be deemed or construed or otherwise operate to change the payment terms or rates provided for under this Agreement.

**3.2 Health Net Policies.** Health Net Policies are set forth in references and forms available to PPG through the Provider Section of Health Net’s website at “<https://providerlibrary.healthnetcalifornia.com>” or by other means which Health Net will communicate to PPG from time to time. Health Net Policies in existence as of the effective date of this Agreement are hereby incorporated into this Agreement by reference. Notwithstanding the foregoing and/or any other provision of this Agreement, the parties agree that a formal amendment to this Agreement shall not be required to effectuate modifications to Health Net Policies. Modifications to Health Net Policies may be made from time to time as determined by Health Net in accordance with the procedures set forth in applicable State law (California Provider Bill of Rights). Such modifications shall be deemed incorporated herein as of the effective date of such modification unless otherwise mutually agreed by the parties in writing at the time of the modification in accordance with applicable State law (California Provider Bill of Rights).

**3.3 Insurance.** Health Net shall maintain appropriate insurance programs or policies including bodily injury and personal injury coverage, which includes persons serving on Health Net committees as insured by definition. In the event that a policy or program is terminated, or the coverage of committee persons is materially changed, Health Net shall so notify PPG.

**3.4 Reporting to Regulators.** Health Net and/or Payor shall accept sole responsibility for filing reports, obtaining approvals and complying with applicable laws and regulations of State, federal and other regulatory agencies having jurisdiction over Health Net and/or Payor; provided, however, that PPG agrees to cooperate in providing Health Net and/or Payor with any information and assistance reasonably required in connection therewith, including without limitation, permitting the regulatory agencies to conduct periodic site evaluations of PPG, Facilities, Professional Providers and any of their equipment, operations, and billing and medical records of Beneficiaries. Such records shall be located in the State.

**3.5 Access to This Agreement.** The following provisions apply to Covered Services compensated on a FFS basis:

3.5.1 **Access by Health Net.** As of the effective date of this Agreement, the following Health Net subsidiaries and affiliates may at their option access this Agreement: Health Net of California, Inc., Health Net Life Insurance Company, Health Net Community Solutions, Inc., Wellcare of California, Inc., Arizona Complete Plan, Health Net Health Plan of Oregon, Inc., Health Net Insurance Services, Inc., Health Net Federal Services, LLC., and Network Providers LLC. Notwithstanding the foregoing, PPG agrees that any other subsidiary or affiliate of Health Net not listed above may access the rates and terms set forth in this Agreement. This would include members of non-California based health plan affiliates who may be treated by PPG. To the extent Health Net allows a Health Net subsidiary or affiliate to access this Agreement, Health Net binds such subsidiaries and/or affiliates to the terms and conditions of this Agreement.

3.5.2 **Access by Payors.** To the extent Health Net allows a Payor to access this Agreement for Covered Services compensated on a FFS basis, Health Net has obligated such self-funded Payor to fund a claims payment account in a sufficient and timely manner to pay claims for services provided by health care providers like PPG. In the event a self-funded Payor accessing this Agreement fails to sufficiently and timely fund a claims payment account to the material detriment of PPG, PPG may terminate this Agreement as to such self-funded Payor in accordance with Section 5.3 hereof, and, notwithstanding the provisions of Section 4.11 of this Agreement, take legal action against the self-funded Payor and/or Beneficiary as may be permitted by law. Additional information regarding Payors and conditions for accessing this Agreement is set forth in Addendum A of this Agreement.

3.6 **Enrollment List.** Health Net shall on a monthly basis provide PPG with a list of Beneficiaries assigned to PPG for Capitated Services via electronic transmission or magnetic media. Health Net shall maintain a system to allow PPG and Professional Providers to make telephonic or electronic inquiries regarding Beneficiary eligibility.

3.7 **Timely Assignment of Beneficiaries.** Health Net shall require Beneficiaries to select a PCP and/or a PPG assigned at the time of enrollment when required under a Benefit Program. Health Net may assist Beneficiaries in such selection by providing information, as determined by Health Net, regarding PCPs and PPGs. Nothing in this Agreement shall be construed to require Health Net to assign a minimum or maximum number of Beneficiaries to PPG or to utilize PPG for any Beneficiaries. In the event Health Net issues a Notice of Breach pursuant to Section 5.3 of the Agreement, Health Net reserves the right to freeze the assignment of new Beneficiaries to PPG until the breach is cured.

**IV. FINANCIAL OBLIGATIONS.** The terms of this Article IV shall survive termination of this Agreement with respect to Covered Services rendered during the term of the Agreement:

4.1 **Capitation.** Health Net shall pay, and PPG shall accept as payment in full for Capitated Services the Capitation amounts set forth in the applicable Addendum for each Beneficiary assigned to PPG and eligible to receive Capitated Services from PPG during any particular month. Capitation shall be payable on a PMPM basis. Each Capitation payment shall be accompanied by a remittance summary. The remittance summary identifies the total Capitation payable and those Beneficiaries for whom Capitation is being paid pursuant to this Agreement.

Health Net reserves the right to create new benefit plans and to establish Capitation rates for new benefit plans based on actuarial assumptions that are consistent with existing actuarial assumptions. Health Net shall adjust the actuarial assumptions, which support the rates in the applicable Addendum on a periodic basis and shall advise PPG of any such adjustments in methodology. Capitation may also be adjusted in the event benefits are added or deleted from Capitated Services.

4.2 **Stop Loss.** PPG may elect not to participate in stop loss programs related to Capitation offered through Health Net effective the first day of any calendar year, provided that PPG provides written notice to Health Net at least thirty (30) calendar days prior to the beginning of the calendar year that PPG shall not participate in such stop loss program and specifies the name of the alternative third-party insurance carrier and proposed effective date, coverage levels and charges. In such event, PPG shall be required to obtain stop loss coverage in the amounts required by Health Net and State and federal law from a third-party insurance carrier reasonably acceptable to Health Net. If Health Net does not object to such coverage in writing within fifteen (15) days of the date of the notice, PPG shall be required to purchase such coverage as of the effective date specified in the notice. If such notice is not received when due or if coverage levels are not reasonably acceptable, Health Net shall automatically enroll PPG in Health Net's stop loss programs to afford protection effective on the first day of the calendar year.

PPG shall submit requests for reimbursement for Covered Services under the applicable stop loss programs in accordance with the procedures set forth in Health Net Policies but no later than one hundred twenty (120) calendar days following the end of the calendar year. PPG shall have sixty (60) days, from date of first notification, to submit requested information for any reimbursement requests under the stop loss programs that have been pended or denied due to insufficient information. Health Net shall

not be under any obligation to pay PPG for any reimbursement request not timely submitted as set forth herein. PPG shall not seek payment from any Beneficiary in the event Health Net does not pay PPG for reimbursement requests under the stop loss programs not timely submitted.

For purposes of calculating stop loss thresholds, the following shall apply: i) for PPG and Professional Providers, the compensation schedule set forth in the applicable Addendum shall be utilized; ii) for any other Participating Provider who has a subcontract with PPG, such subcontract rates shall be utilized; or if options i) or ii) do not apply, the lesser of: iii) for a Participating Provider who does not have a subcontract with PPG but who does have a contract with Health Net, Health Net's contract rate shall be utilized; or iv) the actual charges paid for Covered Services by PPG when none of the above applies. Health Net shall compensate PPG for reimbursement requests for Covered Services in excess of the stop loss threshold at eighty percent (80%) of the FFS rates set forth in the applicable Addendum unless otherwise provided for in such Addendum, or if no such FFS rates exist for the Covered Services provided, the actual charges paid by PPG, less applicable Copayments, Coinsurance, Deductibles, and payments from third parties or Coordination of Benefits.

#### **4.3. Offsetting Against Capitation.**

4.3.1 Health Net shall have the right to offset against Capitation any amounts owed to Health Net by PPG, including but not limited to, amounts owed by PPG under loans guaranteed by Health Net, errors, or Health Net interim payment for Capitated Services, including prior Capitation payments except that Health Net shall not offset against Capitation any deficit in a Shared Risk Program between PPG and Health Net. However, nothing in this section, nor in any other provision in this Agreement, nor in any other contract shall preclude Health Net from (i) offsetting Shared Risk Program deficits against payments to PPG including, but not limited to, surpluses from other Shared Risk Programs, stop loss payments, bonus or other incentive program payments; (ii) establishing reasonable Withhold Funds approved by DMHC as set forth in the applicable Addendum to offset PPG liability when the cost of Shared Risk Services exceed the Shared Risk Budget; or (iii) carrying forward such Shared Risk Program deficits to be applied against future year's program surpluses and Withhold Funds. Each PPG numbered site shall be calculated as a separate entity and any payments to or from PPG with multiple sites shall be net amount due/owed from all sites. In no event shall PPG be required to make any cash payment to Health Net for any deficit in a Shared Risk Program for institutional services.

4.3.2 If Health Net is obligated to pay for services which Health Net determines are the financial responsibility of PPG or which Health Net would not otherwise be obligated to pay, Health Net shall have the right to deduct the cost of such services from Capitation due to PPG. Health Net agrees not to deduct any amount as set forth in this Section without first giving PPG ten (10) days prior written notice during which time PPG shall have the opportunity to show cause why such amount should not be deducted by Health Net.

For purposes of calculating the amount Health Net shall pay and may deduct from Capitation under this provision, the following shall apply: (i) for PPG and Professional Providers, the FFS rates set forth in the applicable Addendum to this Agreement shall be utilized; (ii) for any other provider who is subcontracted to PPG, such subcontract rates shall be utilized if the subcontract documenting such rates are provided to Health Net by PPG sufficiently in advance of payment to allow Health Net to determine the payment amount under such subcontract; (iii) for a Participating Provider who is contracted with Health Net but who is not subcontracted with PPG or for whom PPG has not timely delivered to Health Net the subcontract documenting PPG's subcontract rate, Health Net's contract rate shall be utilized; or (iv) the actual amount paid by Health Net when none of the above applies.

**4.4 Reciprocity.** PPG agrees that Health Net may allow the FFS rates set forth in this Agreement to be used by other Participating Providers who may from time to time be responsible for compensating PPG for Covered Services rendered by PPG to a Beneficiary.

**4.5 Extension of Benefit Beneficiaries.** Capitation for a Beneficiary who is or becomes eligible for coverage under the extension of benefits provisions of the Beneficiary's Benefit Program shall be equal to the current amount for the plan type under which the Beneficiary is or was enrolled. PPG shall provide services to any Beneficiary who is totally disabled on the original date of the Beneficiary's Benefit Program. In the event payment for such Covered Services is obtained by Health Net from a prior carrier as an extension of benefits, Health Net shall reimburse PPG to the extent payment is received from the prior carrier.

#### **4.6 PPG's Claims Settlement Practices and Dispute Resolution Mechanism.**

4.6.1 PPG shall accept and pay all claims for Capitated Services provided to Beneficiaries. In the event that PPG does not pay such claims in full within applicable time limits, Health Net may pay such claims and deduct amount paid from Capitation pursuant to Section 4.3 of this Agreement.

4.6.2 PPG shall establish and maintain a fair, fast, and cost-effective dispute resolution mechanism to process and resolve PPG disputes in accordance with applicable State law, including the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations, unless Health Net assumes these functions.

4.6.3 PPG shall submit the following reports to Health Net with respect to claims for Capitated Services adjudicated by PPG, in the formats requested by Health Net, and which reports shall at a minimum, disclose PPG's compliance status with the enumerated statutes and regulations listed above.

(i) Monthly and Quarterly Claims Payment Reports ("Monthly/Quarterly Claims Report") within fifteen (15) days following the close of each of calendar month, except that the report for the final month of each quarter and the quarter shall be submitted within thirty (30) days following the close of the calendar quarter.

(ii) A Quarterly PPG Dispute Resolution Report which shall include a tabulated record of each dispute it received, categorized by date of receipt, and including the identification of the provider, type of dispute, disposition, and working days to resolution, as to each dispute received. Each individual dispute contained in a provider's bundled notice of dispute shall be reported separately to Health Net. Each Quarterly PPG Dispute Resolution Report shall be signed by and include the written verification of the principal officer(s) of PPG who have been duly designated to verify that the report is true and correct to the best knowledge and belief of the principal officer(s).

4.6.4 PPG shall make available to Health Net and the Department of Managed Health Care all records, notes and documents regarding its provider dispute resolution mechanism(s) and the resolution of its disputes.

4.6.5 PPG's dispute resolution mechanism shall provide any provider that submits a claims dispute to PPG's dispute resolution mechanism(s) involving an issue of medical necessity or utilization review with an unconditional right of appeal for that claim dispute to Health Net's dispute resolution process for a *de novo* review and resolution for a period of 60 working days from the date of PPG's initial determination of the issue.

4.6.6 PPG hereby authorizes Health Net to assume, and Health Net shall be obligated to assume, responsibility for the processing and timely reimbursement of PPG claims or for the administration of PPG's dispute resolution mechanism in the event that PPG fails to timely and accurately reimburse its claims (including the payment of interest and penalties) or fails to timely resolve provider disputes including the issuance of a written decision. Health Net may deduct all such payments from Capitation pursuant to this Agreement.

**NOTE TO NEGOTIATOR: This language is non-negotiable. Changes require VP and Legal approval**

4.6.7 Benefit Programs Funded with Federal Funds. PPG shall, for Benefit Programs funded in whole or in part with federal funds, ensure compliance with all State and/or federal laws, rules, regulations, and other mandates governing payment to providers whose names appear on one or more excluded provider lists maintained by State and/or federal agencies. Such agencies include, but are not limited to, the U.S. Office of the Inspector General (OIG), the CA Department of Healthcare Services (DHCS), and the General Services Administration (GSA). Where any such law, rule, regulation, and/or mandate impose a compliance obligation on a party, and where such compliance depends upon the other party's cooperation, the other party shall not unreasonably withhold such cooperation, sought on reasonable notice.

4.7 Payment for Covered Services Compensated on a FFS Basis. Health Net shall pay (or shall require Payor to pay), and PPG shall accept as payment in full for Covered Services compensated on a FFS basis under this Agreement, the amounts payable by Health Net or Payor under the terms and conditions set forth in the applicable Addenda to this Agreement, less Copayments, Coinsurance and Deductibles payable by Beneficiaries in accordance with the applicable Benefit Program or as otherwise permitted by the section of this Agreement covering Third Party Lien Recoveries.

4.8 Billing and Payment for Covered Services Compensated on a FFS Basis.

4.8.1 Billing. If PPG is compensated for a Complete Claim for a Covered Service on a FFS basis, PPG shall submit to Health Net/Payor, via Health Net's/Payor's electronic claims submission program or hardcopy as determined by Health Net/Payor, Complete Claims within one hundred twenty (120) days after PPG renders Covered Services unless PPG demonstrates good cause pursuant to applicable State law. Where Health Net and/or Payor is the secondary payor under Coordination of Benefits, PPG shall submit such Complete Claims accompanied by the explanation of benefits (EOB) or explanation of payment (EOP) from the primary payor to Health Net or a Payor within one hundred twenty (120) days of the date of the EOB/EOP. If PPG fails to comply with the timely claims submission/filing requirements set forth herein, Health Net shall have no obligation to pay for such claims, and PPG shall be prohibited from billing the Beneficiary as set forth in this Agreement.

PPG agrees that Health Net or a Payor shall have the right to determine the accuracy of all Complete Claims submitted to it, including but not limited to verification of diagnostic codes, procedure codes, any and all other elements of the submitted claim that affect the liability of Health Net/Payor, including whether PPG or Professional Provider has delivered the Covered Service in good faith and pursuant to the terms of an applicable Prior Authorization.

4.8.2 Payment. Health Net or Payor, as applicable, shall make FFS payment on each of PPG's timely-submitted Complete Claims in accordance with this Agreement and pursuant to the timeframes, procedures and other requirements of applicable State and federal law, including without limitation the calculation and payment of interest on overdue FFS payments. Payment of interest plus the amount of any Complete Claim payment deficiency shall be PPG's sole measure of damages (i.e., claims for consequential or incidental damages do not apply) for failure of Health Net or Payor to make timely payments. In no event shall Health Net be under any obligation to pay PPG for any claim or expense, payment of which is the responsibility of a self-funded Payor.

4.8.3 Appeals. In addition to the dispute resolution and arbitration rights described in Section 7.5 and Section 7.6 herein, PPG may dispute any Health Net action that adjusts, denies, or contests a FFS claim, billing practice, or other contractual provision if PPG submits a written dispute to the Health Net Provider Appeals Unit. Unless PPG demonstrates good cause pursuant to applicable State or federal law, Health Net or Payor shall not grant PPG reconsideration or appeal of a FFS claims payment for Covered Services that exceed three hundred sixty-five (365) days of Health Net's action or in the case of inaction, within three hundred sixty-five (365) days after the time for contesting or denying such claims (as defined in applicable State or federal law) has expired. Appeals shall be submitted by PPG in accordance with the procedures, and to the address for Health Net's Provider appeals unit, listed in Health Net Policies. If PPG fails to comply with the timely appeals submission/filing requirements set forth herein, Health Net shall have no obligation to pay for such claims except as otherwise required by applicable State and federal law, and PPG shall be prohibited from billing the Beneficiary as set forth in this Agreement. PPG and Health Net agree to comply with all timeliness and procedural requirements for submitting and responding to disputes submitted to Health Net's Provider appeals unit set forth in Health Net Policies.

4.8.4 Recoupment for Covered Services Compensated on a FFS Basis: Right of Offset. Health Net shall have the right to recoup overpayments for FFS claims, in accordance with the procedures and timelines set forth in applicable State and federal law.

4.8.4.1 PPG shall inform Health Net of any overpayment made to PPG and shall return any such overpayment to Health Net within thirty (30) business days from the date PPG first becomes aware of any such overpayment.

4.8.4.2 In the event Health Net determines that it has overpaid a claim, either in connection with an audit or otherwise, Health Net shall notify PPG in writing through a separate overpayment notice clearly identifying the claim, the name of the Beneficiary, the date of service and explanation of the basis upon which Health Net or Payor believes the amount paid on the claim was in excess of the amount due, including any interest and penalties that may be due on the claim. Such overpayment notice shall be issued within (i) three hundred sixty-five (365) days of the date of payment on the overpaid amount for claims arising from Benefit Programs regulated by the California Department of Managed Health Care or the California Department of Insurance, or within (ii) three (3) years from the date of payment on the overpaid amount for claims arising from other types of Benefit Programs that are not regulated by the California Department of Managed Health Care or the California Department of Insurance, or (iii) at any time, in the event of fraud and/or misrepresentation. Such notice shall be sent to PPG's address of record with Health Net for the receipt of claim related correspondence and payments unless PPG informs Health Net in writing of an alternative address to which such notices are to be sent at least thirty (30) days in advance of the address change.

4.8.4.3 If PPG does not contest Health Net's overpayment notice, PPG shall reimburse Health Net or Payor within thirty (30) business days from the date PPG receives the overpayment notice. If PPG fails to reimburse Health Net or Payor within those thirty (30) business days, then, beginning on the first calendar day after the expiration of this thirty (30) business day time period, Health Net shall commence offsetting, as set forth herein and interest shall accrue on any and all unpaid amounts at the rate of ten percent (10%) per annum.

4.8.4.4 In the event, PPG wishes to contest the overpayment notice, it must do so within thirty (30) business days from the date PPG receives the overpayment notice, by sending to Health Net's Provider Appeals Unit (at the address listed in Health Net Policies) a written appeal clearly stating the basis upon which PPG believes that the claim was not overpaid. Health Net shall review and make a decision with respect to PPG's appeal and shall notify PPG of its decision in writing within forty-five (45) business days from the date Health Net receives PPG's written appeal. In the event Health Net denies PPG's appeal and upholds Health Net's determination that an overpayment has been made, PPG shall reimburse Health Net or Payor for the overpayment within thirty (30) business days from the date it receives the written notice of Health Net's denial of PPG's written appeal. If PPG fails to reimburse Health Net or Payor within those thirty (30) business days, then beginning on the first calendar day after the expiration of this thirty (30) business day time period, Health Net may commence offsetting as set forth herein, and interest shall accrue on any and all unpaid amounts at the rate of ten percent (10%) per annum.

If Health Net or Payor exercises offset rights hereunder against PPG's current claims payments, Health Net or Payor shall give PPG a detailed written explanation identifying the specific overpayments that have been offset against the specific current claims payments.

4.8.4.5 If PPG desires to continue to contest the overpayment, it shall do so by following the dispute resolution process set forth in Sections 7.5 and 7.6 of this Agreement.

**4.9 Eligibility.** The parties acknowledge that verification of eligibility by Health Net is based on information available to Health Net from its customers on the date PPG seeks verification. Health Net shall use reasonable efforts to discourage its customers from retroactively canceling or adding Beneficiaries to a Benefit Program and encourage its customers to timely and accurately provide eligibility information.

In the event Covered Services are provided to an individual who is not a Beneficiary, based on an erroneous or delayed enrollment/eligibility list the following shall apply: (i) when the individual is enrolled in a substitute or replacement health care service or insurance plan which is obligated under applicable law to make payment to PPG for services delivered to the individual, PPG shall seek payment from the substitute or replacement carrier; and (ii) when the individual does not have substitute or replacement coverage, Health Net shall pay PPG for Covered Services delivered to the individual by PPG prior to the time PPG received notice of that individual's ineligibility pursuant to the terms and conditions of this Agreement, provided, however, for those Benefit Programs that are not regulated by the California Department of Managed Health Care or the California Department of Insurance, as an additional prerequisite for payment pursuant to this Section 4.9(ii), PPG shall submit to Health Net evidence that PPG has unsuccessfully sought payment through two billing cycles for all or a portion of such charges from the patient or the person having legal responsibility for the patient, or from the entity having financial responsibility for such payment. In the event Health Net pays PPG pursuant to this Section 4.9, PPG shall have no further right and shall not attempt to collect any additional payment from the individual for said services (except for applicable Copayments, Coinsurance and Deductibles) and PPG hereby assigns and transfers all legal rights of collection and Coordination of Benefits for services to Health Net.

**4.10 Collection of Copayments.** PPG shall collect all Copayments due from Beneficiaries, and shall not waive or fail to pursue collection of Copayments, Coinsurance and Deductibles from Beneficiaries except when otherwise permitted through PPG's established patient financial assistance program. PPG shall not charge Beneficiary any fees or Surcharges for Covered Services rendered pursuant to this Agreement (except for authorized Copayments, Coinsurance and Deductibles). In addition, PPG shall not collect a sales, use or other applicable tax from Beneficiaries for the sale or delivery of Covered Services unless otherwise required by applicable State or federal law. If Health Net or any Payor receives notice of any attempt to collect or the receipt of any inappropriate additional charges, including without limitation Surcharges, Health Net or Payor shall take appropriate action. PPG shall cooperate with Health Net or such Payor to investigate such allegations and shall promptly refund to the party who made the payment, any payment reasonably determined to be improper by Health Net or a Payor.

**4.11 Beneficiary Held Harmless.** PPG agrees that in no event, including, but not limited to, non-payment by Health Net or a Payor, insolvency of Health Net or a Payor, or breach of this Agreement, shall PPG or Professional Provider or Facility bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries

or persons acting on their behalf other than Health Net or a Payor for Covered Services provided pursuant to this Agreement except for Copayments, Coinsurance, Deductibles, Excluded Services or as otherwise expressly permitted under this Agreement. This provision shall not prohibit collection of Copayments, Coinsurance or Deductibles or Excluded Services or permitted third party liens under this Agreement made in accordance with applicable Benefit Program Requirements. PPG agrees that: (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Beneficiaries; and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between PPG and Beneficiaries or persons acting on their behalf. PPG agrees to address any and all concerns it has with claims payment through Health Net's provider appeal process pursuant to Health Net Policies.

**4.12 Conditions for Compensation for Excluded Services.** PPG may bill a Beneficiary for Excluded Services rendered or arranged by PPG to such Beneficiary only if the Beneficiary is notified in advance that the services to be provided are not Covered Services under the Beneficiary's Benefit Program, and the Beneficiary requests in writing that PPG render the Excluded Services, prior to PPG's rendition of such services.

**4.13 Coordination of Benefits.** PPG agrees to conduct Coordination of Benefits in accordance with federal and State laws and regulations and Health Net Policies ("Coordination of Benefit Rules"), including but not limited to, the prompt notification to Health Net or a Payor of any third-party entity who may be responsible for payment and collection of Copayments. PPG shall not bill Beneficiaries for any portion of Covered Services not paid by the primary carrier when Health Net or a Payor is the secondary carrier but shall seek payment from Health Net/Payor. When Health Net or a Payor is secondary under the Coordination of Benefits Rules, Health Net or a Payor shall pay PPG an amount up to Beneficiary's primary plan's copayment, coinsurance, or deductibles as applicable, where that payment does not exceed Health Net's contracted rate under this Agreement. In the event that Medicare is the primary carrier and Health Net Commercial Benefit Program is secondary, Health Net shall pay PPG only up to Medicare's allowable amount and/or the Beneficiary's Copayment, Coinsurance or Deductibles as applicable. When Health Net Medi-Cal is the secondary Payor, Health Net will not pay more than the PPG would receive if DHCS were paying secondary in accordance with Medi-Cal Coordination of Benefits. Such recoveries shall be performed in accordance with the applicable Benefit Program Requirements and Health Net Policies.

**4.14 Third Party Recoveries; Workers Compensation.** In the event PPG provides Covered Services to Health Net Beneficiaries for injuries resulting from the acts of third parties, or resulting from work related injuries, PPG shall have the right to recover from any settlement, award, or recovery from any responsible third-party the reasonable and necessary charges for such Covered Services to the extent permitted by applicable law. PPG shall notify Health Net of any such recovery and shall provide Health Net with an accounting of all such sums recovered. In the event PPG has recovered sums from a third party, PPG agrees to pay such recovered sums to Health Net up to the FFS amounts that Health Net paid to PPG, to the extent that Health Net has not recovered such amounts from its own third-party recovery efforts. PPG shall pay these amounts to Health Net within sixty (60) days of Health Net informing PPG of the amounts Health Net recovered from its own third-party recovery efforts, if any. This Section does not obligate, nor does it prohibit, either Health Net or PPG to undertake such third-party recovery efforts.

## V. **TERM AND TERMINATION**

**5.1 Term.** The term of this Agreement shall commence on the Effective Date and shall continue for a period of two (2) years thereafter (the "Initial Term"). Either party may terminate this Agreement effective as of the end of the Initial Term by providing at least one hundred eighty (180) days prior written notice to the other party. This Agreement shall automatically renew for successive one (1) year periods (the "Renewal Terms").

**5.2 Immediate Termination.** Either party may terminate this Agreement immediately upon notice to the other party, in the event of: (i) a party's violation of material law, rule or regulation; (ii) a party's failure to maintain the insurance coverage specified hereunder; or (iii) a felony conviction, or a plea of guilty, nolo contendere or no contest related to the medical and/or financial practices of a party. Health Net may terminate this Agreement immediately upon notice to PPG in the event of (iv) action taken by a State or federal regulator that results in a material restriction upon PPG's ability to operate a Facility or reportable discipline against PPG's license, accreditation, or certification; (v) Health Net's determination that the health, safety or welfare of any Beneficiary may be in jeopardy if this Agreement is not terminated; (vi) any material adverse finding as a result of a lawsuit or claim, related to the medical and/or financial practices of Provider.

**5.3 Termination Due to Material Breach.** In the event either party believes the other party has committed a material breach of this Agreement, the non-breaching party shall send the other party a written Notice of Breach and Demand to Cure ("Notice"). Without limiting either party's other termination rights under this Article V, in the event that either party fails to cure a

material breach of this Agreement within thirty (30) days of receipt of the Notice from the other party (the “Cure Period”), the non-defaulting party may terminate this Agreement by providing the defaulting party thirty (30) days prior written notice of termination. The non-defaulting party may exercise this termination option, if at all; within thirty (30) days of the date the Cure Period expires. Alternatively, Health Net may address such breach through cure measures deemed by Health Net to be appropriate, including but not limited to reduced capitation, withholding capitation, de-delegate any delegated functions, freezing enrollment, and/or the aforementioned termination of the Agreement. If the breach is cured within the Cure Period, or if the breach is one that cannot reasonably be corrected within the Cure Period, and the defaulting party is making substantial and diligent progress toward correction during the Cure Period to the reasonable satisfaction of the non-defaulting party, this Agreement shall remain in full force and effect. The provisions of this Section 5.3 shall not apply to Health Net claims payment timeliness issues which are governed by Article IV of this Agreement, unless and until the parties have completed the dispute resolution process set forth in Section 7.5 of this Agreement, and the dispute relates to habitual, chronic, and material claims payment timeliness issues.

In the event a Payor fails in its obligations under the terms of this Agreement to make Complete Claim payments to PPG when due, PPG may terminate the specific delinquent Payor without terminating this Agreement in its entirety, but only after all of the following conditions have been met: (i) Payor has failed to make a payment to PPG within the applicable time frame set forth in this Agreement; (ii) PPG provides written notice to Payor that such payment has not been made; (iii) Payor fails to remit payment to PPG within 10 days following Payor’s receipt of PPG’s written notice; (iv) PPG has made a good-faith attempt to meet with Health Net and Payor to resolve the payment issue(s).

**5.4 Termination Upon Notice.** Either party may terminate this Agreement during a Renewal Term for any reason or no reason upon one hundred eighty (180) days prior written notice to the other party. In the event either party provides the other party with such notice and following Health Net’s completion of any regulatory filing requirements, Health Net may, at its option, begin to transition Beneficiaries under this Agreement to another PPG.

**5.5 Professional Provider Termination.** The following provisions apply if PPG employs or otherwise engages Professional Providers to deliver Covered Services to Beneficiaries under the terms of this Agreement: PPG shall notify Health Net in writing at least ninety (90) days prior to any termination of an agreement between PPG and a Professional Provider, or if Professional Provider decides to close his or her medical practice or refuse to accept any additional Beneficiaries. When ninety (90) days prior written notice is not possible, PPG shall nonetheless provide as much advance notice as possible under the circumstances. PPG shall immediately notify Health Net whenever a Professional Provider fails to renew his or her agreement with PPG, whenever PPG has reason to believe a Professional Provider will fail to renew his or her agreement with PPG, and whenever PPG knows of an occurrence giving rise to an immediate termination of a Professional Provider by PPG. In the event of a Professional Provider termination, PPG shall ensure that there is sufficient capacity in PPG’s network to meet the access standards set forth in Health Net Policies.

Health Net may reasonably request, and PPG shall terminate any Professional Provider from providing Covered Services to Beneficiaries under this Agreement, at any time, upon at least thirty (30) days prior written notice from Health Net to PPG; provided, however, that no such termination shall be because a Professional Provider is advocating on behalf of a Beneficiary for health care services. PPG shall notify Health Net within five (5) working days of PPG becoming aware that a Professional Provider has been found guilty of a criminal offense or has been barred or sanctioned from participation under the Medicare program, in which case, upon Health Net’s written request, PPG shall terminate Professional Provider from providing Covered Services to Beneficiaries under this Agreement. If Health Net makes a determination, at its sole discretion, that treatment by a Professional Provider may jeopardize the health and safety of any Beneficiary, PPG shall terminate such Professional Provider from providing Covered Services to Beneficiaries under this Agreement upon Health Net’s written request.

PPG shall notify Beneficiaries who are affected by the termination of a specialist Professional Provider in writing, immediately upon notification of such termination but no later than thirty (30) calendar days prior to the effective date of such specialist’s termination. Applicable to Commercial HMO Benefit Programs only: For Beneficiaries covered by an HMO Benefit Program, PPG shall be required to issue a notice regarding the termination of a specialist’s contract that contains the following language in not less than eight-point type: “If you have been receiving care from a health care Provider, you may have a right to keep your Provider for a designated time period. Please contact Health Net’s customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO customers, by telephone at its toll-free number, 1-888-466-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at [www.dmhc.ca.gov](http://www.dmhc.ca.gov).”

**5.6 Information to Beneficiaries.** The parties each agree not to disparage the other in any information supplied by either party to Beneficiaries or other third parties in connection with any expiration, termination, or non-renewal of this Agreement. Health Net shall assume sole responsibility for notifying Beneficiaries, and Health Net may commence transferring Beneficiaries to alternate providers, prior to the effective date of any expiration, termination, or non-renewal of this Agreement in accordance with State and

federal law. If Beneficiaries seek services or Participating Providers order tests or seek services from PPG after the effective date of any expiration, termination or non-renewal, PPG shall inform such Beneficiaries and Participating Providers only that PPG no longer has an agreement with Health Net to render Covered Services and shall direct them to Health Net's customer service department. PPG shall not otherwise initiate communications with Beneficiaries or other third parties, verbally or in writing, concerning the expiration, termination or non-renewal of this Agreement and PPG's participation in Health Net's Participating Provider network, unless the parties have agreed in writing to the content of such communications in the context of a mutually agreed communication plan. Nothing in this provision is intended nor shall it be construed to prohibit or restrict PPG, Professional Provider, or other Participating Providers from (i) disclosing to any Beneficiary information regarding treatment options available, the risks, benefits and alternatives thereto, or (ii) disclosing to any Beneficiary the decision or process of Health Net or a Payor to Prior Authorize or deny benefits under a Benefit Program, or (iii) posting a reasonable notice on PPG's website or in PPG's Facilities listing by name those insurance carriers that are accepted by PPG, provided that the notice lists each name in substantially similar format. The terms of this Section shall survive termination of this Agreement.

**5.7 Effect of Termination.** In the event that a Beneficiary is receiving Covered Services on the date this Agreement expires, non-renews, and/or terminates, upon the request of Beneficiary and Health Net, PPG shall continue to provide Covered Services to the Beneficiary until the later of: i) treatment is completed; ii) the Beneficiary is discharged from an inpatient facility; iii) the Beneficiary is assigned to another Participating Provider; or iv) the anniversary date of the Beneficiary's Benefit Program. PPG's compensation for such Covered Services shall be at the FFS rates contained in the applicable Addendum hereto. If PPG's services are continued beyond the expiration, non-renewal, and/or termination of this Agreement, PPG shall be subject to the same contractual terms and conditions that were imposed on PPG prior to the expiration/non-renewal/termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.

**5.8 Termination Withhold from Capitation.** In the event either party gives the other party notice of termination as set forth in this Agreement, Health Net may, at its sole discretion, withhold up to one-third of each of the final three months of Capitation due PPG in addition to the Withhold Fund. Health Net may use such funds to offset any PPG liability to Health Net or for payment of claims for Capitated Services on behalf of PPG. PPG understands and agrees that a decision by Health Net to withhold any Capitation shall not relieve PPG of its obligations to perform under this Agreement. All amounts withheld by Health Net as set forth in this Section shall be included in any calculations regarding a final settlement between the parties.

Notwithstanding any other provision of this Agreement, in the event Health Net decides to withhold Capitation from PPG as set forth in this Section, Health Net may, upon three (3) days prior written notice to PPG, administer or oversee all or part of Capitated Services on behalf of PPG. PPG agrees to fully cooperate with Health Net in the administration of such claims, including providing all necessary information, and to take no action which may jeopardize the payment of such claims.

**5.9 Financial Settlement Upon Termination.** Within one hundred eighty (180) calendar days of the effective date of termination of this Agreement, an accounting shall be made by Health Net of the monies due and owing either party and payment shall be forthcoming by the appropriate party to settle such balance within thirty (30) calendar days of such accounting. PPG may request an independent audit of such Health Net accounting. Such audit may be performed by a mutually acceptable independent certified public accountant and shall be paid for solely by PPG. In the event such independent audit results in findings different from Health Net's findings, the parties shall meet and confer to resolve such differences.

## **VI. RECORDS, AUDITS AND REGULATORY REQUIREMENTS**

**6.1 Medical and Other Records.** PPG and Professional Providers shall prepare and maintain complete and accurate medical records, financial records and policies and procedures relating to this Agreement, and other books and records required by applicable federal and State law ("Records") in a form maintained in accordance with the general standards applicable to such Record keeping and in compliance with all applicable federal and State confidentiality and privacy laws. To the extent permitted by applicable State and federal confidentiality and privacy laws, PPG also agrees to provide such review data and other utilization information as may be required or requested under a Health Net Policy, including outcome reporting in accordance with, but not limited to, the Healthcare Effectiveness Data and Information Set (HEDIS), Version 3.0, or its successor. PPG shall maintain such Records for at least ten (10) years after the rendition of Covered Services, and Records of a minor child shall be kept for at least three (3) years after the minor has reached the age of eighteen (18), but in no event less than ten (10) years after the rendition of Covered Services. Additionally, PPG shall maintain other Records as may be necessary and reasonably requested by Health Net or Payor to comply with applicable federal and State law, and accrediting agency rules and regulations. PPG shall comply with and require Professional Providers and Facilities to comply with all confidentiality and Beneficiary records accuracy requirements. Records shall remain the

property of PPG. PPG shall provide Electronic Health Record (EHR) logon access to Health Net associates to view and extract complete medical records for Health Net members.

**6.2 Access to Records and Audits by Regulatory Agencies.** Subject only to applicable State and federal confidentiality or privacy laws, PPG shall permit designated representatives of local, State, and federal regulatory agencies having jurisdiction over Health Net or Payor and designated representatives of public and private exchange-based purchasers and accreditation agencies having jurisdiction over Health Net or Payor (collectively referred to as “Regulatory Agencies), access to PPG's Records, at PPG's place of business in this State during normal business hours, in order to audit, inspect and review and make copies of such Records. Such Regulatory Agencies shall include, but not be limited to, the State Department of Health Care Services, the State Department of Insurance, the State Department of Managed Healthcare, the United States Justice Department, CMS, the United States Department of Health and Human Services, Covered California, the National Committee for Quality Assurance, and any of their representatives. When requested by Regulatory Agencies, PPG shall produce copies of any such Records at no charge. Additionally, PPG agrees to permit Regulatory Agencies or their representatives, to conduct site evaluations, inspections and audits of PPG's and Professional Provider's Records, offices, and service locations at no cost to Health Net, Payor, and/or Regulatory Agencies, and within a reasonable time period, but not more than five (5) days after the request is submitted to PPG.

**6.3 Access to Records and Audits by Health Net.** Subject only to applicable State and federal confidentiality or privacy laws, PPG shall permit Health Net or its designated representative access to Records, at PPG and/or Professional Provider's place of business in this State during normal business hours, in order to audit, inspect, review, perform chart reviews, and duplicate such Records unless PPG agrees to a remote audit of such records. If performed on site, access to Records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least thirty (30) business days prior written notice by Health Net or its designated representative, but not more than sixty (60) days following such written notice. PPG shall attend an exit interview upon completion of the audit for the purpose of obtaining a mutually agreed upon reconciliation of the initial audit findings. Such exit interview shall be conducted at a mutually agreeable time at PPG's place of business in this State during normal business hours upon at least ten (10) days prior written notice by Health Net or its designated representative, but not more than thirty (30) days following such written notice. In the event PPG fails to attend the scheduled exit interview, PPG shall be deemed to have accepted the audit findings. If the audit was performed remotely, such exit interview shall consist of Health Net or its designated representative sharing its audit findings with PPG via written or electronic communications as determined by Health Net. PPG shall be allowed ten (10) days to contest the audit results. If not contested within ten (10) days, then PPG shall be deemed to have accepted the audit findings. Except when Health Net or its designated representative requests PPG Records that are related to care management or claims, PPG may require reasonable fees associated with the retrieval of PPG's Records and or duplication and preparation of requested PPG Records. Such fees shall not be more than those provided in California Health and Safety code Section 123110. Actions taken as a result of audit findings shall include adjustments for late charges, overcharges, and undercharges. Any such adjustments shall be the net amounts as reflected in the audit findings.

Any payments owed by one party to the other as the result of an audit shall be paid within thirty (30) days of the exit interview for such audit.

**6.4 Continuing Obligation.** The obligations of PPG under this Article VI shall not be terminated upon termination of this Agreement, whether by rescission, non-renewal or otherwise. After such termination of this Agreement, Health Net, Payors and Regulatory Agencies shall continue to have access to Records as necessary to fulfill the requirements of this Agreement and to comply with all applicable laws, rules, and regulations.

**6.5 Regulatory Compliance.** PPG, Professional Providers, and Health Net agree to carry out their respective obligations under this Agreement and in Health Net Policies in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to PPG's or Professional Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Health Net, Health Net may, in its sole discretion, offset such amounts against any amounts due PPG or Professional Provider from Health Net or require PPG or the Professional Provider to reimburse Health Net for such amounts.

## **VII. GENERAL PROVISIONS**

**7.1 Amendments.** This Agreement may be amended by mutual written agreement of the parties. Notwithstanding the foregoing, amendments required to comply with State or federal laws or regulations, requirements of Regulatory Agencies, or requirements of Accreditation Agencies, shall not require the consent of PPG or Health Net and shall be effective immediately on the effective date of the requirement. The parties acknowledge that changes to Health Net Policies that may affect a party's rights or obligations under this Agreement are addressed in Section 3.2 hereof.

**7.2 Separate Obligations.** The rights and obligations of Health Net under this Agreement shall apply to each Health Net subsidiary or affiliate and/or Payor accessing this Agreement only to the extent such Health Net subsidiary or affiliate and/or Payor has accessed this Agreement with respect to the Benefit Programs of such Health Net subsidiary or affiliate or Payor. A Health Net subsidiary or affiliate or Payor shall not be responsible for the obligations of any other Health Net subsidiary or affiliate or Payor under this Agreement with respect to the other's Benefit Programs. The terms of this Section 7.2 shall survive termination of this Agreement.

**7.3 Assignment.** PPG shall not assign this Agreement in whole or in part without Health Net's prior written consent, which consent shall not be unreasonably withheld, conditioned, or delayed. Any change in control of PPG resulting from a merger, consolidation, stock transfer or asset sale shall be deemed an assignment or transfer for purposes of this Agreement that requires Health Net's prior written consent. Health Net expressly reserves the right to assign, delegate or transfer any or all of its rights, obligations, or privileges under this Agreement to an entity controlling, controlled by, or under common control with Health Net, LLC.

**7.4 Confidentiality.** The Parties each agree that, unless disclosure is required by state or federal law, they shall hold Beneficiary health information and all confidential or proprietary information or trade secrets of each other, in trust and confidence. The Parties each agree that, unless disclosure is required by state or federal law, they shall keep strictly confidential all customized, non-template terms and rates set forth in this Agreement (including without limitation all addenda, exhibits, and any past or future amendments to this Agreement). The Parties further agree that in the event a disclosure is required by state or federal law, they shall disclose only the specific information mandated by such law in order to comply with the applicable legal requirements. Notwithstanding the foregoing, the Parties acknowledge and agree that this provision does not preclude disclosure by Health Net to Beneficiaries, customers, Regulatory Agencies and exchanges of certain financial terms of this Agreement, including without limitation detailed information contained in the Explanation of Benefits, Records under the conditions set forth in Article VI of this Agreement, and/or information regarding the method of compensation used by Health Net with respect to Health Net's Participating Provider networks, e.g., fee-for-service, capitation, shared risk pool, DRG or per diem. Health Net, Payors and PPG agree that such information shall be used only for the purposes contemplated herein, and not for any other purpose. Health Net, Payors and PPG agree that nothing in this Agreement shall be construed as a limitation of (i) PPG's rights or obligations to discuss with the Beneficiaries matters pertaining to the Beneficiaries' health regardless of Benefit Program coverage options or (ii) Health Net's rights or obligations with respect to subcontractors, including without limitation delegated providers, or (iii) disclosures to counsel or a consultant of a party for the purpose of monitoring regulatory compliance or rendering legal advice pertaining only to this Agreement or disclosures to internal or independent auditors of a party for audit purposes pertaining to this Agreement, provided that in either case the counsel or consultant agrees in writing to comply with the provisions of this Section 7.4 and agrees that the terms of this Agreement may not be disclosed to any other person or entity or used in any manner whatsoever in connection with any other agreement involving Health Net. The terms of this Section 7.4 shall survive termination of this Agreement.

*Note to Negotiator: The following language must be added and is non-negotiable.*

Nothing in this provision or this Agreement shall be construed to prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to an enrollee, Member, or subscriber of Health Net, to a qualified entity, as defined in Section 1395kk(e)(2) of Title 42 of the United States Code. All disclosures of data made under this provision shall comply with all applicable state and federal laws for the protection of the privacy and security of the data, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the federal Health Information Technology for Economic and Clinical Health Act, Title XIII of the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and implementing regulations.

*Note to Negotiator: The following language must be added if PPG is a public entity.*

If PPG is a public institution, subject to the provisions of the California Public Records Act ("PRA"), PPG shall notify Health Net promptly upon determining that confidential information from Health Net may be subject to a pending PRA request. Such notification shall include a reasonably specific description of the confidential information potentially subject to disclosure pursuant to the pending PRA request. To the extent permitted by law, PPG shall then give Health Net a reasonable time period to demonstrate to

PPG that some or all such records are: (i) not relevant to the pending PRA request and/or (ii) protected from disclosure pursuant to an exception codified in the PRA. If PPG thereafter concludes that some or all such records must be disclosed, PPG shall so notify Health Net and, to the extent permitted by law, give Health Net a reasonable opportunity to seek a court order protecting such records. Unless such a court order is secured in a timely fashion, PPG may disclose those records it reasonably determines must by law be released pursuant to the pending PRA request.

**7.5 Provider Dispute Resolution Procedure.** The parties agree to use the dispute resolution process set forth in this Section 7.5, and binding arbitration as described in Section 7.6, as the final steps in resolving any Dispute. The parties each understand and agree that any and all Health Net internal appeals processes (including without limitation as set forth in Section 4.8.4 hereof) must be properly pursued and exhausted before engaging in the dispute resolution process set forth in this Section 7.5.

(i) Meet and Confer Process:

Initiation: If the parties are unable to resolve any Dispute through applicable Health Net internal appeal processes, if any, the parties agree to meet and confer within thirty (30) days of a written request by either party in a good faith effort to informally settle any Dispute. The parties each agree and understand that the meet and confer requirements set forth herein may be satisfied only by meeting each of the following requirements: (a) an actual meeting must occur between executive level employees of the parties who have authority to resolve the Dispute and are each prepared to discuss in good faith the Dispute and proposed resolution(s) to the Dispute, and (b) such meeting may take place either in person or on the telephone at a mutually agreeable time, and (c) unless otherwise mutually agreed by the parties, neither party is allowed to have legal counsel present at the meeting or to substitute legal counsel for the executive level employee, and (d) such meeting and all related discussions between the parties shall be treated in the same manner as confidential protected settlement discussions under the State Rules of Civil Procedure.

Confidentiality: All documents created for the purpose of, and exchanged during, the meet and confer process and all meet and confer discussions, negotiations and proceedings shall be treated as compromise and settlement negotiations subject to applicable State law. To the extent the parties produce or exchange any documents, the parties agree that such production or exchange shall not waive the protected nature of those documents and shall not otherwise affect their inadmissibility as evidence in any subsequent proceedings.

(ii) Voluntary Mediation:

If the parties are unable to resolve any Dispute through the meet and confer process set forth above, and desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, a joint request for such services may be made to the American Arbitration Association ("AAA"), or the Judicial Arbitration and Mediation Services ("JAMS") prior to submitting a Dispute to arbitration, or the parties may initiate such other procedures as they may mutually agree upon.

**7.6 Binding Arbitration.** If the parties are unable to resolve a Dispute through the dispute resolution process set forth in Section 7.5, the parties agree that such Dispute shall be settled by final and binding arbitration, upon the motion of either party, under the appropriate rules of the AAA or JAMS, as agreed by the parties. Any Arbitrator must be either a judge, or an attorney licensed to practice law in the State of California, who is in good standing with the State Bar, and has at least ten (10) years of experience with health care matters and the arbitration of managed care disputes. The parties each understand and agree that the exhaustion of any Health Net internal appeals processes, and the Meet and Confer Process set forth in Section 7.5 (i) hereof are conditions precedent to binding arbitration under this Section 7.6. Notwithstanding the foregoing, nothing contained herein is intended to require binding arbitration of disputes alleging medical malpractice between a Beneficiary and PPG or to Disputes between the parties' alleging breaches of confidentiality of Beneficiary information, trade secret or intellectual property obligations. The arbitration shall be conducted in San Francisco, California or Los Angeles, California. The written demand shall contain a detailed statement of the matter and facts and include copies of all material documents supporting the demand. Arbitration must be initiated within one year after the date the Dispute arose by submitting a written notice to the other party.

The parties expressly agree that the deadlines to file arbitration set forth above shall not be subject to waiver, tolling, alteration, or modification of any kind or for any reason except for fraud. The failure to initiate arbitration before such deadlines shall mean the complaining party shall be barred forever from initiating such proceedings.

All such arbitration proceedings shall be administered by the AAA or JAMS, as agreed by the parties; however, the arbitrator shall be bound by applicable State and federal law and shall issue a written opinion setting forth findings of fact and conclusions of law. The

parties agree that the decision of the arbitrator shall be final and binding as to each of them. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. The arbitrator shall have no authority to make material errors of law or to award punitive damages or to add to, modify, or refuse to enforce any agreements between the parties. The arbitrator shall make findings of fact and conclusions of law and shall have no authority to make any award, which could not have been made by a court of law. The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of the entry of judgment on the award. The parties waive their right to a jury or court trial.

The parties recognize and agree that theirs is an ongoing business relationship, which may lead to sensitive issues with respect to the exchange of information related to any Dispute. The parties agree, therefore, to enter into such protective orders (including without limitation creating a category of discovery documents “for attorney’s eyes only” to the extent feasible given the nature of the evidence and the Dispute). All discovery information shall be used solely and exclusively for arbitration of the Dispute between the parties and may not be used for any other purpose. After the arbitration award becomes final, each party shall return or destroy all documents obtained from the other party during the course of the arbitration that are subject to a protective order, and within thirty (30) days of such date shall provide to the other party an officer’s certificate signed under penalty of perjury indicating that all such information has been returned or destroyed.

In all cases submitted to arbitration, the parties agree to share equally the administrative fee as well as the arbitrator's fee, if any, unless otherwise assessed by the arbitrator. The administrative fees shall be advanced by the initiating party subject to final apportionment by the arbitrator in this award. The parties agree that the content and decision of any arbitration proceeding shall be confidential unless disclosure is required by applicable State or federal statutes or regulations. The terms of Section 7.5 and Section 7.6 shall survive termination of this Agreement.

**7.7 Entire Agreement.** This Agreement represents the entire agreement between the parties hereto with respect to the subject matter hereof and supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding.

**7.8 Governing Law.** This Agreement shall be governed by and construed and enforced in accordance with the laws of the State, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern. Health Net is subject to the requirements of various local, State, and federal laws, rules and regulations including, but not limited to, the requirements of Chapter 2.2 of Division 2 of the California Health & Safety Code (the Knox-Keene Health Care Service Plan Act) and of Chapters 1 and 2, of Division 1 of Title 28 of the California Code of Regulations (“C.C.R.”) and Title 10 of the C.C.R. as well as the California Insurance Code. Any provision required to be in this Agreement by any of the above shall bind Provider and Health Net whether or not expressly set forth herein.

**7.9 Indemnification.**

7.9.1 **Responsibility for Own Acts.** Each party shall be responsible for its own acts or omissions and for any and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that party or its employees or representatives in the performance or omission of any act or responsibility of that party under this Agreement.

7.9.2 PPG agrees to indemnify, defend, and hold harmless Health Net, its agents, officers, and employees from and against any and all liability expense including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from PPG's performance or failure to perform its obligations hereunder.

7.9.3 Health Net agrees to indemnify, defend, and hold harmless PPG, its agents, officers, and employees from and against any and all liability expense, including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from Health Net's performance or failure to perform its obligations hereunder.

**7.10 Non-Exclusive Contract.** This Agreement is non-exclusive and shall not prohibit PPG or Health Net or Payor from entering into agreements with other health care providers or purchasers of health care services.

**7.11 No Third-Party Beneficiary.** Nothing in this Agreement is intended to, or shall be deemed or construed to, create any rights or remedies in any third party, including a Beneficiary. Nothing contained herein shall operate (or be construed to operate)

in any manner whatsoever to increase the rights of any such Beneficiary or the duties or responsibilities of PPG or Health Net or Payor with respect to such Beneficiaries.

**7.12 Notice.** Notices regarding the term, termination, breach, or renewal of this Agreement shall be given in writing in accordance with this Section 7.12 and shall be deemed given five (5) days post deposit in the U.S. mail, postage prepaid. If sent by hand delivery, overnight courier, or facsimile, notices shall be deemed given upon documentation of delivery. All notices shall be addressed as follows:

Health Net:

Health Net of California, Inc.  
Attn: Provider Contracts Administration - Regional  
21281 Burbank Blvd.  
Woodland Hills, CA 91367

Electronic copy to: [RegionalContractNotices@healthnet.com](mailto:RegionalContractNotices@healthnet.com)

PPG: \_\_\_\_\_  
\_\_\_\_\_  
Facsimile number: \_\_\_\_\_

The addresses to which notices are to be sent may be changed by written notice given in accordance with this Section. Notwithstanding the previous paragraph, Health Net may provide all other notices by electronic mail, through its provider newsletter, or on its provider website.

**7.13 Severability.** If any provision of this Agreement is rendered invalid or unenforceable by any local, State, or federal law, rule, or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.

**7.14 Status as Independent Entities.** None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between PPG and Health Net or a Payor other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither PPG nor Health Net/Payor, nor any of their respective agents, employees or representatives shall be construed to be the agent, employee, or representative of the other.

**7.15 Addenda.** Each Addendum to this Agreement is made a part of this Agreement as though set forth fully herein. Any provision of an Addendum that is in conflict with any provision of this Agreement shall take precedence and supersede the conflicting provision of this Agreement only with respect to the subject matter of the Addendum.

**7.16 Calculation of Time.** The parties agree that for purposes of calculating time under this Agreement, any time period of less than ten (10) days shall be deemed to refer to business days and any time period of ten (10) days or more shall be deemed to refer to calendar days unless the term "business" precedes the term "days".

**7.17 Waiver of Breach.** The waiver of any breach of this Agreement by either party shall not constitute a continuing waiver of any subsequent breach of either the same or any other provision(s) of this Agreement. Further, any such waiver shall not be construed to be a waiver on the part of such party to enforce strict compliance in the future and to exercise any right or remedy related thereto.

**THIS CONTRACT CONTAINS A BINDING ARBITRATION CLAUSE WHICH MAY BE ENFORCED BY THE PARTIES.**

IN WITNESS WHEREOF, the parties have executed this Agreement.

Note to Negotiator: Insert Full Legal Name of PPG/Provider here as set forth in the first paragraph of the Agreement above, and delete word "PPG"

PPG

HEALTH NET OF CALIFORNIA, INC.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

Regional Health Plan Officer  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

## PPG INFORMATION GRID

The information below is mandatory. Please complete all applicable fields.

**PPG must submit all National Provider Identifiers and a populated billing form (CMS 1500, or successor standard form) for each as directed by Health Net. In addition, the corresponding Tax Identification Number, with a completed W-9 for each TIN, shall be indicated. The billing information on the billing form must be consistent with the W-9 form.**

Provider/Facility Name, Address, Telephone and Facsimile Phone	Specialty	State License Number	Federal Tax Identification Number	Medicare Provider Number	National Provider Identifier	Medicaid Number	Other Language(s)	Drug Enforcement Agency Number
<i>Additional Location(s):</i>								
<i>Billing/Remit Address:</i>								

## **ADDENDUM A**

### **COMMERCIAL BENEFIT PROGRAMS**

This Addendum and accompanying exhibits apply to Covered Services delivered to Beneficiaries covered by commercial Benefit Programs that include but are not limited to HMO, POS, PPO, EPO, Medicare COB and any leased networks. All Covered Services delivered to a Beneficiary covered by a commercial Benefit Program shall be paid in accordance with this Addendum regardless of product specific name unless otherwise specifically agreed by the parties and set forth in a separate rate exhibit.

This Addendum includes each of the following with respect to commercial Benefit Programs: (i) Exhibit A-1, which covers commercial Benefit Program capitation provisions for Capitated Services rendered under this Addendum; (ii) Exhibit A-2, covers Age, Sex and Benefit Plan Factors for Capitated Services rendered under this Addendum; (iii) Exhibit A-3, which outlines the Division of Financial Responsibility (DOFR); (iv) Exhibits A-4 and A-5, which cover commercial Benefit Program Fee-For-Service (FFS) provisions for non-capitated Covered Services rendered under this Addendum and the FFS rate exhibit for this Addendum.

The Capitation provisions set forth herein shall be applicable to only those Beneficiaries listed on the applicable Capitation eligibility roster lists provided to PPG under the terms of this Agreement. PPG understands and agrees that the obligations of Health Net set forth in this Addendum are only the obligations of Health Net of California, a California Health Care Service Plan, and not the obligations of any other Health Net subsidiary or affiliate.

**EXHIBIT A-1**

**COMMERCIAL BENEFIT PROGRAMS  
CAPITATION PROVISIONS**

**I. GENERAL PROVISIONS**

**1.1 Capitation Payment.** Capitation shall be computed on the basis of the most current information available and shall be paid by Health Net by wire transfer on or before the fifteenth (15<sup>th</sup>) day of each month or the first business day following the fifteenth if the fifteenth is a holiday or on a weekend.

**1.2 Payment for Non-Capitated Services.** PPG and Professional Providers shall render Covered Services for which Capitation is not paid under this Addendum and for which PPG has no financial responsibility under the DOFR. Health Net shall compensate such services on a FFS basis at the rates set forth in Exhibit A-5, subject to the payment conditions set forth in Addendum E. PPG and Professional Providers shall submit claims for such services in accordance with the terms of this Agreement and applicable State and federal law.

**II. COMMERCIAL HMO BENEFIT PROGRAM PROFESSIONAL CAPITATION RATES**

Capitation for Beneficiaries under this Exhibit shall be determined on a monthly basis by multiplying the following normalized PMPM rates by the age, sex and Benefit Plan factors set forth herein for each assigned Beneficiary. Normalized PMPM rates represent the PMPM prior to the adjustment for PPG’s assigned Beneficiaries’ age, sex and Benefit Plan factors set forth in Exhibit A-2. Actual gross Capitation shall fluctuate from month to month to the extent that PPG’s age, sex, and Benefit Plan factor mix fluctuates.

Standard HMO Capitation	Small Group HMO Capitation
\$ [redacted] PMPM	\$ [redacted] PMPM

**III. COMMERCIAL HMO BENEFIT PROGRAM PROFESSIONAL STOP LOSS PROGRAM**

**SELECT OPTION ONE OR OPTION TWO**

**OPTION ONE:** PPG elects not to participate in the professional stop loss program. PPG shall provide Health Net with proof of professional stop loss coverage.

**OPTION TWO:** PPG’s professional stop loss threshold shall be \$ [redacted] per Beneficiary during the calendar year. The cost to PPG for the professional stop loss program shall be \$ [redacted] PMPM, which, shall be deducted from Capitation. PPG shall report potential stop loss claims and receive payment for such claims in accordance with procedures set forth in Health Net Policies.

**IV. INTEGRATED HEALTHCARE ASSOCIATION (IHA) ALIGN MEASURE PERFORM (AMP) HMO INCENTIVE PROGRAM**

**NOTE TO NEGOTIATOR:**

- **IHA AMP HMO is available for Professional Cap/Shared Risk PPGs Only**
- **Commercial Performance Program is available for Professional Cap/Shared Risk/Dual risk/Global Risk PPGs**

The IHA AMP HMO incentive program is a payment program that shall be handled separate from this Agreement.

**V. MEDICARE COORDINATION OF BENEFITS (COB)**

The Medicare COB Benefit Programs provide Beneficiaries with coverage for Copayments, Coinsurance, and Deductibles not otherwise paid by the Beneficiary’s primary coverage through Medicare. Capitation for Beneficiaries enrolled in the Medicare COB Benefit Program (“Medicare COB Beneficiaries”) compensates PPG for Copayments, Coinsurance, and Deductibles that would be normally a Beneficiary’s responsibility under Medicare.

**5.1. Capitation Rates.** Capitation rates for Medicare COB Beneficiaries shall be at the following PMPM levels, subject to Benefit Plan factors set forth in Addendum A:

Medicare COB HMO	Medicare COB POS
PMPM	PMPM

**5.2. Professional Stop Loss Programs.** Medicare COB Beneficiaries shall not be included in the Professional Stop Loss Program.

**VI. COMMERCIAL POS**

**INTEGRATED HEALTHCARE ASSOCIATION (IHA) ALIGN MEASURE PERFORM (AMP) HMO INCENTIVE PROGRAM**

**NOTE TO NEGOTIATOR:**

- IHA AMP HMO is available for Professional Cap/Shared Risk PPGs Only
- Commercial Performance Program is available for Professional Cap/Shared Risk/Dual risk/Global Risk PPGs

The IHA AMP HMO incentive program is a payment program that shall be handled separate from this Agreement.

**6.1. Commercial POS Benefit Program.** Under a POS Benefit Program, Beneficiaries may elect, at the time of obtaining each Covered Service, to utilize: i) HMO coverage through PPG; ii) coverage by self-referring to any PPO provider; or iii) indemnity coverage for self-referring to non-Participating Providers in accordance with Benefit Program requirements. Standard HMO Beneficiaries, Small Group HMO Beneficiaries, and Medicare COB HMO Beneficiaries may be eligible for Commercial POS Benefit Programs.

**6.2. Definitions.**

6.2.1 In-Network. Capitated Services provided or arranged by PPG.

6.2.2 Out-of-Network. In accordance with Benefit Program requirements, Covered Services provided as a result of a Beneficiary’s self-referral to a PPO or HMO Participating Provider or to a non-Participating Provider.

**6.3. Compensation.** Compensation to PPG for Commercial POS Beneficiaries shall include PPG professional Capitation for In-Network professional services.

**NOTE TO NEGOTIATOR: PER FINANCE, THE MAXIMUM RATE FOR THE PROFESSIONAL CAPITATION RATE BELOW WILL BE 95% OF THE HMO PMPM.**

**PLEASE REQUEST FINANCE APPROVAL BEFORE PROPOSING THIS PROFESSIONAL CAPITATION RATE TO THE PPG/PROVIDER.**

**6.4. Professional Capitation Rate.** PPG shall be compensated for rendering professional In-Network Services to Commercial POS Beneficiaries at the PMPM amount set forth below.

<b>Commercial POS Capitation</b>
\$ PMPM

6.5. **Professional Stop Loss Program.** The Professional Stop Loss Program includes coverage for In-Network Services, an optional program, as well as for Out-of-Network Services, a program in which PPG's participation is required.

(i) In-Network Professional Stop Loss.

**SELECT OPTION ONE OR OPTION TWO**

**OPTION ONE:** PPG elects not to participate in the Professional Stop Loss Program. PPG shall provide Health Net with proof of Professional Stop Loss coverage.

**OPTION TWO:** PPG's Professional Stop Loss threshold shall be as set forth in paragraph (ii) below. The cost to PPG for the Professional Stop Loss Program shall be \$ [REDACTED] PMPM, which, shall be deducted from Capitation. PPG shall report potential stop loss claims and receive payment for such claims in accordance with procedures set forth in Health Net Policies.

(ii) Out-of-Network Professional Stop Loss. PPG's Out-of-Network Professional Stop Loss threshold shall be \$ [REDACTED] per Commercial POS Beneficiary during the calendar year. The cost to PPG for the Out-of-Network Professional Stop Loss program shall be \$ [REDACTED] PMPM.

**NOTE TO NEGOTIATOR – CONFIGURATION HAS REQUESTED THAT PHARMACEUTICALS, INJECTABLES AND IMMUNIZATIONS ALL HAVE THE SAME REIMBURSEMENT RATES. PHARMACEUTICAL RATES ARE LISTED IN THE RATE EXHIBIT. PHARMACEUTICALS/INJECTIONS AND IMMUNIZATIONS SHARE THE SAME J-CODES. HAVING THE SAME RATES ENSURES AUTOMATION.**

## VII. INJECTABLES

### Injectables and Health Net Designated Participating Provider

As to injectables for which Health Net is responsible for reimbursement, PPG shall obtain such injectables from Health Net designated Participating Providers as described in Health Net Policies. If PPG does not utilize a Health Net designated Participating Provider, Health Net shall not be responsible for such injectables unless such injectables are not available from the Health Net designated Participating Provider. PPG shall be compensated at the Health Net Fee Schedule for such pharmaceuticals which shall be comprised of the lesser of 100% of provider's Allowable charges or XXX% of Medicare allowable for drugs with an established Medicare value. For drugs with no established Medicare value, the payment shall be the lesser of 100% of provider's Allowable charges or X% of AWP. AWP pricing shall be determined by Health Net utilizing a nationally recognized source for pharmaceutical pricing to be updated at least quarterly. PPG shall bill administered dosage in accordance with applicable HCPCS codes. Multi-dose vials shall be reimbursed on a per dose basis.

Such rates shall be payment-in-full, except for the applicable Coinsurance amount. Health Net shall reimburse PPG at such rates, less the applicable Coinsurance. Health Net shall not be responsible for reimbursing the Beneficiary's Professional Provider for such injectables. PPG shall seek reimbursement from Health Net for such injectables and shall submit claims for such services to Health Net using the CMS 1500 Form and the appropriate CPT-4, HCPCS and NDC codes.

As to California Health & Safety Code §§ 1375.5 & 1375.8 services, which include chemotherapy drugs, self-injectables, hemophilic blood factors, adult immunizations, transplant immunosuppressives, and therapeutic injectable and implantable medications (described in regulation as "other") with a cost per value greater than \$250.00 the Parties agree that risk shall be accepted on such injectables, as set forth in the Division of Financial Responsibility Matrix. Such cost value shall be determined by the Medicare allowable fee schedule. If such medication is not listed on the Medicare allowable fee schedule, the value will be determined by the Average Wholesale Price (AWP) as calculated by Health Net in accordance with the CMS methodology.

## VIII. IMMUNIZATIONS

**Immunizations:** The applicable DOFR sets forth PPG and Health Net's respective financial responsibility for Immunizations.

Where Health Net has financial responsibility for a particular immunization, PPG shall seek reimbursement from Health Net for that immunization by submitting claims for such service to Health Net using the CMS 1500, or successor standard form, and the appropriate CPT-4, HCPC, or other applicable procedure code in accordance with Health Net Policies. Health Net shall compensate PPG in accordance with Exhibit A-5, subject to the applicable payment conditions in Addendum E, as payment-in-full, except for applicable Copayments. Health Net shall not be responsible for reimbursing Professional Providers for immunizations.

For any new immunizations approved by American Academy of Pediatrics and the Advisory Committee on Immunization Practices (ACIP) of the US Public Health Service after the effective date of this Agreement, Health Net shall reimburse PPG at the lowest of the following: (1) the average wholesale price (AWP) as published in the Drug Topics Red Book, or (2) the lowest acquisition cost through sources made available to PPG by Health Net, unless and until Health Net develops experiential data for that new immunization, and PPG has agreed to accept financial responsibility for that new immunization.

## EXHIBIT A-2

### AGE, SEX AND BENEFIT PLAN FACTORS

The age, sex and benefit plan factors shall be developed by Health Net based upon actuarial assumptions consistent with existing actuarial assumptions and Health Net's utilization experience. Such factors, as updated periodically to reflect changing demographic and utilization patterns shall be forwarded to PPG and are incorporated into this Agreement by reference.

1. A. Age, Sex and Benefit Plan Factors for PPG Capitation and Shared Risk Budgets:

#### **A.1 Age, Sex Factors for PPG Capitation and Hospital Capitation/ Shared Risk Budgets.**

<b>Sex</b>	<b>Age</b>	<b>Prof Factor</b>	<b>Inst Factor</b>
Child	0	2.008	5.228
	1	1.075	0.644
	2 – 4	0.598	0.406
	5 – 9	0.439	0.296
	10 – 14	0.418	0.338
	15 – 19	0.590	0.607
Female	20 – 24	1.195	1.066
	25 – 29	1.653	1.431
	30 – 34	1.509	1.315
	35 – 39	1.378	1.143
	40 – 44	1.322	1.031
	45 – 49	1.386	1.102
	50 – 54	1.551	1.338
	55 – 59	1.794	1.741
	60 – 64	2.090	2.313
	65 +	2.414	2.907
	Medicare Eligible	1.000	1.000
Male	20 – 24	0.398	0.477
	25 – 29	0.477	0.486
	30 – 34	0.546	0.506
	35 – 39	0.626	0.589
	40 – 44	0.734	0.768
	45 – 49	0.890	1.087
	50 – 54	1.139	1.580
	55 – 59	1.516	2.203
	60 – 64	2.009	2.880
	65 +	2.561	3.586
	Medicare Eligible	1.000	1.000

## A.2 Benefit Plan Factors for Capitation and Shared Risk Budgets

### Standard HMO

Plan	Pro Factor	Instl Factor
100	0.6755	0.7686
101	0.9679	0.9771
104	0.9492	0.9733
106	0.9908	0.9903
109	1.0481	0.9776
10F	0.9485	0.8984
10J	0.8439	0.8794
10S	0.9483	0.9776
10T	1.0517	0.9888
10V	0.8532	0.9728
10W	0.9497	0.9779
10Z	0.9552	0.9776
112	0.9457	0.9782
115	0.9464	0.9624
117	0.8867	0.9056
11M	0.9017	0.9725
11R	0.8785	0.9084
11S	0.9894	0.9811
11T	0.9325	0.9805
11X	0.9481	0.9699
11Y	0.9452	0.9733
12B	1.0543	0.9776
12D	0.9452	0.9776
12G	0.9457	0.9782
12P	0.8998	0.9475
12R	0.9423	0.9371
12S	0.9485	0.9771
12U	0.9371	0.9693
12W	0.9146	0.9774
12X	0.9590	0.9837
12Z	0.9710	0.9779
131	0.9464	0.9308
132	0.9884	0.9897
133	0.9481	0.9587
134	0.8929	0.9463
135	0.9903	0.9400
138	0.8532	0.8817
13K	1.1107	1.0222
140	0.9598	0.9742
142	0.9101	0.9739
143	0.9624	0.9452
146	0.9543	0.9779
147	0.9559	0.9779
14L	0.9423	0.9722
14N	0.9385	0.9397
14U	1.0450	0.9035
14V	1.0450	0.8771
14W	0.9965	0.9035
14X	0.9965	0.8771

Plan	Pro Factor	Instl Factor
14Y	0.9965	0.9035
14Z	0.9965	0.8771
150	0.9485	0.9035
151	0.9485	0.8771
152	0.9015	0.9035
153	0.9015	0.8771
154	0.8821	0.9035
155	0.8821	0.8771
156	0.8315	0.9035
157	0.8315	0.8771
158	0.8566	0.9030
159	0.8566	0.8768
15B	0.8129	0.9030
15C	0.8129	0.8765
15D	1.0565	0.9817
15E	1.0761	0.9817
15G	1.0037	0.9728
15N	0.9485	0.9776
15P	0.9932	0.9776
15Q	1.0512	0.9776
15R	0.9015	0.9394
15S	0.8671	0.9544
15T	0.9452	0.9776
15U	0.9932	0.9673
15V	0.9965	0.9035
15W	0.9965	0.8771
15X	0.9485	0.9035
15Y	0.9485	0.8771
15Z	0.9015	0.9033
160	0.9015	0.8771
161	0.8616	0.9033
162	0.8616	0.8771
164	0.9082	0.9774
165	1.0178	0.9794
16S	0.9965	0.9776
16T	0.8704	0.9544
16X	1.0450	0.9776
16Y	1.0512	0.9888
17J	0.9485	0.9733
17M	0.9526	0.9782
17N	0.9117	0.9776
17O	0.8912	0.9736
17Q	0.9989	0.9805
17R	0.9932	0.9805
17S	0.9519	0.9937
17T	0.9488	0.9736
17W	1.0066	0.9894
184	0.9452	0.9354
185	0.8876	0.9733

Plan	Pro Factor	Instl Factor
187	0.9932	0.9601
188	0.9932	0.9756
189	0.9380	0.9733
18W	0.9301	0.9314
18Y	0.9490	0.9438
18Z	0.9039	0.9748
192	0.9485	0.9776
196	0.8250	0.8771
198	0.9418	0.9581
199	0.8129	0.9728
19B	0.9576	0.9779
19C	0.8606	0.9779
19D	0.8289	0.9199
19Q	0.8867	0.9056
19R	0.9015	0.9024
19S	0.8193	0.7895
19T	0.9965	0.9756
19V	0.8427	0.9596
19W	0.8081	0.9326
19X	0.8396	0.8022
19Y	0.9208	0.9888
1D1	0.8193	0.7927
1D7	0.8277	0.8122
1D8	0.9184	0.9662
1E2	0.8621	0.8846
1E3	0.7689	0.6942
1F3	0.8726	0.9027
1F4	0.7933	0.9168
1F5	0.9275	0.8872
1FA	1.0006	0.9765
1G1	0.8226	0.9242
1G3	0.8573	0.9027
1G4	0.8527	0.9165
1G5	0.9485	0.9742
1G6	0.8315	0.9297
1G7	0.7770	0.8116
1G8	0.9399	0.9354
1I2	0.8370	0.8935
1I3	0.8845	0.9389
1I5	0.8353	0.8843
1I9	0.7713	0.9337
1IA	1.0059	0.9903
1KA	0.9973	0.9811
1OA	1.0188	0.9834
1Q7	0.8492	0.9555
1Q8	0.8759	0.9317
1Q9	0.8095	0.7528
1R1	0.8396	0.6528
1R2	0.8704	0.9280

Plan	Pro Factor	Instl Factor
1R4	0.9586	0.9604
1RA	1.0565	0.9765
1TF	0.8917	0.9018
1TG	0.8917	0.8384
1TH	0.9418	0.9656
1TJ	0.8917	0.9650
1TK	0.8437	0.9012
1TL	0.8437	0.8378
1TM	0.7565	0.7100
1TP	0.8437	0.7243
1TQ	0.8437	0.8315
1TR	0.7565	0.8306
1TS	0.6755	0.8294
1TT	0.7565	0.7697
1TU	0.6755	0.7686
1UN	0.8867	0.9056
1UP	0.8867	0.8401
1VZ	0.8917	0.9018
1WB	0.8437	0.9644
1WC	0.8437	0.9012
1WD	0.8437	0.8378
1WF	0.6755	0.7088
1WG	0.8437	0.7243
1WH	0.8437	0.8315
1WJ	0.7565	0.8306
1WK	0.6755	0.8294
1WL	0.7565	0.7697
1WM	0.6755	0.7686
1WN	0.9418	0.9656
1WQ	0.8917	0.9650
1XM	0.8628	0.8315
1XQ	0.7830	0.7697
1XS	0.9519	0.9656
1XV	0.9065	0.9018
1XW	0.9065	0.8384
1XX	0.9519	0.9656
1XY	0.9519	0.9024
1XZ	0.9065	0.9650
1YB	0.8628	0.9644
1YC	0.8628	0.9012
1YD	0.8628	0.8378
1YE	0.7830	0.7100
1YF	0.7089	0.7088
1YG	0.8628	0.7243
1YH	0.8628	0.8315
1YJ	0.7830	0.8306
1YK	0.7089	0.8294
1YL	0.7830	0.7697
1YM	0.7087	0.7686

CALIFORNIA

Provider Participation Agreement – Revised 1.10.25

Participation Physician Group (PPG) Template – DMHC Approved 2008

Plan	Pro Factor	Instl Factor
1ZF	0.8957	0.9056
1ZG	0.9089	0.9056
1ZH	0.9089	0.8401
1ZJ	0.8957	0.8401
205	0.9397	0.9774
20E	0.8566	0.8852
20G	0.8418	0.9521
20H	0.9015	0.9596
210	0.8917	0.8384
211	0.8129	0.5767
212	0.8917	0.9018
213	0.8437	0.9644
214	0.8437	0.9012
215	0.8437	0.8378
216	0.7565	0.7100
217	0.6755	0.7088
219	0.8437	0.7243
21C	0.8437	0.8315
21G	0.7565	0.8306
21J	0.6755	0.8294
21M	0.7565	0.7697
21N	0.6755	0.7686
21Q	0.9418	0.9656
21R	0.9418	0.9024
21S	0.8917	0.9650
21T	0.8129	0.9728
21U	0.8019	0.8877
21V	0.7935	0.8932
21W	0.9485	0.9776
24E	0.7078	0.7723
24Q	0.8461	0.9337
24T	0.8666	0.9308
25N	0.8446	0.9297
268	0.8575	0.8765
26B	0.8167	0.9618
26J	0.8437	0.8665
26L	0.9588	0.9733
26X	0.8867	0.9492
26Y	0.7973	0.9015
270	0.9015	0.9776
272	0.8790	0.7660
274	0.9072	0.9354
278	0.9211	0.9759
27E	0.8384	0.6835
27F	0.7653	0.4687
27G	0.8542	0.6936
27H	0.9586	0.9377
27S	0.8427	0.8699
27Y	0.9304	0.9547
284	0.7990	0.9142
285	0.8922	0.9317
287	0.8969	0.9788

Plan	Pro Factor	Instl Factor
288	0.9039	0.9277
28D	0.9965	0.8372
28E	0.9485	0.8372
28F	0.9015	0.8372
28G	0.8616	0.8372
28H	1.0450	0.8372
28J	0.9965	0.8372
28K	0.9485	0.8372
28L	0.9015	0.8372
28M	0.8821	0.8932
28N	0.8315	0.8932
28P	0.8566	0.8369
28Q	0.8129	0.8366
28V	0.9017	0.9349
28W	0.9681	0.9888
28X	0.9449	0.9360
28Y	0.8981	0.8926
28Z	0.9015	0.9774
290	0.8998	0.9828
291	0.9676	0.9776
292	0.9908	0.9834
296	0.9433	0.9782
297	0.9953	0.9561
298	0.9067	0.9774
299	0.9433	0.9837
29B	0.9970	0.9825
29C	0.9146	0.9774
29D	0.8986	0.9716
29E	0.8537	0.9374
29G	0.9578	0.9745
29K	0.9973	0.9848
29L	0.8986	0.9544
29M	1.0481	0.9024
29N	1.0512	0.8760
29P	0.9965	0.9024
29Q	0.9965	0.8760
29R	0.9485	0.9024
29S	0.9485	0.8760
29T	0.9015	0.9024
29U	0.9015	0.8760
29V	0.8821	0.9024
29W	0.8821	0.8760
29X	0.8315	0.9024
29Y	0.8315	0.8760
29Z	0.8566	0.9021
2BF	0.9065	0.8384
2BG	0.9065	0.9018
2BH	0.8628	0.9644
2BJ	0.8628	0.9012
2BK	0.8628	0.8378
2BL	0.7830	0.7100
2BM	0.7089	0.7088

Plan	Pro Factor	Instl Factor
2BN	0.8628	0.7243
2BP	0.8628	0.8315
2BQ	0.7830	0.8306
2BR	0.7089	0.8294
2BS	0.7830	0.7697
2BT	0.7087	0.7686
2BU	0.9519	0.9656
2BV	0.9519	0.9024
2BW	0.9065	0.9650
2C3	1.0512	0.9811
2C8	0.8296	0.9575
2CQ	0.8437	0.9644
2CR	0.8998	0.9056
2CW	0.7845	0.7775
2CX	0.7845	0.8389
2CY	0.7909	0.7775
2CZ	0.7909	0.8389
2D3	0.9354	0.9745
2D8	0.7851	0.8378
2DD	0.9485	0.9035
2DF	0.8566	0.9030
2DQ	0.8129	0.9018
2DS	0.7708	0.8900
2DT	0.8193	0.7892
2ED	0.8129	0.9030
2EN	0.8129	0.8366
2EP	0.8566	0.9021
2ER	0.9418	0.8329
2EY	0.8437	0.7709
2FF	0.8129	0.6950
2FG	0.9015	0.9679
2FH	0.8704	0.9452
2FJ	0.8566	0.9679
2FQ	0.9965	0.9756
2FS	0.9488	0.9779
2FT	0.6898	0.7105
2G5	0.9041	0.9412
2G6	0.9414	0.9409
2GB	0.9385	0.9656
2GE	0.9020	0.9730
2GF	0.9418	0.9397
2H2	0.9017	0.9498
2H5	0.9015	0.9380
2H6	0.7995	0.9242
2H7	0.9550	0.9509
2H8	0.8836	0.9426
2H9	0.7734	0.8843
2I4	0.9211	0.9555
2I5	0.8124	0.9113
2I6	0.7804	0.8401
2I7	0.9254	0.9073
2I9	0.9031	0.9300

Plan	Pro Factor	Instl Factor
2J1	0.9418	0.9656
2J2	0.9418	0.9024
2J3	0.9418	0.8455
2J4	0.9418	0.8389
2J5	0.9418	0.7255
2J6	0.9418	0.8329
2J7	0.9418	0.7720
2J8	0.8917	0.9650
2J9	0.8917	0.9018
2JZ	0.8222	0.8027
2K1	0.8917	0.8450
2K2	0.8917	0.8384
2K3	0.8917	0.6824
2K4	0.8917	0.8320
2K5	0.8917	0.7714
2K6	0.8437	0.9644
2K7	0.8437	0.9012
2K8	0.8437	0.8444
2K9	0.8437	0.8378
2KB	0.8437	0.8378
2KC	0.8437	0.6818
2KD	0.7565	0.8504
2KF	0.8917	0.9033
2KG	0.7985	0.8510
2KH	0.7247	0.8007
2KJ	0.5835	0.7898
2KL	0.8315	0.9027
2KN	0.7383	0.5744
2KP	0.9965	0.9776
2KR	0.8437	0.9021
2KS	0.9418	0.9038
2KT	0.8437	0.8378
2KU	0.7247	0.8007
2KV	0.8095	0.8108
2KW	0.9015	0.9776
2KX	0.9418	0.8329
2KZ	0.8917	0.7714
2L1	0.8437	0.6818
2L2	0.8437	0.8315
2L3	0.8437	0.7709
2LC	0.8437	0.8315
2LG	0.9015	0.9774
2LJ	0.9965	0.9776
2LK	0.9485	0.9776
2LL	1.0512	0.9776
2LM	0.8881	0.8846
2LP	0.9163	0.9035
2LQ	0.8754	0.9030
2LZ	0.8358	0.9018
2MB	0.9163	0.9578
2MC	0.7973	0.8900
2MD	0.8523	0.7892

Plan	Pro Factor	Instl Factor
2ME	0.8087	0.6942
2MN	0.8358	0.9030
2MW	0.8754	0.8369
2MX	0.8358	0.8366
2MY	0.8754	0.9021
2NB	0.9519	0.8329
2ND	0.9065	0.8450
2NF	0.9065	0.8320
2NH	0.8628	0.8444
2NJ	0.8628	0.7709
2NK	0.8358	0.6950
2NL	0.9163	0.9679
2NM	0.8845	0.9452
2NN	0.8754	0.9679
2NR	0.9163	0.9730
2NX	1.0018	0.9756
2NZ	0.9662	0.9779
2PB	0.7230	0.7105
2PD	0.9537	0.9693
2PF	0.7976	0.8900
2PG	0.7233	0.7105
2PL	0.8754	0.9776
2PM	0.9168	0.9730
2PU	0.8033	0.7766
2SL	0.8413	0.8027
2SM	0.8628	0.8378
2SN	0.8628	0.6818
2SP	0.7830	0.8504
2SQ	0.6113	0.6479
2SR	0.9065	0.9033
2SS	0.8215	0.8510
2ST	0.7515	0.8007
2SU	0.6232	0.7898
2SV	0.6375	0.7835
2SW	0.8575	0.9027
2SY	0.7650	0.5744
2SZ	1.0018	0.9776
2T2	0.8449	0.9501
2T5	0.7995	0.8444
2TG	0.8628	0.8378
2TH	0.7515	0.8007
2TJ	0.8286	0.8108
2TL	0.9519	0.8329
2TQ	0.8628	0.8315
2TR	0.7973	0.8900
2TT	0.9586	0.9624
2TU	0.9163	0.9774
2TW	1.0018	0.9776
2TX	0.9586	0.9776
2TY	1.0512	0.9776
300	0.8566	0.8757
301	0.8129	0.9018

Plan	Pro Factor	Instl Factor
302	0.8129	0.8754
304	0.9457	0.9716
305	0.9485	0.9776
30D	0.9015	0.9469
30Z	0.9524	0.9805
316	0.9473	0.9035
317	1.0161	0.9811
318	0.8898	0.8932
319	0.9672	0.9696
31J	0.8566	0.9776
31K	0.8222	0.8125
31M	0.9103	0.9578
31Q	0.8570	0.9730
31R	0.8981	0.9670
31T	0.8807	0.9331
31U	0.8922	0.9504
31Y	0.9547	0.9489
31Z	0.8917	0.9627
320	0.9485	0.7732
321	0.9485	0.7665
322	0.9485	0.7016
323	0.9015	0.7729
324	0.9015	0.7663
325	0.9015	0.6953
326	0.8566	0.7729
327	0.8566	0.7660
328	0.8566	0.6953
329	0.8129	0.7726
32B	0.8129	0.7660
32C	0.8129	0.6950
32D	0.9485	0.9682
32E	0.9485	0.8343
32F	0.9015	0.9303
32G	0.9015	0.9679
32H	0.9048	0.8326
32J	0.8704	0.9452
32K	0.8566	0.9679
32L	0.8566	0.8340
32M	0.8129	0.9676
32N	0.8129	0.8338
33K	0.8193	0.8036
33X	0.7997	0.7252
33Y	0.7995	0.8079
33Z	0.8226	0.9242
342	0.9079	0.9685
345	0.9168	0.9354
346	0.9545	0.9351
347	0.9070	0.9354
348	0.9973	0.9820
349	0.9449	0.9251
34B	0.8351	0.9380
34C	0.8938	0.8800

Plan	Pro Factor	Instl Factor
34D	0.7990	0.8151
34F	0.9684	0.9475
34K	0.8757	0.9007
34L	0.8709	0.9420
34M	0.8351	0.8157
34N	0.8578	0.8765
34Q	0.8090	0.8349
34W	0.8764	0.8938
34Z	0.8764	0.8938
350	0.8764	0.8938
356	0.8186	0.8036
35D	1.0515	0.9776
35J	0.9141	0.9506
35K	0.8981	0.9374
35L	0.8437	0.9073
35P	0.8998	0.9590
35Q	0.8449	0.9771
35R	0.8680	0.9837
35S	0.8931	0.9774
35T	0.8539	0.9828
35V	0.8449	0.9828
35Y	0.9027	0.9673
35Z	0.9020	0.9573
360	0.9488	0.9736
362	0.9884	0.9897
363	0.9435	0.9834
364	0.9051	0.9751
367	0.8539	0.9828
379	0.9015	0.9627
37B	0.8998	0.9848
37C	0.9015	0.9021
37E	0.9994	0.9776
37F	0.9039	0.9644
37L	0.8532	0.9776
37M	0.8981	0.9805
37Q	0.9072	0.9461
37R	0.9576	0.9854
37S	0.9015	0.9730
37U	0.9452	0.9733
37V	0.8981	0.9776
39G	0.9528	0.9776
39L	0.8398	0.9722
3A2	0.8566	0.9679
3A6	0.9067	0.9429
3A7	0.9588	0.9716
3B1	0.9020	0.8995
3B2	0.8578	0.9168
3B6	0.9648	0.9776
3B7	1.0233	0.9756
3B8	0.8757	0.9776
3BB	0.8678	0.9311
3BH	0.8917	0.9004

Plan	Pro Factor	Instl Factor
3BL	0.9065	0.9004
3BQ	0.9065	0.9650
3BS	0.8215	0.8510
3BT	0.9065	0.9524
3BV	0.9163	0.9679
3BX	0.8566	0.7660
3BZ	0.9488	0.9736
3C6	0.8566	0.9728
3C9	0.8580	0.9294
3CC	0.8129	0.8338
3D1	0.8580	0.9294
3D3	0.7832	0.8912
3D4	0.7226	0.6089
3D5	0.7309	0.7301
3DJ	0.7985	0.6812
3DK	0.9418	0.9710
3DL	0.8917	0.9705
3DP	0.7985	0.6812
3DS	0.8754	0.7660
3EX	0.8456	0.6818
3F1	0.9538	0.9776
3FC	0.8215	0.6812
3FD	0.9519	0.9710
3FE	0.9065	0.9705
3FH	0.8215	0.6812
3FL	0.9485	0.9733
3G8	0.7579	0.7775
3G9	0.7579	0.8389
3GJ	0.8095	0.8108
3GK	0.8917	0.8384
3GL	0.9485	0.9776
3GM	0.8917	0.9705
3GN	0.9418	0.9710
3GP	0.9586	0.9733
3H3	0.7708	0.9015
3H8	0.9089	0.9550
3HR	0.9519	0.9710
3HT	0.9065	0.8320
3HY	0.8090	0.8450
3JH	0.8628	0.9012
3JL	0.7089	0.7088
3JM	0.8628	0.7243
3JN	0.8628	0.8315
3JQ	0.7089	0.8294
3JT	0.9519	0.9656
3JV	0.9065	0.9650
3KA	0.8532	0.9728
3KF	0.8473	0.8705
3KH	0.9344	0.9458
3KP	0.8133	0.8585
3KQ	0.9041	0.9435
3KT	0.9041	0.9435

Plan	Pro Factor	Instl Factor
3LA	0.9481	0.9452
3LH	0.6755	0.8294
3LP	0.9459	0.9719
3LS	0.9301	0.9314
3MF	0.9399	0.9354
3MH	1.0059	0.9903
3N9	0.8566	0.7749
3PS	0.8286	0.7528
3PT	0.8585	0.6528
3SA	0.8986	0.9748
3SJ	0.7990	0.9142
3SK	0.9015	0.8372
3SM	0.9485	0.8760
3SN	0.9015	0.9024
3TA	0.9490	0.9751
3TD	0.7851	0.8378
3TG	0.9017	0.9498
3TJ	0.8836	0.9426
3TL	0.9031	0.9300
3TS	0.9015	0.9303
3UA	1.0006	0.9794
3UJ	0.8566	0.9728
3UQ	0.9435	0.9811
3UR	0.9483	0.9837
3UT	0.8948	0.9366
3UU	0.9416	0.9756
3VB	0.8957	0.9056
3VN	0.8566	0.9007
3VR	0.8570	0.9317
3VS	0.9485	0.9733
3VV	0.9681	0.9776
3VX	0.9399	0.9461
3WA	0.9385	0.9478
3WN	0.8950	0.9311
3WR	0.6461	0.7878
3XN	0.9103	0.8355
3Y5	0.9392	0.9736
3ZV	0.9851	0.9820
403	0.9015	0.9165
404	0.8566	0.8768
405	0.8539	0.9426
40C	0.8566	0.9776
40W	0.9965	0.9024
40X	0.9965	0.8760
40Y	0.9485	0.9024
40Z	0.9485	0.8760
412	0.9046	0.9633
413	0.8129	0.8378
414	0.8284	0.9641
416	0.9187	0.9877
417	0.9612	0.9785
41X	0.9435	0.9903

Plan	Pro Factor	Instl Factor
41Z	0.9932	0.9662
421	0.9452	0.9627
42E	0.8788	0.9771
42F	0.9490	0.9581
42G	0.7851	0.8771
42M	0.9168	0.9354
42N	0.9084	0.8438
42R	0.9464	0.9794
42T	0.8759	0.9728
42U	0.9015	0.9616
42V	0.9015	0.9024
42W	1.0063	0.9776
42Y	0.8616	0.8651
430	0.8566	0.9728
432	0.8238	0.9050
434	0.8876	0.9730
43F	0.8917	0.9004
43G	0.9965	0.9756
44K	0.8998	0.8401
450	1.0305	0.9776
453	0.9015	0.9578
45W	0.9488	0.9779
46D	0.9218	0.9596
46F	0.9485	0.9779
46G	1.0039	0.9894
46J	0.9485	0.9024
46K	0.8129	0.9776
46M	0.9084	0.8438
46S	0.8867	0.9374
46U	0.8917	0.9314
46W	0.8704	0.9644
473	0.8807	0.9007
474	0.9535	0.9604
475	0.8129	0.8987
476	0.8513	0.9426
477	0.8807	0.9038
478	0.9442	0.9751
47C	0.9485	0.9624
47H	0.8704	0.9538
47K	0.8981	0.9351
47M	0.8816	0.9288
47N	0.8950	0.9337
47R	0.9058	0.9690
47S	0.8891	0.8381
47Z	0.9015	0.9550
481	0.9435	0.9811
482	0.8453	0.9392
483	0.8972	0.9228
485	0.8578	0.9667
486	0.8934	0.9461
487	0.9435	0.9782
488	0.9512	0.9733

Plan	Pro Factor	Instl Factor
489	1.0200	0.9797
48A	0.9435	0.9667
48B	0.7677	0.8990
48C	0.8482	0.9426
48D	0.8212	0.9383
48E	0.9483	0.9837
48F	0.9027	0.9702
48H	0.8542	0.9492
491	0.8449	0.9828
493	0.8315	0.9165
494	0.9824	0.9776
495	0.8095	0.9170
497	0.8566	0.9394
498	0.8652	0.9024
499	0.9686	0.9739
49T	0.9488	0.9753
49V	0.9215	0.9532
49Y	0.9015	0.9394
4BC	0.8566	0.9337
4CF	0.8346	0.9774
4CG	0.8470	0.9311
4CH	0.8566	0.9687
4CN	0.8845	0.8450
4CP	0.7469	0.7973
4CQ	0.9399	0.9354
4CV	0.9507	0.9483
4DE	0.9060	0.9730
4DH	0.8537	0.8573
4DL	0.8621	0.9193
4DM	0.9507	0.9753
4DQ	0.8762	0.9463
4DR	0.8762	0.9463
4DV	0.8253	0.8898
4DW	0.8764	0.8725
4DY	0.8917	0.6824
4DZ	0.9306	0.9725
4EB	0.9865	0.9728
4EE	0.8315	0.8765
4EL	0.9435	0.9733
4EP	0.7730	0.8582
4F4	0.6898	0.7105
4F7	0.9015	0.9294
4FN	0.8917	0.9033
4FQ	0.9965	0.9805
4FR	1.0656	0.9903
4FS	0.9965	0.9776
4FV	0.9851	0.9820
4FX	0.9449	0.9314
4G9	0.8456	0.8381
4GH	0.8226	0.9242
4GP	0.8286	0.7528
4GQ	0.8585	0.6528

Plan	Pro Factor	Instl Factor
4GU	0.9586	0.9776
4GZ	0.9163	0.9024
4HN	0.8955	0.9331
4HQ	0.9586	0.9682
4HR	0.9163	0.9303
4HX	0.8754	0.9728
4I2	0.9593	0.9705
4JD	0.9098	0.9337
4JM	0.8936	0.8995
4JQ	0.8957	0.9056
4JZ	0.8754	0.9007
4K4	0.8962	0.9116
4K5	0.8081	0.7849
4K6	0.9485	0.9710
4K7	0.9438	0.9693
4K9	0.7711	0.8900
4KB	0.9230	0.9690
4KD	0.8761	0.9317
4KL	0.8226	0.9291
4L1	0.6901	0.7105
4L9	0.8494	0.9116
4LU	0.8425	0.9779
4M1	0.8845	0.9351
4M7	0.8948	0.9366
4N1	0.7985	0.8504
4N2	0.9416	0.9756
4N3	0.8157	0.7806
4N4	0.8441	0.8182
4N5	0.8936	0.8995
4N9	0.8370	0.8935
4NG	0.9950	0.9820
4P1	0.8487	0.8240
4PJ	0.9590	0.9776
4PM	0.9617	0.9817
4PY	0.9989	0.9771
4R6	0.8637	0.9334
4RF	0.8585	0.8990
4RS	0.8950	0.9463
4RT	0.8950	0.9463
4RV	0.8707	0.9420
4SG	0.8575	0.8765
4SH	1.0214	0.9756
4SJ	0.9550	0.9730
4SK	0.9521	0.9685
4SN	0.9535	0.9733
4TP	0.9196	0.8332
4TY	0.9065	0.9394
4UF	0.6796	0.7901
4UQ	0.8296	0.9018
4US	0.9425	0.9776
4UT	0.8358	0.8754
4UX	0.9586	0.9776

Plan	Pro Factor	Instl Factor
4VF	0.8757	0.9679
4VG	0.9586	0.9682
4VK	0.8262	0.9202
4VN	0.9163	0.9035
4VQ	0.8754	0.9021
4VW	0.7830	0.8504
4WB	0.8575	0.9027
4WE	1.0006	0.9817
4WJ	0.9519	0.9656
4WL	0.7995	0.9469
4WM	0.8164	0.8932
4WR	0.9617	0.9817
4WT	0.9149	0.9756
4WU	0.8513	0.9340
4X1	0.8867	0.9056
4XB	0.9263	0.9225
4XC	0.7988	0.8846
4XD	0.9519	0.9710
4XE	0.8215	0.6812
4XF	0.7515	0.8007
4XG	0.6375	0.7835
4XM	0.8967	0.9432
4XN	0.8554	0.8932
4XP	0.8458	0.9386
4XR	0.8575	0.9168
4XT	0.8957	0.8401
4XU	0.8628	0.9012
4XW	0.9065	0.8384
4XZ	0.7820	0.9725
4Y9	0.9385	0.9656
4YB	0.9516	0.9799
4YD	0.8358	0.7726
4YK	0.8628	0.8315
4YL	0.8957	0.9056
4YM	0.7089	0.7088
4YN	0.6232	0.7898
4YU	0.9065	0.9004
4YV	0.8754	0.9030
4YX	0.8215	0.8820
4YY	0.8215	0.8875
4YZ	0.9569	0.9776
4Z7	0.9342	0.9756
4ZB	0.8238	0.8995
4ZC	0.8427	0.9535
4ZD	1.0450	0.9811
4ZF	0.8628	0.7243
4ZR	0.9065	0.9705
4ZV	0.7830	0.7697
500	0.9015	0.9021
501	0.9015	0.8760
502	0.8616	0.9021
503	0.8616	0.8760

Plan	Pro Factor	Instl Factor
504	0.9051	0.9262
50M	0.8671	0.9208
50S	0.8874	0.8771
50T	0.9459	0.9733
50V	0.9208	0.9728
50X	0.9583	0.9776
50Y	0.9098	0.8260
51K	0.8640	0.8720
51L	0.8981	0.9578
51P	0.8566	0.9771
521	0.8107	0.9291
523	0.9932	0.9785
526	0.8129	0.8418
52Y	0.9660	0.9794
52Z	0.8704	0.9621
531	0.7708	0.8900
532	0.8527	0.9463
534	0.9022	0.9756
535	0.9485	0.9794
537	0.7861	0.9010
53A	0.9017	0.9710
53F	0.8437	0.9196
53S	0.8566	0.9007
53U	1.0450	0.9776
53V	0.8566	0.8929
53W	0.9485	0.9354
53X	0.8910	0.9733
53Y	0.9965	0.9601
53Z	0.9414	0.9733
54B	0.9082	0.9690
54C	0.8317	0.9575
54D	0.8269	0.8992
54E	0.8910	0.9730
54F	0.8547	0.9426
54G	0.8129	0.9314
54H	0.9965	0.9785
54J	0.8566	0.9728
54K	0.9485	0.9776
54L	0.9965	0.9805
54M	0.9015	0.9262
54N	0.9020	0.9699
54P	0.8570	0.9317
54Q	0.9557	0.9805
54R	0.9137	0.9578
54S	0.9015	0.9656
54T	0.8955	0.9504
54U	0.9015	0.9314
54V	0.9072	0.9578
54W	0.8566	0.9776
54X	0.9015	0.9805
54Y	0.9485	0.9733
54Z	0.9020	0.9730

Plan	Pro Factor	Instl Factor
558	0.8532	0.9475
559	1.0419	0.9785
55C	0.8193	0.7895
55D	0.9266	0.9173
55E	0.7689	0.8521
55J	0.9117	0.8438
55K	0.9117	0.8438
55L	0.8900	0.9314
55M	0.9015	0.9351
55N	0.7711	0.8926
55P	0.8704	0.9168
55Q	0.9485	0.9690
55R	0.9058	0.9035
55S	1.0450	0.9811
55T	0.9117	0.8355
55U	0.9485	0.9771
55V	0.9082	0.9774
55W	0.9077	0.8725
55X	0.9117	0.8441
55Y	0.9485	0.9581
55Z	0.9015	0.9317
560	0.8554	0.8768
562	0.9053	0.9782
56B	0.9122	0.9547
56C	0.9015	0.9394
56D	0.9490	0.9705
56E	0.9082	0.9449
56F	0.9421	0.9708
56G	0.9485	0.9397
56H	0.9569	0.9776
56J	0.9681	0.9776
56K	0.8922	0.9027
56L	0.9965	0.9397
56M	0.8917	0.9024
56N	0.9485	0.9805
56P	0.9485	0.9590
56Q	0.9414	0.9699
56R	0.9418	0.9397
56S	0.8917	0.9024
56T	1.0178	0.9753
59L	0.9399	0.9461
59M	0.9399	0.9461
59P	0.5649	0.8010
59Q	0.9015	0.9397
59R	0.9058	0.9035
59S	0.9132	0.9259
59T	0.8943	0.9751
59U	0.7995	0.9291
59V	0.8081	0.9326
59W	0.8449	0.9127
59X	0.8355	0.9596
59Y	0.8539	0.9762

Plan	Pro Factor	Instl Factor
5A2	0.8797	0.8705
5A5	0.8762	0.9492
5A6	0.8124	0.8320
5A9	0.8200	0.8900
5AC	0.9163	0.9730
5AU	0.8317	0.9544
5B1	0.8998	0.9225
5B2	0.8501	0.8369
5B3	0.8625	0.9165
5B4	0.8098	0.8582
5B6	0.8566	0.9058
5B7	0.9965	0.9693
5B8	0.9414	0.9682
5B9	0.8566	0.9679
5BF	0.9418	0.9038
5BH	0.9015	0.9303
5BJ	0.8437	0.7243
5BK	0.8222	0.8027
5BL	0.8704	0.9168
5C1	1.0450	0.9693
5C7	0.8064	0.9044
5CH	0.9122	0.9547
5CM	0.6755	0.6850
5CU	0.8917	0.8384
5CV	0.9965	0.9776
5D2	0.9504	0.9745
5D3	0.8602	0.9326
5D4	0.9485	0.9438
5ED	0.8566	0.9300
5EE	1.0011	0.9776
5EK	0.9490	0.9751
5EZ	0.9982	0.9817
5F8	0.9485	0.9693
5FB	0.9208	0.9888
5FE	0.9485	0.9377
5FF	0.8728	0.9349
5G5	0.8950	0.9311
5G6	0.8129	0.8338
5GC	0.9519	0.8389
5GR	0.9022	0.9038
5H7	0.8867	0.9056
5H8	0.8867	0.8401
5H9	0.8998	0.9056
5HL	0.7364	0.8082
5HR	0.9230	0.9547
5HV	0.7089	0.6850
5JC	0.8575	0.8378
5JE	1.0018	0.9776
5JL	1.0116	0.9776
5JM	0.9925	0.9776
5K7	0.8910	0.9426
5K8	0.8728	0.9349

Plan	Pro Factor	Instl Factor
5KC	0.8757	0.9679
5KF	1.0023	0.9843
5KK	0.9586	0.9696
5L4	0.7711	0.8843
5LK	0.8466	0.8122
5LM	0.9586	0.9377
5LT	0.8215	0.8510
5M1	0.6461	0.7878
5M5	0.7722	0.7766
5MB	0.9015	0.9656
5ML	0.7973	0.8900
5MM	0.7976	0.8900
5MR	0.9065	0.9650
5MU	0.8793	0.9337
5MX	0.9586	0.9581
5N4	0.9065	0.9018
5NG	0.9163	0.9805
5PQ	0.9015	0.9590
5PR	1.0000	1.0000
5PY	0.8215	0.7238
5Q5	0.9263	0.9142
5Q6	0.8131	0.8562
5Q7	0.7536	0.8007
5Q8	0.6397	0.7835
5R2	0.8628	0.8848
5R3	0.7830	0.8862
5SD	0.8033	0.7766
5T9	0.7089	0.8541
5TV	0.7660	0.5744
5TX	0.7562	0.7545
5UL	0.9022	0.9038
5UR	0.8628	0.8315
5US	0.7562	0.7553
5UV	0.9154	0.9035
5VV	0.7087	0.7686
5WH	0.9065	0.8450
5WN	0.7424	0.9601
5WP	0.9058	0.8211
5WS	0.9230	0.9690
5WU	0.9050	0.9116
5WV	0.7973	0.8900
5WY	0.7233	0.7105
5XE	0.9304	0.9550
5XH	0.8327	0.8610
5XJ	0.9163	0.9627
5XK	0.8286	0.8108
5YG	0.9282	0.9699
5YH	0.9586	0.9710
5YK	0.8527	0.9728
5YW	0.7089	0.6864
5YY	0.7089	0.6864
5ZF	0.8628	0.7243

Plan	Pro Factor	Instl Factor
5ZG	0.7973	0.9015
5ZH	0.9586	0.9035
5ZL	0.7230	0.7105
600	0.9330	0.9710
601	0.9330	0.9570
602	0.8785	0.9216
603	0.8222	0.8981
60C	0.9452	0.9682
60L	0.9531	0.9805
60M	0.9965	0.9776
61M	0.8683	0.9446
61Q	0.9681	0.9742
61R	0.8317	0.9544
61S	0.8900	0.9730
61Y	0.9103	0.8355
61Z	0.8843	0.8843
621	0.8427	0.9351
623	0.9485	0.9598
624	0.8129	0.8656
625	0.7933	0.9165
626	0.9975	0.9794
627	0.9034	0.9794
62C	0.8773	0.9610
62E	0.9987	0.9079
637	0.9965	0.9756
638	0.9015	0.9776
639	0.9132	0.8355
646	0.8078	0.8022
647	0.7257	0.7930
648	0.5941	0.7832
649	0.8250	0.9779
64L	0.9485	0.9472
64P	0.8984	0.9765
64S	0.9015	0.9730
64T	0.8129	0.9687
64V	0.8107	0.9280
654	0.7668	0.8093
655	0.8451	0.8751
65N	0.7734	0.8191
65W	0.8850	0.9461
65X	0.6554	0.7180
65Y	0.7734	0.8392
660	0.7092	0.9601
661	0.9218	0.9578
663	0.8683	0.9495
66B	0.8238	0.8995
66C	0.8427	0.9535
66E	0.8499	0.9282
66H	0.8609	0.9495
66K	0.9015	0.9073
66L	0.9418	0.9038
66T	0.9418	0.9710

Plan	Pro Factor	Instl Factor
66V	0.9418	0.8389
66W	0.9418	0.6973
66X	0.8917	0.9705
66Y	0.8917	0.9033
66Z	0.8917	0.8384
671	0.8917	0.6824
672	0.8437	0.8378
673	0.8437	0.6818
674	0.7985	0.8510
675	0.7985	0.6812
676	0.7565	0.8504
67Y	0.9457	0.9693
68K	0.8129	0.8926
68M	0.8095	0.8108
68N	0.7247	0.8007
68P	0.5835	0.7898
68Q	0.8129	0.8228
68R	0.8654	0.9400
68S	0.8284	1.0894
68T	0.7383	0.5744
68X	0.9149	0.9351
68Y	0.9449	0.9265
690	0.8164	0.8932
69T	0.8969	0.9397
69W	0.8539	0.9762
6A3	0.6478	0.5474
6AA	1.0512	0.9725
6AB	0.9072	0.9354
6AD	0.9547	0.9351
6AE	0.9168	0.9354
6BT	0.8979	0.9670
6BV	0.7668	0.8093
6BY	0.8425	0.8699
6BZ	0.8673	0.9728
6CA	1.0386	0.9785
6CB	0.9564	0.9728
6CD	0.8979	0.8944
6CF	0.8979	0.9670
6CJ	0.9684	0.9475
6DB	0.9578	0.9745
6EH	0.8248	0.8648
6EJ	0.8183	0.8648
6EX	0.7601	0.9636
6FA	0.9015	0.9165
6FC	0.8979	0.8662
6FD	0.9282	0.9196
6FN	0.8559	0.9728
6FR	0.8762	0.9311
6GN	0.8762	0.9311
6GQ	0.8762	0.8938
6H3	0.8628	0.9012
6H6	0.8633	0.9702

Plan	Pro Factor	Instl Factor
6HA	0.9932	0.9776
6JL	0.7309	0.6112
6JP	0.8525	0.7924
6JQ	0.8525	0.7924
6JR	0.6351	0.6479
6JS	0.7722	0.7355
6JT	0.8745	0.8846
6JU	0.8979	0.9670
6K8	0.9086	0.9056
6KR	0.9015	0.9776
6KT	0.8090	0.8349
6KW	0.8628	0.9214
6KY	0.9547	0.9070
6KZ	0.9989	0.9079
6L1	1.0496	0.9076
6L3	0.9065	0.8384
6L5	0.8616	0.9012
6L6	0.8616	0.9012
6L8	0.7830	0.8912
6LC	0.9098	0.9685
6LH	0.8210	0.8622
6LN	0.8513	0.9340
6LT	0.8262	0.8602
6LU	0.7992	0.8079
6LV	0.7997	0.7252
6M7	0.6349	0.6568
6M8	0.8747	0.8490
6M9	0.7722	0.7723
6MB	0.6268	0.5319
6MC	0.6268	0.7157
6MD	0.6882	0.7806
6ME	0.7625	0.8142
6MF	0.8425	0.8473
6MG	0.9490	0.8813
6MP	0.8016	0.9725
6MQ	0.9710	0.9799
6MV	0.6335	0.6907
6MW	0.7706	0.7355
6MX	0.8745	0.8846
6MZ	0.7708	0.7723
6N1	0.8747	0.8490
6N2	0.6335	0.6568
6N4	0.9163	0.9679
6N6	0.9516	0.9725
6N7	0.9996	0.9728
6N8	0.9098	0.9337
6N9	0.7562	0.7680
6NB	0.9098	0.9337
6NC	0.7562	0.7671
6NF	0.9086	0.9056
6NH	0.8561	0.9771
6NJ	0.9481	0.9776

Plan	Pro Factor	Instl Factor
6NK	0.8124	0.9676
6RA	0.9485	0.9776
6RY	0.9220	0.9076
6RZ	0.8317	0.8404
6S1	0.7594	0.7473
6S8	0.9490	0.8813
6S9	0.8425	0.8473
6SB	0.7625	0.8142
6SC	0.6882	0.7806
6SD	0.6268	0.7157
6SE	0.6268	0.5319
6SF	0.8575	0.8378
6SG	0.8215	0.7238
6SH	0.9586	0.9733
6SJ	0.9230	0.9690
6VA	0.9452	0.9624
6WA	0.9851	0.9820
6WE	0.7794	0.8309
6WT	0.9163	0.9656
6WW	0.8162	0.8622
6WZ	0.7976	0.8837
6X8	0.9485	0.9776
6ZB	0.8578	0.9027
6ZD	0.8496	0.9337
6ZE	0.8258	0.9383
6ZG	0.9273	0.9650
6ZJ	0.8630	0.9012
6ZN	0.9067	0.8384
6ZW	0.8523	0.7223
6ZX	0.9115	0.9193
709	0.8609	0.9472
70D	0.8566	0.8786
70K	0.9058	0.9073
70X	0.8456	0.9346
70Y	0.9015	0.9024
710	0.8164	0.8932
719	0.7734	0.8843
71G	0.8874	0.9765
71J	0.8453	0.9351
71P	0.8566	0.9300
72N	0.9146	0.9679
72P	0.9146	0.9719
72Q	0.9146	0.9716
72S	0.8090	0.9705
72T	0.8136	0.9705
72X	0.9366	0.9817
72Y	0.9901	0.9811
72Z	0.9366	0.9894
731	0.9903	0.9894
732	0.9538	0.9788
733	0.9344	0.9162
735	0.9731	0.9799

Plan	Pro Factor	Instl Factor
736	0.9731	0.9799
737	0.8090	0.9044
739	1.0278	0.8406
73C	0.9146	0.8398
73D	0.9146	0.8398
73J	1.0283	0.9805
73P	0.9194	0.9716
73Q	0.8186	0.8203
73R	0.8186	0.8251
73S	0.8186	0.8251
73T	0.8186	0.8203
73U	0.9277	0.9716
73Z	0.9196	0.9558
741	0.9199	0.9598
742	0.8969	0.9728
743	0.9158	0.9794
747	1.0496	0.9076
748	0.9989	0.9079
74E	0.8078	0.7407
74H	0.8408	0.8608
74J	0.9586	0.9716
74K	0.8129	0.9010
74S	0.8348	0.8381
74U	0.8348	0.8381
74V	0.8351	0.9380
74X	0.7300	0.9647
750	0.8315	0.8191
752	0.9884	0.9776
755	0.8384	0.9280
756	0.8284	0.8995
757	0.8473	0.9535
759	0.9017	0.9429
75B	0.9153	0.9751
75C	0.9153	0.9751
75N	0.9538	0.9788
75T	0.9153	0.9751
75U	0.9153	0.9751
75W	0.9146	0.9716
75X	0.9731	0.9799
75Y	1.0278	0.8406
75Z	0.9146	0.8398
760	0.8604	0.9501
764	0.8186	0.8251
765	0.8186	0.8203
766	0.8129	0.9314
767	0.9435	0.9380
76B	0.9199	0.9598
76F	0.8136	0.9021
76L	0.8136	0.9705
76M	0.9146	0.9719
76N	0.8136	0.9024
76P	0.9676	0.9722

Plan	Pro Factor	Instl Factor
76Q	0.8136	0.9705
76R	0.9146	0.9719
76S	0.8136	0.9024
76T	0.9676	0.9722
76U	0.9194	0.5971
76V	0.7500	0.5948
76Z	0.9194	0.5971
771	0.9029	0.9736
773	0.8095	0.8108
774	0.7247	0.8007
775	0.5835	0.7898
77E	0.7500	0.5948
77F	0.9015	0.9303
77Q	0.8090	0.9021
77T	0.8186	0.9730
77U	0.8186	0.9730
77V	0.9676	0.9722
77W	0.8186	0.9730
77X	0.8676	0.9524
77Y	0.8676	0.9524
781	0.8055	0.8938
791	0.8762	0.9613
794	0.7985	0.8427
7A4	0.7794	0.7823
7A7	0.6755	0.6850
7B2	0.9163	0.9403
7B3	0.7699	0.8791
7L2	0.8566	0.9679
7P9	0.8917	0.9018
7Q1	0.8917	0.8384
7Q2	0.9418	0.9656
7Q3	0.9418	0.9024
7Q4	0.8917	0.9650
7Q5	0.8437	0.9644
7Q6	0.8437	0.9012
7Q7	0.8437	0.8378
7Q8	0.7565	0.7100
7Q9	0.6755	0.7088
7QA	0.9452	0.9776
7R1	0.8437	0.7243
7R2	0.8437	0.8315
7R3	0.7565	0.8306
7R4	0.6755	0.8294
7R5	0.7565	0.7697
7R6	0.6755	0.7686
7SA	0.8883	0.9394
7TA	0.9452	0.9472
7YA	1.0333	0.9903
7Z4	0.7668	0.7849
7Z7	0.8867	0.8401
7Z8	0.9435	0.9420
806	0.7995	0.9326

Plan	Pro Factor	Instl Factor
817	0.8396	0.8174
818	0.9934	0.9733
81Q	0.9275	0.9251
82L	1.0214	0.9753
82M	0.9590	0.9776
82N	0.8637	0.9394
82T	0.9488	0.9458
82Y	0.8702	0.8788
833	0.8642	0.7680
835	0.8250	0.9024
836	0.7754	0.8622
837	0.9660	0.9357
839	0.8492	0.9567
83J	0.8566	0.9337
83K	0.9058	0.9073
83M	0.9397	0.9771
83R	0.9545	0.9817
83S	0.8704	0.9280
83V	0.9015	0.9774
83W	0.7751	0.9461
843	0.8957	0.8372
847	0.9485	0.9389
84E	0.9328	0.9259
84K	0.9987	0.9079
853	0.9903	0.9771
859	0.8453	0.9679
85J	0.9211	0.9596
85K	0.9614	0.9805
865	0.8193	0.7895
868	0.9289	0.6973
869	0.8821	0.6965
86B	0.8265	0.7243
86C	0.8095	0.8159
86D	0.7247	0.8007
86E	0.5835	0.7884
86F	0.7933	0.9165
86N	0.9399	0.9403
86P	0.9949	0.9843
86Y	0.7431	0.8777
88P	0.8563	0.9762
88T	0.9017	0.9394
88V	0.8917	0.8320
88W	0.8542	0.8114
8H1	0.8346	0.9774
8H2	0.8470	0.9311
8H3	0.6755	0.8122
8H4	0.8566	0.9687
8H5	0.8867	0.8401
8H6	0.9965	0.9756
8H7	0.8193	0.7881
8H8	0.9015	0.9004
8H9	0.8867	0.9056

Plan	Pro Factor	Instl Factor
8J1	0.9015	0.9004
8J2	1.0000	1.0000
8J3	1.0000	1.0000
8J6	0.7801	0.8375
8K1	0.9459	0.9719
8K2	0.8265	0.6818
8K4	0.8845	0.8450
8K5	0.7247	0.8007
8K6	0.7469	0.7973
8K9	0.9084	0.9762
8L2	0.9399	0.9354
8L6	0.8019	0.8877
8L7	0.8219	0.8751
8L8	0.9507	0.9483
8L9	0.7935	0.8932
8M5	0.8403	0.8237
8M7	0.8678	0.9311
8N2	0.7364	0.8082
8R4	0.9015	0.9596
8R5	0.8129	0.9687
8T8	0.8910	0.9753
8T9	0.8394	0.8990
8U3	0.9060	0.9730
8V3	0.8537	0.8573
8V7	0.7543	0.8846
8X8	0.8621	0.9193
8X9	0.9507	0.9753
8Y1	0.7438	0.8883
8Y4	0.9414	0.9409
8Y7	0.8762	0.9463
8Y8	0.8762	0.9463
8Z1	0.9325	0.9756
8Z2	0.8707	0.9420
8Z3	0.8148	0.8608
8Z4	0.8253	0.8898
8Z6	0.9547	0.9070
8Z7	0.9547	0.9070
8Z8	0.8764	0.8725
8Z9	0.9383	0.9483
909	0.7861	0.9015
90D	0.8969	0.9820
90E	0.8222	0.8027
90F	0.7390	0.7933
90G	0.8917	0.6824
90H	0.8437	0.8378
90J	0.8437	0.6818
90K	0.7985	0.6812
90L	0.7565	0.8504
90N	0.9029	0.9736
90P	0.9266	0.9179
90Q	0.7689	0.7829
90R	0.9485	0.9696

Plan	Pro Factor	Instl Factor
90S	0.5649	0.6479
90T	0.9418	0.9038
90U	0.9418	0.9710
90V	0.8917	0.9705
90W	0.8917	0.9033
90X	0.8095	0.8108
90Y	0.8284	0.8027
90Z	0.9306	0.9722
911	0.9306	0.8404
913	0.8246	0.9710
914	0.8246	0.9027
915	0.8246	0.9710
916	0.9949	0.9794
917	0.9418	0.8389
918	0.9418	0.6973
919	0.8917	0.8384
91B	0.7985	0.8510
91C	0.7247	0.8007
91D	0.5835	0.7898
91F	0.5976	0.7835
91G	0.9129	0.9728
91H	0.8198	0.9710
91J	0.9306	0.9725
91K	0.9865	0.9728
91L	0.9306	0.9725
91M	0.8246	0.9027
91N	0.7562	0.5954
91P	0.7562	0.5954
926	0.8193	0.7892
93L	0.8396	0.8177
93M	0.8642	0.7686
93N	0.9925	0.9730
944	0.8821	0.9038
945	0.8315	0.9038
946	0.8315	0.8777
947	0.8250	0.8777
948	0.8384	0.9168
94B	0.7933	0.9168
94C	0.8198	0.9044
94D	0.8384	0.9285
94E	0.8055	0.8941
94F	0.9934	0.9733
94G	0.8250	0.9027
94H	0.7754	0.8622
94J	0.8821	0.8378
94K	0.8315	0.8378
94L	0.8821	0.9027
94M	0.8315	0.9027
94N	0.8315	0.8765
94P	0.7851	0.8777
94Q	0.9488	0.9753
94R	0.8640	0.8725

Plan	Pro Factor	Instl Factor
94S	0.9965	0.9601
94T	0.9306	0.9679
94U	0.9306	0.9722
94V	0.8246	0.9710
94W	0.9354	0.9722
94X	0.9356	0.9558
94Y	0.8246	0.9027
94Z	0.9352	0.5977
951	0.8198	0.9027
952	0.9865	0.9728
953	1.0214	0.9756
954	0.7751	0.9337
955	0.9449	0.9730
956	0.8981	0.9730
957	0.9383	0.9685
95D	0.9942	0.9817
95G	0.8874	0.8777
960	0.9755	0.9733
96W	0.8566	0.9300
97X	0.8193	0.7892
98W	0.7383	0.5744
998	0.8193	0.7892
99B	0.8969	0.9412
99C	0.9435	0.9733
9A4	0.7730	0.8582
9A6	0.8241	0.8705
9AA	0.9934	0.9776
9B1	0.8917	0.9394
9B5	0.8470	0.9058
9B8	0.8566	0.9386
9BA	0.9965	0.9776
9CJ	0.8757	0.9679
9CK	0.9588	0.9682
9CL	0.9163	0.9679
9CM	0.9619	0.9817
9CN	0.8790	0.7660
9CR	0.9516	0.9725
9CS	0.9996	0.9728
9CT	0.7644	0.7973
9CV	0.8172	0.8306
9CW	0.8217	0.4923
9CX	0.8238	0.8995
9DA	0.9127	0.9794
9DB	0.9067	0.7249
9DK	0.9067	0.9018
9DL	0.8630	0.8378
9DP	0.6480	0.6336
9EF	0.8516	0.9340
9EG	0.8618	0.9012
9EH	0.8618	0.9012
9EJ	0.8470	0.9544
9EK	0.7226	0.6089

Plan	Pro Factor	Instl Factor
9EM	0.9588	0.9377
9F5	0.8437	0.7243
9FA	1.0512	0.9776
9FJ	0.9588	0.9328
9FM	0.8019	0.8708
9FQ	0.9211	0.9759
9FS	0.8470	0.9575
9FT	0.7089	0.7686
9FU	0.9149	0.9756
9FX	0.9521	0.9038
9FY	0.7089	0.6850
9FZ	0.8848	0.9452
9GA	1.0011	0.9776
9GG	0.8633	0.7671
9H4	0.9325	0.9776
9HB	0.7565	0.7841
9HC	1.0515	0.9811
9HP	0.9122	0.9547
9HR	0.9530	0.9801
9HV	0.9107	0.8411
9HW	0.9110	0.9046
9HX	0.8671	0.9667
9HY	0.8668	0.9041
9HZ	0.8668	0.8405
9IB	0.7866	0.7123
9IC	0.7123	0.7103
9ID	0.8668	0.7266
9IE	0.8671	0.8343
9IF	0.7866	0.8333
9IG	0.7122	0.8321
9IH	0.7866	0.7722
9IJ	0.7120	0.7711
9IK	0.9563	0.9687
9IM	0.9107	0.9681
9IN	0.7122	0.6886
9IR	0.8293	0.8108
9IS	0.9163	0.9567
9IW	0.9107	0.9047
9IX	0.9110	0.8404
9IY	0.9563	0.9687
9IZ	0.9567	0.9052
9JB	0.9107	0.9681
9JC	0.8668	0.9675
9JD	0.8668	0.9041
9JE	0.8668	0.8405
9JF	0.7866	0.7123
9JG	0.7122	0.7111
9JH	0.8668	0.7266
9JJ	0.8668	0.8342
9JK	0.7866	0.8333
9JL	0.7122	0.8321
9JM	0.7866	0.7722

Plan	Pro Factor	Instl Factor
9JN	0.7120	0.7711
9JP	0.7122	0.6886
9JQ	0.8917	0.9026
9JS	0.8437	0.8323
9JT	0.6755	0.7693
9JU	0.8917	0.9659
9JV	0.8917	0.9026
9JX	0.8437	0.9020
9JY	0.8437	0.8386
9JZ	0.8437	0.8323
9KA	0.9015	0.9621
9KB	0.7565	0.8314
9KC	0.7565	0.7704
9NA	0.9485	0.9397
9OA	0.9559	0.9776
9QA	0.9965	0.9776
9RA	0.9970	0.9848
9T5	0.8129	0.5767
9UA	0.9865	0.9811
9V1	0.8566	0.9030
9V2	0.8129	0.9018
9V3	0.8566	0.9021
9V4	0.9015	0.6953
9V5	0.8129	0.7726
9V6	0.8129	0.6950
9V7	0.9015	0.9303
9V8	0.9048	0.8332
9V9	0.8566	0.9679
9VZ	0.9531	0.9788
9W1	0.8437	0.9021
9W2	0.9485	0.9776
9W3	0.9418	0.9038
9W4	0.8917	0.9033
9W5	0.8437	0.8378
9W6	0.7565	0.8504
9W7	0.9418	0.8389
9W8	0.8917	0.9705
9W9	0.8917	0.8384
9WB	0.9531	0.9788
9WZ	0.8757	0.9030
9X1	0.8917	0.7249
9X2	0.8437	0.7243
9X3	0.7985	0.8510
9X4	0.7985	0.6812
9X5	0.9418	0.9710
9X6	0.7247	0.8007
9X7	0.5835	0.7898
9X8	0.8095	0.8108
9X9	0.8222	0.8027
9XA	0.9015	0.9776
9XB	0.8360	0.9010
9XJ	0.7644	0.7973

Plan	Pro Factor	Instl Factor
9XL	0.7696	0.6833
9XM	0.7780	0.6930
9XP	0.8630	0.8315
9XQ	0.9232	0.9690
9Y1	0.8917	0.9524
9Y2	0.9418	0.9656
9Y3	0.9418	0.9024
9Y4	0.9418	0.8329
9Y5	0.8917	0.9650
9Y6	0.8917	0.9018
9Y7	0.8917	0.8384
9Y8	0.8917	0.8320
9Y9	0.8917	0.7714
9YA	0.9989	0.9079
9Z1	0.8437	0.9644
9Z2	0.8437	0.9012
9Z3	0.8437	0.8444
9Z4	0.8437	0.8378
9Z5	0.8437	0.7243
9Z6	0.8437	0.8315
9Z7	0.8437	0.7709
9Z8	0.7708	0.8900
9Z9	0.8566	0.7749
9ZA	1.0546	0.9923
9ZH	0.7832	0.8633
9ZS	0.9268	0.9185
A24	0.8757	0.9679
A26	0.7995	0.8321
A2A	1.0481	0.9776
A3A	1.0481	0.9811
A3R	0.8790	0.7660
A3S	0.9619	0.9817
A3V	0.7997	0.7252
A3W	0.9080	0.9687
A40	0.8217	0.8309
A41	0.8666	0.8395
A42	0.9072	0.9354
A43	0.9070	0.9366
A44	0.9535	0.9639
A45	0.9063	0.8376
A46	0.8611	0.8426
A47	0.8195	0.7166
A48	0.7808	0.7215
A49	0.7431	0.5931
A4A	1.0481	0.9776
A4B	0.7061	0.7778
A4C	0.6445	0.7184
A4E	0.8611	0.8221
A4F	0.7808	0.7549
A4G	0.7061	0.6852
A4H	0.6445	0.5952
A4J	0.8195	0.7881

Plan	Pro Factor	Instl Factor
A4K	0.7431	0.7200
A4L	0.6738	0.6535
A4M	0.8678	0.8376
A4N	0.7928	0.7163
A4P	0.7880	0.7497
A4Q	0.7211	0.6800
A4S	0.9579	0.9791
A4W	0.8516	0.9340
A4X	0.8618	0.9012
A55	0.8630	0.9020
A56	0.9067	0.8414
A58	0.9516	0.9734
A59	0.9996	0.9737
A5B	0.8671	0.8429
A5C	0.8253	0.8561
A5D	0.9567	0.9768
A5E	0.6261	0.7945
A5F	0.9110	0.9086
A5G	0.7866	0.8555
A5J	0.8255	0.7281
A5K	0.7550	0.8055
A5L	0.8668	0.6834
A5N	0.7985	0.6837
A5P	0.8437	0.7269
A5Q	0.8437	0.8408
A5T	0.9418	0.9745
A5Z	0.9110	0.8501
A60	0.9110	0.9763
A62	0.8537	0.8581
A63	0.9519	0.9745
A67	0.8628	0.7250
A68	0.9567	0.9688
A69	0.9110	0.9682
A6A	0.9932	0.9673
A6B	0.9206	0.9056
A6F	0.9593	0.9639
A6G	0.9177	0.8346
A6H	0.8721	0.8426
A6J	0.8329	0.7166
A6K	0.7964	0.7215
A6L	0.7422	0.5953
A6M	0.7261	0.4880
A6N	0.6445	0.7509
A6P	0.9641	0.8884
A6Q	0.8721	0.8191
A6R	0.7940	0.7522
A6S	0.7226	0.6835
A6T	0.6638	0.5931
A6U	0.8265	0.7852
A6V	0.7422	0.7200
A6W	0.6688	0.6535
A6Z	0.8618	0.9020

Plan	Pro Factor	Instl Factor
A78	0.8671	0.8365
A7B	0.6268	0.7944
A7C	0.8671	0.8429
A7D	0.8095	0.8137
A8A	1.0512	0.9776
A8D	0.9107	0.9047
A8E	0.8668	0.8877
A9A	0.9994	0.9776
AA0	0.9535	0.8866
AA1	0.8465	0.8524
AA2	0.7663	0.8192
AA3	0.6913	0.7853
AA4	0.6296	0.7206
AA5	0.6296	0.5351
AAK	1.0000	1.0000
AAL	1.0000	1.0000
AAM	0.8317	0.8404
AAN	0.7594	0.7473
AAP	0.9220	0.9076
AAQ	0.7866	0.8891
AAR	0.7122	0.8569
AAS	1.0065	0.9779
AAT	0.7269	0.7120
AAV	0.8563	0.7910
AC4	0.6508	0.5492
AC6	0.9110	0.9047
AHE	0.9110	0.9024
AHX	0.9638	0.9837
AHZ	0.8618	0.7941
AI2	0.8565	0.7942
AI3	0.7758	0.7372
AI4	0.8788	0.8510
AI5	0.7758	0.7741
AI6	0.6381	0.6494
AI7	0.8786	0.8867
AI8	0.6379	0.6583
AIB	0.6364	0.6923
AIC	0.7742	0.7372
AID	0.8788	0.8866
AIE	0.7744	0.7741
AIF	0.8788	0.8510
AIG	0.6364	0.6583
AJ1	0.8324	0.8108
AK5	0.8938	0.8800
AK6	0.7990	0.8151
AK7	0.8537	0.8581
AN5	0.9015	0.9776
AN6	0.9275	0.8872
AN7	0.8867	0.9056
AN8	0.8867	0.8401
AN9	0.8999	0.9077
ANB	0.9132	0.9076

Plan	Pro Factor	Instl Factor
ANC	0.9131	0.8421
AND	0.9089	0.8401
ANE	0.9633	0.9753
ANF	0.7882	0.7793
ANG	0.7882	0.8409
ANH	0.8999	0.8421
ANJ	0.7946	0.8409
ANK	0.9485	0.9035
ANL	0.8566	0.9030
ANN	0.8129	0.8366
ANP	0.8566	0.9021
ANR	0.9015	0.9679
ANS	0.8566	0.9679
ANT	0.9965	0.9756
ANV	0.9965	0.9776
ANX	0.9015	0.9776
ANY	0.9965	0.9776
ANZ	0.9485	0.9776
AO1	0.9206	0.9056
AO2	0.8754	0.9030
AO3	0.8358	0.9018
AO5	0.8010	0.8921
AO6	0.8754	0.8369
AO7	0.8398	0.8386
AO8	0.8754	0.9021
AOB	0.9206	0.9702
AOD	0.9206	0.9753
AOE	0.7266	0.7120
AOG	0.9211	0.9753
AOI	0.6375	0.7835
AOJ	0.8575	0.9027
AON	0.9206	0.9797
AOO	1.0068	0.9799
AOP	0.9586	0.9776
AOQ	1.0512	0.9776
AOR	0.8566	0.9776
AOZ	0.9586	0.9733
AP1	1.0059	0.9903
AP2	0.9017	0.9498
AP4	0.9015	0.9303
AP5	0.9435	0.9811
AP8	0.8570	0.9317
APC	0.9103	0.8355
APF	0.8470	0.9311
APG	0.8566	0.9687
API	0.8845	0.8450
APJ	0.8762	0.9463
APL	0.9965	0.9805
APM	1.0656	0.9903
APN	0.9965	0.9776
APO	0.9851	0.9820
APQ	0.9163	0.9024

Plan	Pro Factor	Instl Factor
APR	0.8955	0.9331
APS	0.9163	0.9303
APT	0.8797	0.9751
APU	0.9230	0.9690
APV	0.8761	0.9317
APW	0.8464	0.9802
APY	0.9989	0.9771
APZ	0.9586	0.9776
AQ0	0.9617	0.9817
AQ1	0.8358	0.7726
AQ2	0.8797	0.9053
AQ3	0.8427	0.9535
AQ7	0.8704	0.9168
AQ8	0.8566	0.9300
AQ9	0.9535	0.9759
AQD	0.9065	0.9058
AQH	1.0068	0.9799
AQI	1.0137	0.9799
AQJ	0.9973	0.9799
AQP	0.9586	0.9035
AQY	1.0512	0.9776
AQZ	0.8764	0.8045
AR1	0.8764	0.8045
ATX	0.8581	0.9296
AU5	0.7701	0.8289
AV5	0.8329	0.7217
AV6	0.8625	0.7240
AV7	0.9115	0.9153
AV8	0.9141	0.9216
AV9	0.9132	0.9076
AVC	0.9122	0.9267
AVD	0.9502	0.9276
AVE	0.8341	0.8255
AVF	0.8773	0.8241
AVG	0.7534	0.8238
AVH	0.7926	0.8238
AW0	0.7122	0.8321
AW5	0.9089	0.9056
AWC	0.8661	0.9199
AWK	0.7285	0.8294
AY7	0.7515	0.8036
AYI	0.9098	0.9193
AYJ	0.8136	0.7223
AYK	0.7866	0.8333
AYR	0.9586	0.9733
AZI	0.8999	0.9077
AZO	0.8566	0.7240
AZP	0.9141	0.9216
AZW	0.9569	0.9776
B10	0.9485	0.9733
B11	0.8999	0.8421
B12	0.9015	0.9776

Plan	Pro Factor	Instl Factor
B13	0.7550	0.8055
B17	0.8332	0.8158
B1A	0.9084	0.8251
B1L	0.8671	0.8466
B2A	0.9084	0.8251
B2L	0.9633	0.9400
B2Y	0.9633	0.9753
B3A	0.9084	0.8251
B3B	0.8754	0.9030
B41	0.8561	0.9771
B42	0.9481	0.9776
B43	0.8124	0.9676
B4A	0.9084	0.8458
B4C	0.9206	0.9323
B4D	0.9206	0.9323
B4G	0.9211	0.9521
B5A	0.9084	0.8355
B5B	0.7794	0.8309
B5C	0.7756	0.8423
B6A	0.9932	0.8757
B6F	0.8437	0.7269
B6K	0.8673	0.7688
B76	0.9485	0.9733
B8A	0.9383	0.9693
B8V	0.9633	0.9799
B9W	0.8795	0.9794
B9X	0.9629	0.9799
B9Y	0.8394	0.9699
BBP	0.7756	0.6468
BBQ	0.7713	0.4449
BBR	0.7732	0.6468
BBS	0.7689	0.4449
BBT	0.7816	0.6563
BJ6	0.9110	0.9047
BJ7	0.8668	0.8877
BJ8	0.7866	0.8891
BJ9	0.7122	0.8569
BJB	0.6508	0.5492
BJC	0.9158	0.9038
BJD	0.9110	0.8404
BJJ	0.8719	0.9033
BJK	0.8671	0.8398
BJL	0.7868	0.7114
BJN	0.8719	0.7261
BJP	0.8671	0.8335
BJQ	0.7916	0.8323
BJS	0.7868	0.7714
BJT	0.7120	0.7711
BJU	0.7123	0.6881
BKD	0.9132	0.9076
BKF	0.9180	0.8418
BKG	0.9132	0.8418

Plan	Pro Factor	Instl Factor
BKH	0.7947	0.7795
BKJ	0.7947	0.8406
BKK	0.7947	0.7795
BKL	0.7995	0.8406
BM4	0.9110	0.8404
BM5	0.9110	0.9046
BM7	0.8671	0.9033
BM8	0.8719	0.8398
BM9	0.7916	0.7114
BMB	0.7171	0.7103
BMD	0.8671	0.8343
BMG	0.7916	0.7714
BMH	0.7171	0.7703
BMM	0.7123	0.6881
BN7	0.7123	0.7710
BN8	0.8511	0.9598
BPR	0.8750	0.9443
BQ4	0.9292	0.9153
BQ5	0.8265	0.9262
BQU	0.9664	0.9840
BQV	0.8833	0.7677
BSR	0.8363	0.8105
BUF	0.8625	0.9317
BX7	0.8769	0.9509
BXH	0.8136	0.7223
BXJ	0.8329	0.7217
BXK	0.9098	0.9193
BXL	0.9115	0.9153
BXQ	0.8566	0.7240
BXR	0.8625	0.7240
BXS	0.9141	0.9216
BXT	0.9141	0.9216
BYN	0.8888	0.8467
BYR	0.8981	0.8820
BYS	0.8026	0.8171
BYT	0.8981	0.8820
BYU	0.8026	0.8171
BYX	0.7663	0.8192
BYY	0.6913	0.7853
BYZ	0.6296	0.7206
BZ0	0.7061	0.7779
BZ1	0.8611	0.8221
BZ2	0.7061	0.6852
BZ3	0.8195	0.7881
BZ4	0.7431	0.7200
BZ5	0.6691	0.6535
BZ6	0.8611	0.8426
BZC	0.8317	0.8404
BZD	0.7594	0.7473
BZE	0.9220	0.9076
BZP	0.7964	0.7215
BZQ	0.7261	0.4880

Plan	Pro Factor	Instl Factor
BZR	0.7940	0.7522
BZS	0.7261	0.6852
BZT	0.8329	0.7852
BZU	0.7610	0.7174
BZV	0.6915	0.6511
C2E	0.8136	0.7223
C2F	0.8329	0.7217
C2G	0.9158	0.9216
C2H	0.9115	0.9153
C2W	0.9664	0.9840
C33	0.8329	0.7217
C34	0.9158	0.9216
C35	0.8136	0.7223
C3B	0.8480	0.8708
C4U	0.8480	0.8720
C52	0.9102	0.9687
C6D	1.0044	0.9751
C6E	0.9562	0.9748
C7A	1.0481	0.9776
C8B	0.7135	0.6881
C8C	0.7171	0.6881
C8P	0.8652	0.8786
C8U	0.6380	0.5964
C8V	0.6311	0.5942
C97	0.8069	0.8246
C9A	0.8981	0.9776
C9B	0.9681	0.9753
C9C	0.9581	0.9708
C9D	0.8955	0.8946
C9E	0.8434	0.7480
CBG	0.8346	0.8157
CBH	0.9254	0.9590
CFU	0.8613	0.9776
CK7	0.6435	0.7521
CK8	0.6210	0.4664
CK9	0.6435	0.7521
CKB	0.6210	0.4668
CKC	0.6435	0.7521
CKJ	0.7770	0.5477
CKK	0.7816	0.5572
CKR	0.7727	0.4449
CL3	0.8647	0.9058
CL4	0.9340	0.8834
CLG	0.9158	0.9216
CLJ	0.9158	0.9216
CLK	0.8690	0.7194
CLL	0.8052	0.7292
CLM	0.9094	0.9216
CLZ	0.9063	0.9776
CM0	0.8965	0.9018
CM1	0.8473	0.9021
CM2	0.8473	0.8378

Plan	Pro Factor	Instl Factor
CM5	0.7613	0.7704
CM7	0.8484	0.8408
CM8	0.9466	0.9746
CMB	0.8613	0.9030
CMD	1.0013	0.9776
CME	0.9063	0.9776
CMF	1.0013	0.9776
CMN	1.0013	0.9805
CMP	1.0013	0.9776
CMR	0.8752	0.9168
CMT	0.8613	0.9300
CMU	0.9633	0.9035
CMV	1.0563	0.9776
CMX	0.9533	0.9733
CNQ	0.8965	0.9026
CNR	0.8484	0.8323
CNV	0.6046	0.4390
CNX	0.6046	0.4386
CNY	0.6046	0.4386
CRV	0.8375	0.6970
CT6	0.8296	0.8435
CT7	0.8105	0.9708
CTH	0.8052	0.7292
CTL	0.8625	0.9317
CTT	0.8195	0.8650
CTZ	0.8052	0.7292
CU0	0.9094	0.9216
CU8	0.8919	0.9524
CU9	0.7111	0.8010
CUB	0.8038	0.8722
CUC	0.8398	0.8705
CUS	0.8735	0.9219
CV0	0.9681	0.9799
CXB	0.8176	0.8116
CXF	0.6351	0.6537
CXP	0.8062	0.8171
CXQ	0.9015	0.8820
CXR	0.7488	0.6881
CXS	1.1107	0.9926
CXT	0.9015	0.8820
CXU	0.8062	0.8171
CYC	0.8052	0.7292
CYD	0.9094	0.9216
CZ2	0.8348	0.7235
CZ3	0.8348	0.7235
D28	0.7808	0.8053
D3A	0.9084	0.8257
D3N	0.8972	0.9538
D3P	0.6485	0.7521
D3Q	0.6261	0.4658
D3R	0.6206	0.4394
D3S	0.6485	0.7521

Plan	Pro Factor	Instl Factor
D3U	0.6206	0.4394
D5A	0.9485	0.9776
D6D	0.9313	0.9535
D6E	0.7503	0.8025
D9C	0.7770	0.5477
D9D	0.7727	0.4449
D9E	0.7863	0.5572
D9F	0.8719	0.9033
D9G	0.8719	0.8398
D9H	0.7916	0.7114
D9I	0.7916	0.7714
D9J	0.7171	0.7703
D9K	0.7171	0.6881
D9L	0.6483	0.7521
D9M	0.6258	0.4658
D9N	0.6093	0.4386
D9P	0.7916	0.8323
D9R	0.7916	0.7714
D9S	0.7171	0.7703
D9T	0.7171	0.6881
D9U	0.6483	0.7521
D9V	0.9158	0.9673
D9W	0.8719	0.9033
D9X	0.8719	0.8398
D9Y	0.7916	0.7114
D9Z	0.8719	0.7261
DA0	0.6258	0.4664
DA1	0.6093	0.4386
DBZ	0.9180	0.9076
DC0	0.9180	0.9076
DC1	0.9180	0.9076
DC2	0.9180	0.8418
DC3	0.9180	0.8418
DC4	0.7995	0.7795
DC5	0.7995	0.8406
DC6	0.7995	0.7795
DC7	0.7995	0.8406
DC8	0.7171	0.6881
DC9	0.7171	0.6881
DCB	0.6485	0.7521
DCC	0.6261	0.4658
DCD	0.6206	0.4394
DCE	0.6485	0.7521
DCG	0.6206	0.4394
DCU	0.9110	0.9047
DCV	0.8671	0.8877
DCW	0.7868	0.8891
DCX	0.7123	0.8569
DCY	0.6511	0.5492
DCZ	0.6483	0.7521
DD0	0.6210	0.4668
DD1	0.6046	0.4390

Plan	Pro Factor	Instl Factor
ddb	0.8052	0.7292
DDC	0.9094	0.9216
DDE	0.8728	0.9058
DEY	0.8719	0.9033
DEZ	0.8719	0.8398
DF0	0.7916	0.7114
DF1	0.7916	0.7714
DF2	0.7171	0.7703
DF3	0.7171	0.6881
DF4	0.8719	0.8335
DF5	0.7916	0.8323
DF6	0.7171	0.8312
DF7	0.7916	0.7714
DF8	0.7171	0.7703
DF9	0.7171	0.6881
DFB	0.9158	0.9673
DFC	0.8719	0.9033
DFD	0.8719	0.8398
DFE	0.7916	0.7114
DFG	0.8719	0.7261
DGI	0.9180	0.8418
DGL	0.7995	0.7795
DGM	0.7995	0.8406
DGP	0.7995	0.8406
DH0	0.9158	0.9047
DH1	0.8719	0.8877
DH2	0.7916	0.8891
DH3	0.7171	0.8569
DH4	0.6559	0.5492
DJQ	1.0613	0.9831
DJX	0.8066	0.7292
DJY	0.9113	0.9216
DL7	0.9048	0.9524
DL9	0.7541	0.8013
DLB	0.8461	0.8740
DLC	0.8100	0.8722
DMS	0.8066	0.7292
DN4	0.8797	0.9443
DQQ	0.9015	0.8820
DQR	0.8062	0.8171
DQS	0.8062	0.8171
DQT	0.9015	0.8820
DQU	0.7488	0.6881
DQV	1.1107	0.9926
DQW	0.8585	0.8573
DQX	0.8585	0.8573
DQZ	0.9629	0.9753
DR1	0.9158	0.9086
DR2	0.7916	0.8725
DR4	0.7570	0.8027
DR6	0.9254	0.9056
DR7	0.8845	0.9053

Plan	Pro Factor	Instl Factor
DR9	0.8059	0.8923
DRB	0.8446	0.8386
DRC	0.9254	0.9702
DRD	0.9206	0.9753
DRE	0.7314	0.7120
DRH	0.9681	0.9799
DRI	0.9254	0.9044
DRJ	1.0111	0.9791
DRN	1.0152	0.9799
DRO	1.0020	0.9799
DRP	0.7171	0.8319
DRR	0.9681	0.9753
DS6	0.7916	0.8323
DSD	0.8719	0.9667
DSE	0.8719	0.9667
DSF	0.7918	0.8932
DU6	1.0116	0.9779
DU8	0.9180	0.9076
DU9	0.9180	0.9076
DUB	0.9180	0.8418
DUC	0.8375	0.8404
DUF	0.7653	0.7473
DUJ	0.9158	0.9047
DUK	0.7677	0.8192
DUL	0.7109	0.7853
DUN	0.6492	0.7206
DUZ	1.0613	0.9799
DV6	0.8243	0.8650
DVC	0.9660	0.9768
DVG	0.8845	0.9593
DW7	0.8661	0.9317
DW9	0.6774	0.6511
DWE	0.8735	0.9168
DWM	0.8666	0.8786
DWO	0.7694	0.7990
DWU	0.9681	0.9799
DWW	0.9614	0.9679
DWX	0.9158	0.9038
DX2	0.9158	0.9038
DY0	0.7171	0.7103
DY1	0.8719	0.7261
DY3	0.7916	0.8323
DY4	0.7171	0.8312
DY5	0.9614	0.9679
DY7	0.9158	0.9673
DYY	0.7880	0.7215
DYZ	0.7140	0.4880
DZ0	0.7856	0.7522
DZ1	0.7140	0.6852
DZ3	0.7508	0.7174
E2A	0.9490	0.9751
E3A	0.9951	0.9776

Plan	Pro Factor	Instl Factor
E4G	0.8093	0.8473
E4T	0.8083	0.7269
E4U	0.9664	0.9840
E4V	0.8516	0.8720
E5A	1.0023	0.9736
E7A	0.9543	0.9736
E7R	0.8296	0.8435
E7S	0.8105	0.9708
E85	0.8816	0.9509
E88	0.8816	0.9509
E8P	0.9664	0.9840
E8Q	0.8845	0.7677
E94	1.0317	0.9779
E9I	0.8843	0.9794
E9J	0.9676	0.9799
E9K	0.8441	0.9699
E9N	0.9158	0.8886
E9O	0.9158	0.8886
E9P	0.9681	0.9400
E9S	0.7808	0.8053
E9Y	0.9180	0.9751
EA2	0.8348	0.7235
EA3	0.8348	0.7235
EA5	0.8972	0.9538
EAA	0.9459	0.9733
EAI	0.8066	0.7292
EAJ	0.9113	0.9216
EB9	0.9215	0.9570
EBD	0.8845	0.9702
EBF	0.9254	0.9782
ECA	0.9368	0.9776
EEA	0.9951	0.9791
EEN	0.6093	0.4392
EEO	0.5895	0.4386
EEQ	0.6206	0.4394
EER	0.6206	0.4394
EFA	0.9918	0.9742
EGA	0.9918	0.9742
EHA	0.9452	0.9771
EIA	0.9965	0.9805
EK7	0.8719	0.8466
EKA	0.8981	0.9751
ELA	1.0481	0.9785
EMO	0.8038	0.7292
EMU	0.8038	0.7292
EMV	0.9024	0.9216
ENS	0.7469	0.5572
ENT	0.7352	0.5477
ENU	0.7352	0.4449
ENW	0.8714	0.8944
EOA	0.9449	0.9369
EQA	0.9457	0.9788

Plan	Pro Factor	Instl Factor
ES5	0.7880	0.8355
ET0	0.7369	0.7672
ET1	0.7945	0.7327
ET2	1.0778	0.9917
ETA	0.9051	0.9774
ETB	0.8066	0.7292
EUA	0.9485	0.9624
EUE	0.9055	0.9541
EUG	0.7560	0.8028
EUI	0.8112	0.8740
EUN	0.8255	0.8329
EVA	0.9932	0.9627
EVG	0.8114	0.8932
EVX	0.7959	0.8734
EWA	0.9949	0.9782
EWO	0.7171	0.6729
EWU	0.7171	0.6729
EY9	0.8038	0.7292
EYA	0.9485	0.9027
EYU	0.8038	0.7292
EYV	0.9024	0.9216
EZA	0.9117	0.8441
F1A	0.9932	0.9627
F2N	0.7945	0.5813
F59	1.0286	0.9659
F5A	0.9927	0.9779
F7A	1.0656	0.9903
FAA	0.9925	0.9722
FCA	0.9956	0.9753
FDK	0.8714	0.8944
FDN	0.9614	0.9052
FDO	0.9158	0.9047
FDP	0.8685	0.8210
FDQ	0.8671	0.8877
FDR	0.7883	0.8891
FDS	0.7123	0.8569
FDT	0.6511	0.5373
FDU	0.6483	0.7521
FDV	0.6210	0.4668
FDW	0.6093	0.4392
FEA	0.9449	0.9722
FEG	1.0000	1.0000
FEH	0.9593	0.9081
FEI	0.9151	0.8289
FEJ	0.9180	0.9076
FEK	0.7985	0.8277
FEL	0.7985	0.7622
FEM	0.7171	0.6781
FEN	0.6480	0.7521
FEO	0.6258	0.4658
FEP	0.6206	0.4394
FET	0.7995	0.8277

Plan	Pro Factor	Instl Factor
FEU	0.7995	0.7622
FEV	0.7171	0.6781
FEW	0.6480	0.7521
FEX	0.6189	0.4658
FEY	0.6206	0.4406
FEZ	0.9614	0.9044
FF0	0.9158	0.9673
FF1	0.8719	0.8203
FF2	0.8719	0.9033
FF3	0.8719	0.8398
FF4	0.8719	0.7261
FF5	0.7916	0.8191
FF6	0.7916	0.7542
FF7	0.7916	0.7114
FF8	0.7171	0.8182
FF9	0.7171	0.7531
FFA	0.9430	0.9776
FFB	0.7171	0.6781
FFC	0.6483	0.7521
FFD	0.6258	0.4664
FFE	0.5895	0.4386
FGA	0.9416	0.9581
FGE	0.8719	0.8200
FGF	0.8719	0.9033
FGG	0.8719	0.8398
FGH	0.7916	0.7542
FGI	0.7916	0.7114
FGJ	0.7171	0.7531
FGK	0.7171	0.6781
FGL	0.6483	0.7521
FGM	0.6258	0.4664
FGN	0.6093	0.4386
FH2	0.9531	0.9788
FH3	0.9531	0.9788
FHV	0.8585	0.8573
FHW	0.8585	0.8573
FIA	0.9449	0.9722
FJA	0.8981	0.9722
FKA	0.9449	0.9297
FLA	0.8981	0.9369
FM5	0.8038	0.7292
FM6	0.9024	0.9216
FM7	0.8114	0.8932
FM9	0.7524	0.8355
FMA	0.9476	0.9779
FMC	0.9681	0.9799
FMD	0.8661	0.9317
FMX	0.7345	0.7665
FMY	0.9015	0.8820
FMZ	0.8062	0.8171
FN1	0.7935	0.8392
FND	0.8038	0.7292

Plan	Pro Factor	Instl Factor
FP2	0.8719	0.8335
FP3	0.7995	0.8406
FPD	0.7369	0.7672
FPE	1.0778	0.9917
FPF	0.8062	0.8171
FPG	0.9015	0.8820
FPH	1.0964	0.9926
FQ8	0.7560	0.8028
FQI	0.9063	0.9776
FR7	0.8843	0.9794
FR8	0.9676	0.9799
FR9	0.8441	0.9699
FRJ	0.8038	0.7292
FSB	0.8021	0.7292
FT3	0.8021	0.7292
FTE	0.8671	0.8877
FUE	0.9180	0.9076
FWD	0.9576	0.9052
FWF	0.9125	0.9047
FWG	0.9034	0.7550
FWH	0.8659	0.8210
FWI	0.8645	0.8877
FWJ	0.7880	0.8199
FWK	0.7880	0.7549
FWL	0.7871	0.8891
FWM	0.7135	0.6787
FWN	0.7121	0.8569
FWO	0.6507	0.5373
FWP	0.6480	0.7521
FWQ	0.6208	0.4668
FWR	0.6091	0.4392
FWT	0.9153	0.9673
FWU	0.9125	0.9038
FWV	0.9005	0.5101
FWW	0.8692	0.8203
FWX	0.8692	0.9033
FWY	0.8692	0.8398
FWZ	0.8692	0.7261
FX0	0.7904	0.8191
FX1	0.7904	0.7542
FX2	0.7904	0.8452
FX3	0.7904	0.7114
FX4	0.7168	0.8182
FX5	0.7168	0.7531
FX6	0.7168	0.6781
FX7	0.7168	0.7238
FX8	0.6480	0.7521
FX9	0.6256	0.4664
FXB	0.5943	0.4386
FXC	0.9576	0.9044
FXF	0.8692	0.8200
FXG	0.8692	0.9033

Plan	Pro Factor	Instl Factor
FXH	0.8692	0.8398
FXI	0.7904	0.8191
FXJ	0.7904	0.7542
FXK	0.7904	0.8452
FXL	0.7904	0.7114
FXM	0.7168	0.7531
FXN	0.7168	0.6781
FXO	0.7168	0.7238
FXP	0.6480	0.7521
FXR	0.6091	0.4386
G1A	0.9452	0.9673
G1Z	0.9254	0.9782
G2A	0.9932	0.9776
G3A	0.9965	0.9776
G4A	0.9452	0.9776
G5A	0.8981	0.9670
G5Z	0.9593	0.9081
G61	0.9153	0.9076
G62	0.9153	0.9076
G63	0.9053	0.7548
G64	0.9053	0.5101
G65	0.8733	0.8280
G67	0.8733	0.8714
G69	0.7985	0.8277
G6B	0.7985	0.8277
G6C	0.7985	0.7622
G6D	0.7985	0.7622
G6E	0.7985	0.8702
G6G	0.7171	0.6781
G6H	0.7171	0.6781
G6K	0.6480	0.7521
G6L	0.6480	0.5026
G6M	0.6203	0.4394
G6N	0.6203	0.4345
G6O	0.6258	0.4653
G6P	0.6258	0.4595
G6Q	1.0000	1.0000
G6Z	0.8035	0.7292
G70	0.9020	0.9216
G80	0.8590	0.9776
G81	1.0565	0.9799
G85	0.7627	0.7272
G86	0.8611	0.8958
G9A	0.9932	0.9776
GBB	0.7469	0.5572
GBC	0.7371	0.5477
GBD	0.7371	0.4449
GBE	0.7345	0.7665
GBF	1.0964	0.9926
GGB	0.8370	0.8915
GGL	0.6492	0.7206
GGM	0.6774	0.6511

Plan	Pro Factor	Instl Factor
G18	0.7123	0.8569
G1B	0.7995	0.7795
G1K	0.9660	0.9768
G1L	0.8035	0.7292
G1V	0.9129	0.9736
G1W	0.7906	0.7213
G17	1.0567	0.9917
G18	1.0567	0.9917
G1D	1.0209	0.9776
G1F	0.7627	0.7272
G1L	0.8363	0.9613
G1M	0.8050	0.9650
G1N	0.7627	0.7272
G1G	0.9258	0.8872
G1N	0.9645	0.9753
G1P	0.7627	0.7272
G15	0.7684	0.7272
G16	0.8671	0.8958
G1P	0.8293	0.8460
G1R	0.8050	0.8923
G1W	0.9225	0.9782
G15	0.6722	0.4951
G16	0.6576	0.4793
G17	0.7075	0.4951
G1C	0.9681	0.9799
G1D	1.0020	0.9799
G1F	0.9531	0.9688
G1P	1.0565	0.9799
G1S	0.7075	0.4951
G1T	0.9129	0.9047
G1U	0.9645	0.9799
G1V	1.0111	0.9799
G1X	0.8671	0.8398
G1Y	0.9151	0.9076
G15	0.8695	0.9033
G17	0.8695	0.7261
G18	0.9151	0.9076
G19	0.8738	0.9463
G1C	0.9151	0.9076
G1F	0.9645	0.9799
G1L	1.0168	0.9776
G1M	0.8797	0.9443
G1N	0.8516	0.8720
G1P	0.8590	0.9776
G14	0.7123	0.7665
G16	0.7985	0.7795
G18	0.9227	0.9056
G19	0.9180	0.9753
G1D	1.0515	0.9776
G1F	0.8800	0.9509
G1Y	0.9624	0.9768
G12	0.9129	0.9728

Plan	Pro Factor	Instl Factor
GW3	0.7906	0.7206
GW4	0.9629	0.9840
GW5	0.8824	0.7677
GWD	0.8642	0.8786
GWH	0.9466	0.9030
GWI	0.9003	0.9024
GWJ	0.8905	0.5132
GWK	0.8527	0.8188
GWL	0.8513	0.8384
GWM	0.7734	0.8180
GWN	0.7734	0.7528
GWO	0.7734	0.8653
GWQ	0.6996	0.6769
GWR	0.6982	0.7651
GWS	0.6772	0.5106
GWT	0.6368	0.6201
GWU	0.6093	0.5098
GWV	0.5926	0.4658
GWV	0.5902	0.4394
GWZ	0.9003	0.9024
GX0	0.8905	0.5132
GX1	0.8561	0.8188
GX2	0.8561	0.9018
GX3	0.8561	0.8384
GX4	0.8561	0.7246
GX5	0.7768	0.8180
GX6	0.7768	0.7528
GX7	0.7768	0.8653
GX8	0.7768	0.7103
GXB	0.7030	0.8182
GXC	0.7030	0.7519
GXD	0.7030	0.6769
GXE	0.7030	0.7651
GXF	0.6772	0.5106
GXG	0.6089	0.5098
GXH	0.6199	0.4653
GXI	0.5905	0.4394
GXK	0.9003	0.9024
GXL	0.8905	0.5132
GXM	0.8561	0.8200
GXN	0.8561	0.9018
GXO	0.8618	0.8384
GXP	0.7768	0.8180
GXQ	0.7768	0.7528
GXS	0.7768	0.7103
GXT	0.7398	0.7396
GXU	0.7030	0.7519
GXV	0.6996	0.6769
GXW	0.7030	0.7651
GXY	0.6089	0.5098
GY0	0.5902	0.4394
H0J	1.0000	1.0000

Plan	Pro Factor	Instl Factor
HON	0.9003	0.9024
HOP	0.9003	0.9024
HOR	0.7572	0.5856
HOS	0.7460	0.4351
HOT	0.6633	0.3708
HOU	0.5974	0.4653
HOV	0.5974	0.4578
HOW	0.5905	0.4394
HOY	0.9466	0.9030
H0Z	0.8929	0.5132
H10	0.8929	0.5132
H11	0.8561	0.8188
H13	0.8561	0.8384
H15	0.7770	0.8180
H16	0.7770	0.8180
H17	0.7770	0.7528
H18	0.7770	0.7528
H19	0.7770	0.8653
H1E	0.7082	0.6769
H1F	0.7082	0.6769
H1G	0.6982	0.7651
H1J	0.6772	0.5106
H1L	0.6093	0.5038
H1M	0.6093	0.5038
H1N	0.5919	0.4411
H6Q	1.0479	0.9041
H6R	0.9003	0.9024
H6S	0.8905	0.4972
H6T	0.8561	0.8188
H6U	0.8561	0.8384
H6V	0.8561	0.7111
H6W	0.7768	0.8039
H6X	0.7768	0.7390
H6Y	0.7768	0.5773
H6Z	0.7398	0.7258
H70	0.7030	0.6629
H71	0.7030	0.5618
H72	0.6772	0.4946
H73	0.6089	0.4937
H74	0.5871	0.4368
H78	0.9965	0.9756
H8X	0.9605	0.9837
H8Z	1.0243	0.9659
HAA	1.0481	0.9673
HBA	0.9932	0.8653
HBP	0.9973	0.9776
HBR	0.9581	0.9811
HBS	0.9452	0.9811
HBT	0.7369	0.7665
HBU	1.0730	0.9917
HBV	0.8062	0.8171
HBW	0.9005	0.8820

Plan	Pro Factor	Instl Factor
HBX	0.7345	0.7665
HBY	1.0916	0.9926
HBZ	0.9005	0.8820
HC1	0.7935	0.8392
HC3	0.8573	0.8573
HC4	0.8573	0.8573
HC7	0.7808	0.8053
HC9	1.0073	0.9768
HCA	1.0481	0.9673
HCB	0.9449	0.9768
HCF	0.7627	0.7272
HCG	0.8611	0.8958
HDN	0.8972	0.9056
HDO	0.7469	0.5572
HDP	0.7371	0.5477
HDQ	0.7371	0.4449
HDR	0.7603	0.7999
HDS	0.8936	0.9018
HDT	0.8936	0.9026
HDU	1.0749	0.9926
HDV	0.8360	0.8915
HDX	0.8105	0.8932
HFR	0.8363	0.9613
HFS	0.8040	0.9650
HFT	0.8695	0.7261
HFU	0.9151	0.9076
HFZ	0.8661	0.9265
HG0	0.8692	0.8398
HG1	0.8888	0.8398
HG3	0.7985	0.8406
HGA	0.9932	0.9673
HGC	0.8776	0.9799
HGD	0.6492	0.4156
HGE	0.6774	0.6511
HGF	0.8179	0.8211
HGG	0.8179	0.8211
HGH	0.8179	0.8211
HGJ	0.9079	0.8671
HGK	0.9082	0.9038
HGT	0.9034	0.9776
HGU	0.7314	0.7120
HH3	1.0274	0.9779
HH6	0.7684	0.7272
HHW	0.9578	0.9679
HHX	0.8050	0.8923
HHZ	0.8800	0.9509
HIG	0.9645	0.9799
HIH	0.9985	0.9799
HIJ	0.9129	0.9047
HIK	0.9645	0.9799
HIL	1.0111	0.9799
HIP	0.9567	0.9688

Plan	Pro Factor	Instl Factor
HIW	0.9645	0.9753
HJ6	0.7627	0.7272
HJA	0.9043	0.8725
HJP	0.6722	0.4951
HJQ	0.6588	0.4793
HJR	0.7075	0.4951
HJS	0.7075	0.4951
HJY	0.9151	0.9076
HK1	0.9153	0.9081
HK2	0.9246	0.9782
HKA	1.0481	0.9776
HKJ	0.7627	0.7272
HKT	0.7627	0.7272
HKU	0.8611	0.8958
HL5	0.7985	0.8277
HL6	0.8554	0.9050
HMA	1.0940	0.9903
HNA	0.9932	0.9776
HOA	0.9452	0.9776
HQI	1.0243	0.9659
HS1	0.8293	0.846
HS4	0.9466	0.9030
HS5	0.9003	0.9024
HS6	0.8905	0.5132
HS7	0.8527	0.8188
HS8	0.8513	0.8384
HS9	0.7734	0.8180
HSB	0.7734	0.7479
HSC	0.7734	0.8653
HSE	0.6996	0.6769
HSF	0.6982	0.7651
HSG	0.6772	0.5106
HSI	0.6093	0.5098
HSJ	0.5902	0.4394
HSM	0.9466	0.903
HSO	0.9003	0.9024
HSP	0.8905	0.5132
HSQ	0.8561	0.8188
HSR	0.8561	0.9018
HSS	0.8561	0.8384
HST	0.8561	0.7246
HSU	0.7768	0.8180
HSV	0.7768	0.7479
HSW	0.7768	0.8653
HSX	0.7768	0.7103
HSZ	0.7030	0.8168
HT0	0.7030	0.7470
HT1	0.7030	0.6769
HT2	0.703	0.7651
HT3	0.6772	0.5046
HT4	0.6089	0.5098

Plan	Pro Factor	Instl Factor
HT5	0.5825	0.4394
HTA	1.0481	0.9776
HU2	1	1
HU5	1.0453	0.6382
HU8	0.9466	0.9030
HUB	0.9106	0.4314
HUC	0.9003	0.9024
HUD	0.9003	0.9024
HUE	0.8929	0.5132
HUF	0.8929	0.5132
HUG	0.8561	0.8188
HUI	0.8461	0.7634
HUJ	0.8561	0.8384
HUL	0.7770	0.8180
HUM	0.7770	0.8180
HUN	0.7770	0.7479
HUO	0.7770	0.7479
HUP	0.7770	0.8653
HUR	0.7572	0.5856
HUS	0.7460	0.4351
HUV	0.7082	0.6769
HUW	0.7082	0.6769
HUX	0.7015	0.7651
HUZ	0.6772	0.5046
HV1	0.6633	0.3708
HV2	0.6093	0.5038
HV3	0.6093	0.5038
HV4	0.5905	0.4394
HV5	0.5905	0.4394
HVE	0.9466	0.903
HVF	0.9003	0.9024
HVG	0.8905	0.5132
HVH	0.8561	0.8188
HVI	0.8561	0.9018
HVJ	0.8618	0.8384
HVK	0.7768	0.8180
HVL	0.7768	0.7528
HVN	0.7768	0.7103
HVO	0.7398	0.7396
HVP	0.7030	0.7470
HVQ	0.6996	0.6769
HVR	0.7030	0.7651
HVT	0.6089	0.5098
HVU	0.5902	0.4394
HXA	0.9385	0.9294
HYA	0.8883	0.8921
HZ0	1.0479	0.8895
HZ1	0.9431	0.6329
HZ2	1.0479	0.5819
HZ3	0.9402	0.5939
HZ4	0.8553	0.6035
HZ5	0.9003	0.8952

Plan	Pro Factor	Instl Factor
HZ6	0.8905	0.5148
HZ7	0.8561	0.8188
HZ8	0.7705	0.7652
HZ9	0.8513	0.8411
HZB	0.7705	0.6658
HZC	0.8561	0.7175
HZD	0.7705	0.6471
HZE	0.7705	0.6021
HZF	0.7768	0.8086
HZG	0.7768	0.7476
HZH	0.7768	0.5957
HZI	0.7398	0.7371
HZJ	0.703	0.6797
HZK	0.703	0.5847
HZL	0.6772	0.5228
HZM	0.6327	0.5698
HZN	0.6093	0.525
HZO	0.859	0.9776
HZQ	1.0515	0.9776
HZU	0.7627	0.7272
HZV	0.8611	0.8958
I4A	0.9084	0.8441
I6A	1.0200	0.9745
I7A	0.9719	0.9776
I8A	0.9452	0.9624
J6A	0.9576	0.9782
J6L	0.918	0.9753
J7A	0.9459	0.9837
J83	0.9624	0.9768
J8B	0.9581	0.9811
J8C	0.9485	0.9811
J8D	1.0713	0.9825
J8E	0.7603	0.7999
J9A	1.0742	0.9937
J9K	0.8738	0.9463
J9P	0.7469	0.5572
J9Q	0.7371	0.5477
J9R	0.7371	0.4449
J9S	0.7808	0.8053
J9U	0.8360	0.8877
J9Y	0.7369	0.7665
J9Z	1.0730	0.9917
JA0	0.9005	0.8820
JA1	0.7345	0.7665
JA2	1.0916	0.9926
JA3	0.9005	0.8820
JA4	0.8573	0.8573
JA5	0.8573	0.8573
JAG	0.6492	0.4156
JAH	0.6774	0.6511
JAI	0.8105	0.8932
JAK	0.9605	0.9837

Plan	Pro Factor	Instl Factor
JAL	0.8807	0.9509
JAN	0.9965	0.9756
JA0	0.995	0.815
JAP	0.7935	0.8392
JAQ	0.8800	0.9509
JAV	0.7123	0.7665
JAX	0.7985	0.7795
JB0	0.8291	0.8211
JB1	0.8324	0.8211
JB2	0.8291	0.8211
JB7	0.8697	0.7261
JB8	0.9151	0.9076
JB9	1.0168	0.9776
JBB	0.9129	0.9728
JBC	0.7906	0.7206
JBD	0.9629	0.9840
JBE	0.8824	0.7677
JBI	0.8661	0.9265
JBJ	0.8776	0.9799
JBK	0.9645	0.9799
JBN	0.9227	0.9056
JBQ	0.8692	0.8398
JBR	0.8888	0.8398
JBS	0.9258	0.8872
JBT	0.9079	0.8671
JBU	0.9082	0.9038
JBY	0.9975	0.9776
JC0	0.8363	0.9613
JC1	0.8040	0.9650
JC4	1.0274	0.9779
JC6	0.9034	0.9776
JCE	0.9005	0.9056
JCF	0.8936	0.9018
JCG	0.8936	0.9026
JCH	0.7627	0.7272
JCZ	0.7314	0.712
JD2	0.8561	0.8662
JD4	0.8561	0.8662
JDJ	0.9151	0.9076
JDR	0.9129	0.9047
JDS	0.9645	0.9799
JDT	1.0111	0.9799
JE0	0.9645	0.9753
JE2	0.7627	0.7272
JEJ	0.9645	0.9799
JEK	0.9985	0.9799
JEM	0.8050	0.8923
JEO	0.7985	0.8277
JEP	0.9567	0.9688
JEU	0.8289	0.8460
JK7	0.7627	0.7272
JLK	0.9466	0.903

Plan	Pro Factor	Instl Factor
JLL	0.9003	0.9024
JLM	0.8905	0.5132
JLN	0.8513	0.9653
JLO	0.8527	0.8188
JLP	0.8513	0.8384
JLQ	0.8119	0.7743
JLR	0.7734	0.818
JLS	0.7734	0.7479
JLT	0.7734	0.8653
JLV	0.7398	0.7396
JLW	0.6996	0.716
JLX	0.7030	0.6769
JLY	0.6982	0.7651
JLZ	0.6772	0.5106
JM0	0.6093	0.5098
JM1	0.5902	0.4394
JM8	0.8905	0.5148
JMB	0.8561	0.8188
JMW	0.9466	0.903
JMX	0.9003	0.9024
JMY	0.8905	0.5132
JMZ	0.8561	0.9653
JN0	0.8561	0.8188
JN1	0.8561	0.8384
JN2	0.815	0.7743
JN3	0.7768	0.818
JN4	0.7768	0.7479
JN5	0.7768	0.8653
JN6	0.7768	0.7103
JN7	0.7398	0.7396
JN8	0.703	0.747
JN9	0.703	0.6769
JNB	0.703	0.7651
JNC	0.6772	0.5046
JND	0.6089	0.5098
JNE	0.5905	0.4394
JNF	1	1
JOE	0.9466	0.903
JOG	0.9106	0.4314
JOH	0.9003	0.9024
JOI	0.9003	0.9024
JOJ	0.8929	0.5132
JOK	0.8929	0.5132
JOL	0.8561	0.9653
JOM	0.8561	0.9653
JON	0.8561	0.8188
JOP	0.8461	0.7634
JOQ	0.8561	0.8384
JOR	0.8561	0.8384
JOV	0.777	0.818
JOX	0.777	0.7479
JOY	0.777	0.7479

Plan	Pro Factor	Instl Factor
JOZ	0.777	0.8653
JP1	0.7572	0.5856
JP2	0.7770	0.7103
JP4	0.746	0.4351
JP8	0.7082	0.747
JP9	0.7082	0.747
JPB	0.7082	0.6769
JPC	0.7082	0.6769
JPD	0.7015	0.7651
JPF	0.6772	0.5046
JPH	0.6633	0.3708
JPI	0.6093	0.5038
JPJ	0.6093	0.5038
JPK	0.5905	0.4394
JPL	0.5905	0.4394
JPO	0.9466	0.903
JPP	0.9003	0.9024
JPQ	0.8905	0.5132
JPR	0.8561	0.9653
JPS	0.8561	0.8188
JPT	0.8561	0.8384
JPU	0.815	0.7743
JPV	0.7768	0.818
JPW	0.7768	0.7479
JPX	0.7734	0.8653
JPY	0.7768	0.7103
JPZ	0.7398	0.7396
JQ0	0.703	0.747
JQ1	0.6996	0.6769
JQ2	0.703	0.7651
JQ3	0.6772	0.5106
JQ4	0.6089	0.5098
JQ5	0.5902	0.4394
JW2	0.9246	0.9782
JW8	0.8590	0.9776
JW9	1.0243	0.9659
JWB	1.0713	0.9825
JXE	1.0515	0.9776
JXG	0.7684	0.7272
JXH	0.8671	0.8958
JZ0	0.8554	0.905
JZ1	0.6492	0.4156
JZ2	0.6774	0.6511
JZ7	0.7897	0.7272
JZ8	0.8611	0.8958
JZ9	0.7627	0.7272
JZB	0.8611	0.8958
K10	0.8776	0.9799
K11	0.7469	0.5572
K12	0.7371	0.5477
K13	0.7371	0.4449
K14	0.7964	0.8171

Plan	Pro Factor	Instl Factor
K15	1.073	0.9917
K16	0.8893	0.882
K17	0.7345	0.7665
K18	1.0916	0.9926
K19	0.9005	0.882
K1A	0.9932	0.9776
K1C	0.9975	0.9776
K1E	0.7608	0.7999
K1F	1.0749	0.9926
K1G	0.8372	0.8877
K1J	0.88	0.9509
K1K	0.7369	0.7665
K1L	0.9645	0.9811
K1M	0.9548	0.9811
K1N	0.7935	0.8392
K1Q	0.9965	0.9756
K1Q	0.9965	0.9756
K1S	0.9645	0.9799
K1T	0.9985	0.9799
K1X	0.8684	0.9289
K20	0.9624	0.9768
K24	0.8105	0.8932
K26	1.0168	0.9776
K27	0.9246	0.9782
K2C	0.995	0.815
K2D	0.8598	0.8573
K2E	0.9005	0.9056
K2F	0.9129	0.9728
K2G	0.7906	0.7206
K2H	0.9629	0.984
K2I	0.8824	0.7677
K2M	0.9645	0.9799
K2O	0.8291	0.8211
K2P	0.8324	0.8211
K2Q	0.8291	0.8211
K2S	0.9079	0.8671
K2T	0.9082	0.9038
K2U	0.8697	0.7261
K2V	0.9151	0.9076
K2Y	0.7159	0.7665
K2Z	0.7985	0.7709
K33	0.9227	0.9056
K36	0.9258	0.8872
K37	0.8807	0.9509
K38	0.7808	0.8053
K39	0.8738	0.9463
K3A	0.9987	0.9779
K3H	1.0274	0.9779
K3J	0.8692	0.8398
K3K	0.8891	0.8398
K3M	0.9605	0.9837
K3Q	0.8363	0.9613

Plan	Pro Factor	Instl Factor
K3R	0.804	0.965
K3S	0.7314	0.7120
K3U	0.9034	0.9776
K43	0.9578	0.9679
K46	0.8561	0.8662
K4B	0.8561	0.8662
K4E	0.7634	0.7272
K4T	0.8050	0.8923
K4Z	0.7634	0.7272
K50	0.7627	0.7272
K5E	0.7634	0.7272
K5F	0.7627	0.7272
K5P	0.9151	0.9076
K5S	0.9129	0.9047
K5T	0.9645	0.9799
K5U	1.0111	0.9799
K5Z	0.9567	0.9688
K62	0.9645	0.9753
K64	0.7985	0.8277
K65	0.8086	0.8171
K66	0.8086	0.8171
K67	0.7902	0.7192
K68	0.8611	0.8975
K6A	0.9485	0.9776
K6M	0.7902	0.7192
K6N	0.8611	0.8975
K7A	0.9700	0.9719
K8A	0.9452	0.9581
KCX	0.8289	0.8460
KCZ	0.8600	0.8573
KD1	0.7634	0.7272
KD2	0.8611	0.8958
KD3	0.7627	0.7272
KD4	0.8611	0.8958
KDE	0.9548	0.9811
KDI	0.9469	0.8975
KDK	0.9005	0.8967
KDL	0.8931	0.4986
KDN	0.8563	0.8188
KDP	0.8537	0.7579
KDQ	0.8563	0.8326
KDU	0.7773	0.8122
KDV	0.7773	0.7513
KDY	0.7572	0.5799
KE0	0.7474	0.4294
KE3	0.7085	0.7433
KE4	0.7085	0.6640
KE7	0.6636	0.3581
KE9	0.5910	0.4377
KEA	0.9015	0.9673
KEH	0.8563	0.8326
KEK	0.7773	0.7513

Plan	Pro Factor	Instl Factor
KEQ	0.7085	0.6640
KEU	0.5910	0.4377
KFV	0.8907	0.4986
KFX	0.8563	0.8188
KGJ	0.9469	0.8975
KGK	0.9005	0.8967
KGL	0.8907	0.4986
KGM	0.8549	0.9598
KGN	0.8563	0.8188
KGP	0.8549	0.8326
KGS	0.7770	0.7513
KGT	0.7770	0.8596
KGU	0.7789	0.8315
KGV	0.7770	0.7045
KGX	0.7032	0.7143
KGZ	0.7032	0.6640
KGZ	0.7018	0.7525
KH0	0.6772	0.5098
KH1	0.6093	0.4949
KH2	0.5910	0.4386
KH4	0.9005	0.8967
KH6	0.8563	0.9598
KH7	0.8563	0.8188
KH9	0.8563	0.8326
KHC	0.7770	0.8177
KHD	0.7770	0.7513
KHH	0.7400	0.7341
KHI	0.7032	0.7433
KHK	0.7032	0.7525
KHL	0.6772	0.5098
KHM	0.6091	0.4949
KIA	0.9449	0.9722
KJA	0.9925	0.9722
KJC	0.9469	0.8975
KJD	0.9005	0.8967
KJE	0.8907	0.4986
KJG	0.8563	0.8188
KJI	0.8563	0.8326
KJK	0.7770	0.8177
KJM	0.7770	0.8596
KJQ	0.7032	0.7433
KJU	0.6091	0.4949
KJV	0.5910	0.4377
KKR	0.7474	0.5572
KKS	0.7371	0.5477
KKT	0.7371	0.4449
KKV	1.0515	0.9776
KKX	0.8590	0.9776
KLA	0.9502	0.9624
KMA	0.8981	0.9722
KOA	0.9970	0.9779
KOC	1.0243	0.9659

Plan	Pro Factor	Instl Factor
KOD	1.0727	0.9825
KOE	0.8800	0.9509
KPA	0.9039	0.9383
KQ5	0.8556	0.9050
KQ7	0.8699	0.7261
KQ8	0.9156	0.9076
KQA	0.9435	0.9733
KQB	0.9965	0.9756
KQC	0.7937	0.8392
KQH	0.7369	0.7665
KQI	0.7966	0.8171
KQJ	0.8893	0.8820
KQK	0.8088	0.8171
KQL	0.7347	0.7665
KQM	0.9008	0.8820
KQN	0.8088	0.8171
KQO	1.0730	0.9917
KQP	1.0916	0.9926
KQQ	0.9624	0.9771
KQT	0.9701	0.9793
KQV	0.6492	0.4093
KQW	0.6774	0.6514
KQX	0.9952	0.8183
KQY	0.9648	0.9802
KQZ	0.9987	0.9802
KR0	0.8107	0.8958
KR2	0.9605	0.9837
KR4	1.0168	0.9776
KR9	0.8686	0.9289
KRA	0.9965	0.9776
KRG	0.9246	0.9782
KRK	0.7613	0.8033
KRL	0.9132	0.9716
KRM	0.7909	0.7217
KRS	0.8695	0.8398
KRT	0.8893	0.8398
KRU	0.9975	0.9776
KS1	0.9227	0.9056
KS2	0.7161	0.7665
KS3	0.7990	0.7795
KS4	0.9082	0.8671
KS5	0.9082	0.9038
KS6	0.8807	0.9509
KS9	0.7811	0.8053
KSA	0.8981	0.9317
KSE	0.8365	0.9613
KSF	0.8043	0.9650
KSI	1.0276	0.9779
KSO	0.9258	0.8872
KSS	0.8778	0.9808
KST	0.9034	0.9776
KTA	0.9968	0.9776

Plan	Pro Factor	Instl Factor
KWA	0.9039	0.9693
KXA	1.0128	0.9776
KYA	0.9492	0.9710
KZA	0.9951	0.9791
L2A	0.9485	0.9776
L4A	0.9015	0.9774
L5A	0.9452	0.9776
L7A	1.0145	0.9753
L9A	0.9452	0.9776
M1A	0.9449	0.9739
M2A	1.0940	0.9903
M3A	0.9932	0.9808
M5A	0.9980	0.9808
M6A	0.9452	0.8912
M7A	0.9557	0.8754
M8A	0.9932	0.9811
MCA	0.9399	0.9705
MDA	0.9965	0.9776
MEA	1.0739	0.9825
MFA	0.9524	0.9776
MMA	0.9160	0.9438
MNA	1.0011	0.9776
MRA	0.9485	0.9776
MSA	1.0030	0.9673
MTA	0.8671	0.9544
MUA	0.9091	0.9547
MVA	0.9385	0.8921
MWA	1.0496	0.9076
N2A	0.9949	0.9776
N3A	0.9932	0.9776
N4A	0.9932	0.9776
N6A	0.9965	0.9776
N7A	0.9965	0.9776
N9A	0.9944	0.9624
NEA	0.8981	0.9394
NMA	0.9452	0.9702
NNA	0.8917	0.8786
NOA	0.9982	0.9817
NQA	0.9051	0.9481
NRA	0.9383	0.9693
NXA	0.9387	0.9708
NYA	1.0708	0.9776
NZA	1.0195	0.9877
O1A	0.9485	0.9776
O2A	0.9452	0.9397
O3A	0.9452	0.9776
O4A	0.9932	0.9397
O5A	0.9452	0.9624
O9A	0.9526	0.9776
P1A	0.9932	0.9702
P2A	0.8917	0.9394
P3A	0.9535	0.9776

Plan	Pro Factor	Instl Factor
P5A	0.8981	0.9730
QOA	0.9165	0.9774
QPA	1.0037	0.9848
R2A	0.9488	0.9776
R3A	0.9648	0.9776
R4A	0.8888	0.9027
R6A	0.9932	0.9397
R7A	0.8883	0.9024
R8A	0.9452	0.9805
R9A	0.9084	0.8409
S01	0.9485	0.9035
S02	0.9485	0.8771
S03	0.9015	0.9035
S04	0.9015	0.8771
S05	0.8821	0.9035
S06	0.8821	0.8771
S07	0.8315	0.9035
S08	0.8315	0.8771
S09	0.8566	0.9030
S0A	0.8129	0.9030
S0B	0.8129	0.8765
S0C	0.9485	0.9733
S0D	0.9485	0.8372
S0E	0.9015	0.8372
S0F	0.8821	0.8932
S0G	0.8315	0.8932
S0H	0.8566	0.8369
S0J	0.8129	0.8366
S0K	0.9485	0.9024
S0L	0.9015	0.9024
S0M	0.9015	0.8760
S0N	0.8129	0.9018
S0P	0.8315	0.9024
S0Q	0.8315	0.8760
S0R	0.8566	0.9021
S0S	0.8821	0.9024
S0T	0.8129	0.8754
S0U	0.9485	0.7016
S0V	0.9015	0.7729
S0W	0.9015	0.6953
S0X	0.8566	0.7729
S0Y	0.8566	0.7660
S0Z	0.8566	0.6953
S11	0.8129	0.7726
S12	0.8570	0.9730
S13	0.8129	0.7660
S14	0.8129	0.6950
S15	0.9485	0.9682
S16	0.9485	0.8343
S17	0.9015	0.9303
S18	0.9015	0.9679
S19	0.9048	0.8326

Plan	Pro Factor	Instl Factor
S1A	0.8704	0.9452
S1B	0.8566	0.9679
S1C	0.8566	0.8340
S1D	0.8437	0.9073
S1E	0.9015	0.9730
S1F	0.9488	0.9736
S1G	0.9435	0.9834
S1H	0.9015	0.9627
S1J	0.7851	0.8771
S1K	1.0063	0.9776
S1L	0.9015	0.9578
S1M	0.9015	0.9165
S1N	1.0011	0.9776
S1P	0.9015	0.9621
S1Q	0.9485	0.9397
S1R	0.9015	0.9776
S1S	0.9490	0.9751
S1T	0.9485	0.9624
S1U	0.9965	0.9776
S1V	0.9015	0.9673
S1W	0.9502	0.9624
S1X	0.9435	0.9733
S1Y	0.9015	0.9774
S1Z	0.9449	0.9739
S21	0.9949	0.9776
S22	0.9965	0.9776
S23	0.9965	0.9776
S24	0.9485	0.9776
S25	0.8917	0.9394
S26	1.0512	0.9776
S27	0.8917	0.9394
S2A	0.9961	0.9843
S32	0.5976	0.7832
S33	0.7390	0.7930
S34	0.8222	0.8022
S35	0.9418	0.9710
S36	0.9418	0.9038
S37	0.9418	0.8389
S38	0.9418	0.6973
S39	0.8917	0.9705
S3A	1.0188	0.9834
S3B	0.8917	0.9033
S3C	0.8917	0.8384
S3D	0.8917	0.6824
S3E	0.8437	0.8378
S3F	0.8437	0.6818
S3G	0.8095	0.8108
S3H	0.7985	0.8510
S3J	0.7985	0.6812
S3K	0.7565	0.8504
S3L	0.7247	0.8007
S3M	0.5835	0.7898

Plan	Pro Factor	Instl Factor
S3N	0.8566	0.6962
S3P	0.8566	0.7950
S3Q	0.9015	0.8662
S3Z	0.8917	0.9524
S49	0.9418	0.9038
S4B	0.8917	0.9033
S4C	0.8437	0.8378
S4D	0.7565	0.8504
S4E	0.8821	0.8378
S4F	0.9418	0.8389
S4G	0.9418	0.6973
S4H	0.8917	0.9705
S4J	0.8315	0.8378
S4K	0.8917	0.8384
S4L	0.8917	0.6824
S4M	0.8315	0.9027
S4N	0.8437	0.6818
S4P	0.7985	0.8510
S4Q	0.7985	0.6812
S4R	0.9418	0.9710
S4S	0.7247	0.8007
S4T	0.5835	0.7898
S4U	0.8095	0.8108
S4V	0.8222	0.8027
S4W	0.8917	0.9524
S52	0.8129	0.9314
S53	0.7390	0.7933
S54	0.8370	0.8935
S55	0.8527	0.9165
S56	0.9418	0.9656
S57	0.9418	0.9024
S58	0.9418	0.8455
S59	0.9418	0.8389
S5A	0.9084	0.8441
S5B	0.9418	0.7255
S5C	0.9418	0.8329
S5D	0.9418	0.7720
S5E	0.8917	0.9650
S5F	0.8917	0.9018
S5G	0.8917	0.8450
S5H	0.8917	0.8384
S5J	0.8917	0.6824
S5K	0.8917	0.8320
S5L	0.8917	0.7714
S5M	0.8437	0.9644
S5N	0.8437	0.9012
S5P	0.8437	0.8444
S5Q	0.8437	0.8378
S5R	0.8437	0.6818
S5S	0.8437	0.8315
S5T	0.8437	0.7709
S61	0.6898	0.7105

Plan	Pro Factor	Instl Factor
S62	0.8566	0.9030
S63	0.7708	0.8900
S64	0.9485	0.9736
S65	0.9015	0.9035
S66	0.8494	0.9116
S67	0.8370	0.8935
S68	0.8566	0.7749
S69	0.8917	0.8384
S6A	1.0500	0.9776
S6Q	0.8129	0.5767
S71	0.8917	0.9018
S72	0.8437	0.9644
S73	0.8437	0.9012
S74	0.8437	0.8378
S75	0.7565	0.7100
S76	0.6755	0.7088
S77	0.8437	0.7243
S78	0.8437	0.8315
S79	0.7565	0.8306
S7A	0.9942	0.9805
S81	0.6755	0.8294
S82	0.7565	0.7697
S83	0.6755	0.7686
S84	0.9418	0.9656
S86	0.8917	0.9650
S96	0.8019	0.8877

Plan	Pro Factor	Instl Factor
S97	0.7935	0.8932
S98	0.9485	0.9776
SIA	0.9452	0.9590
SOA	0.9459	0.9814
SPA	0.8891	0.8277
SQA	0.9074	0.9664
SRA	0.9488	0.9736
SSA	0.9466	0.9745
STA	1.0025	0.9817
SUA	1.0039	0.9848
SVA	0.9521	0.9027
SWA	0.9383	0.9693
T1A	1.0498	0.9776
T2A	1.0512	0.9776
T5A	0.9932	0.9776
TAA	0.9965	0.9894
TCA	1.0104	0.9808
TEA	1.0711	0.9894
TIA	1.0739	0.9877
TJA	1.0047	0.9877
TQA	0.9531	0.9776
TRA	1.0708	0.9888
TTA	0.8891	0.8277
TUA	0.9380	0.9699
TVA	0.9932	0.9776
TWA	0.9734	0.9742

Plan	Pro Factor	Instl Factor
TXA	1.0391	0.9834
TYA	0.8981	0.9751
TZA	0.9481	0.9837
U1A	1.0145	0.9751
U2A	0.9485	0.9397
U3A	0.9485	0.9673
U4A	1.0481	0.9776
U5A	0.9452	0.9805
U8A	0.9965	0.9794
U9A	0.9851	0.9820
UBA	0.9459	0.9733
UDA	0.9430	0.9776
UEA	1.0037	0.9794
UFA	0.9426	0.9751
UHA	0.9970	0.9811
UKA	0.9485	0.8467
ULA	0.9485	0.7479
UMA	0.9485	0.9805
UPA	0.9963	0.9776
URA	0.9485	0.7479
UUA	0.9485	0.9122
UYA	0.9485	0.9122
W1A	1.0362	0.9682
W2A	0.9922	0.9753
W3A	0.9452	0.9805
W5A	0.9973	0.9848

Plan	Pro Factor	Instl Factor
W6A	0.9535	0.9805
W7A	0.9578	0.9693
X1A	0.9524	0.8648
X3A	0.9385	0.9397
X4A	0.9524	0.8757
X7A	0.8981	0.9774
X8A	0.9930	0.9776
Y1A	0.8883	0.9024
Y2A	0.8883	0.9291
Y3A	0.8883	0.9394
Y4A	0.8917	0.9394
Y5A	0.9452	0.9027
Y6A	0.8883	0.9394
Y9A	0.9942	0.9753
YYA	0.9583	0.9837
YZA	0.9610	0.9771
Z9A	1.0161	0.9776
ZKA	1.0481	0.9776
ZNA	0.9932	0.9776
ZOA	0.9452	0.9776
ZSA	1.0512	0.9776

**Q1 – 2024 BENEFIT PLAN FACTORS**

**A.3 Benefit Plan Factors for Capitation and Shared Risk Budgets**

Small Group HMO

Plan	Pro Factor	Instl Factor
105	0.6306	0.6567
10B	0.7925	0.7878
11E	0.8867	0.9105
11G	0.7089	0.7196
11H	0.6306	0.6529
11J	0.7899	0.7878
11K	0.7089	0.7196
12K	0.8351	0.8435
12V	0.7488	0.7211
12Y	0.9363	0.9645
13E	0.6695	0.4889
14Q	0.7488	0.7557
14R	0.9363	0.8894
14T	0.8351	0.8227
163	0.6695	0.6861
16V	0.7899	0.8181
17G	0.7089	0.7497
17K	0.6332	0.6529
182	0.8054	0.7918
191	0.8867	0.9105
1AB	0.9363	0.9645
1AC	0.8351	0.9004
1AD	0.7488	0.8354
1AE	0.6695	0.7084
1AF	0.9363	0.8894
1AG	0.8351	0.8227
1AH	0.7488	0.7557
1AJ	0.6695	0.6861
1BN	0.9363	0.9645
1BP	0.8351	0.8435
1BQ	0.7488	0.7211
1BR	0.6695	0.4889
1BS	0.9363	0.8894
1BT	0.8351	0.8227
1BU	0.7488	0.7557
1BV	0.6695	0.6861
1BW	0.9363	0.9645
1BX	0.8351	0.8435
1BY	0.7488	0.7211
1BZ	0.6695	0.4889
1CB	0.9363	0.8894

Plan	Pro Factor	Instl Factor
1CC	0.8351	0.8227
1CD	0.7488	0.7557
1CE	0.6695	0.6861
1DL	0.8867	0.9105
1DM	0.7797	0.8216
1DQ	1.0000	1.0000
1DR	0.7899	0.8181
1DS	0.7899	0.8181
1DU	0.7089	0.7497
1DV	0.7089	0.7497
1DW	0.7089	0.7497
1EJ	0.9470	0.9645
1EK	0.8560	0.9004
1EL	0.7769	0.8354
1EM	0.7030	0.7084
1EN	0.9470	0.8894
1EP	0.8560	0.8227
1EQ	0.7769	0.7557
1ER	0.7030	0.6861
1F6	0.7625	0.8926
1F7	0.7539	0.7780
1F8	0.7087	0.6991
1F9	0.6215	0.6590
1FV	0.9470	0.9645
1FW	0.8560	0.8435
1FX	0.7769	0.7211
1FY	0.7030	0.4889
1FZ	0.9470	0.8894
1GB	0.8560	0.8227
1GC	0.7769	0.7557
1GD	0.7030	0.6861
1GE	0.9470	0.9645
1GF	0.8560	0.8435
1GG	0.7769	0.7211
1GH	0.7030	0.4889
1GJ	0.9470	0.8894
1GK	0.8560	0.8227
1GL	0.7769	0.7557
1GM	0.7030	0.6861
1GW	0.7852	0.8926
1GX	0.7879	0.8926

Plan	Pro Factor	Instl Factor
1GY	0.7929	0.6994
1GZ	0.7929	0.7043
1HB	0.7933	0.7829
1HC	0.7933	0.7829
1HD	0.7501	0.6991
1HE	0.7511	0.6991
1HF	0.7486	0.7442
1HG	0.7496	0.7442
1HH	0.6696	0.6590
1HJ	0.6696	0.6590
1HK	0.6696	0.6821
1HL	0.6696	0.6821
1HR	0.7933	0.7930
1HS	1.0000	1.0000
1HT	0.8955	0.9105
1HU	0.8028	0.8216
1HX	1.0000	1.0000
1HY	0.8152	0.8181
1HZ	0.8152	0.8181
1JC	0.7396	0.7497
1JD	0.7396	0.7497
1JE	0.7396	0.7497
1JR	0.6666	0.6529
1JS	0.6666	0.6529
1JT	0.8152	0.7878
1JU	0.7396	0.7196
1JV	0.8152	0.7878
1JW	0.7396	0.7196
1JY	0.6666	0.6567
1JZ	0.8152	0.7878
1KB	0.7396	0.7196
1KF	0.7340	0.7231
1LB	0.8867	0.9105
1LF	0.7089	0.7497
1LU	0.9363	0.9645
1LV	0.8351	0.8435
1LW	0.7488	0.7211
1LX	0.6695	0.4889
1MD	0.9363	0.8894
1ME	0.8351	0.8227
1MF	0.7488	0.7557

Plan	Pro Factor	Instl Factor
1MG	0.6695	0.6861
1ML	0.8351	0.8435
1MM	0.7488	0.7214
1MN	0.6695	0.4889
1MX	0.8351	0.8227
1MY	0.7488	0.7557
1MZ	0.6695	0.6861
1N6	0.7039	0.7231
1NM	0.8179	0.7878
1NN	0.7396	0.7196
1NP	0.6666	0.6567
1NS	0.6693	0.6529
1NT	0.9470	0.9645
1NV	0.7769	0.7211
1NW	0.7030	0.4889
1NZ	0.7769	0.7557
1PB	0.7030	0.6861
1PF	0.8890	0.8929
1PG	0.7957	0.7430
1PH	0.7539	0.7375
1PJ	0.6724	0.6590
1PT	0.8955	0.9105
1PU	0.8057	0.8429
1PV	0.7933	0.7872
1PW	0.7340	0.7231
1PX	1.0000	1.0000
1PY	1.0000	1.0000
1QF	0.8179	0.8169
1QG	0.7396	0.7497
1QW	0.8152	0.7878
1QX	0.7396	0.7196
1QY	0.6666	0.6529
1RE	0.9470	0.9645
1RF	0.8560	0.8435
1RG	0.7769	0.7211
1RH	0.7030	0.4889
1RN	0.9470	0.8894
1RP	0.8560	0.8227
1RQ	0.7769	0.7557
1RR	0.7030	0.6861
1RW	0.9470	0.9645

## Q1 – 2024 BENEFIT PLAN FACTORS

Plan	Pro Factor	Instl Factor
1RX	0.8560	0.8435
1RY	0.7769	0.7214
1RZ	0.7030	0.4889
1SN	0.9470	0.8894
1SP	0.8560	0.8227
1SQ	0.7961	0.7829
1SR	0.7769	0.7557
1SS	0.7539	0.7442
1ST	0.7030	0.6861
1SU	0.6724	0.6821
21X	0.8351	0.8435
21Y	0.7488	0.7211
21Z	0.9363	0.9645
220	0.6695	0.4889
221	0.7488	0.7557
222	0.9363	0.8894
223	0.8351	0.8227
225	0.6695	0.6861
226	0.7899	0.8181
227	0.7089	0.7497
229	0.6306	0.6529
22B	0.7899	0.7878
22C	0.7089	0.7196
22D	0.8351	0.8435
22E	0.7488	0.7211
22F	0.9363	0.9645
22H	0.6695	0.4889
22J	0.7488	0.7557
22K	0.9363	0.8894
22L	0.8351	0.8227
22M	0.6695	0.6861
22N	0.7899	0.8181
22P	0.7089	0.7497
22S	0.6215	0.6821
22T	0.7653	0.8926
22V	0.7097	0.6991
22Y	0.6215	0.6590
231	0.7555	0.7829
236	0.7082	0.7442
237	0.7550	0.7043
23X	0.8351	0.8435
23Y	0.7488	0.7211
23Z	0.9363	0.9645
240	0.6695	0.4889
241	0.7488	0.7557
242	0.9363	0.8894
243	0.8351	0.8227

Plan	Pro Factor	Instl Factor
244	0.6695	0.6861
245	0.7899	0.8181
246	0.7089	0.7497
247	0.6306	0.6529
248	0.7899	0.7878
249	0.7089	0.7196
250	0.6215	0.6821
251	0.7653	0.8926
252	0.7097	0.6991
253	0.6215	0.6590
254	0.7555	0.7829
255	0.7082	0.7442
256	0.7550	0.7043
31V	0.9602	0.9735
31W	0.8948	0.9223
31X	0.7104	0.7800
35W	1.0000	1.0000
35X	1.0000	1.0000
37K	1.0000	1.0000
3AJ	0.9363	0.9645
3AK	0.9363	0.8894
3AM	0.7825	0.8429
3AR	0.7961	0.7829
3AS	0.7496	0.7442
3AT	0.7929	0.7043
3AU	0.6696	0.6821
3AW	0.7511	0.6991
3AX	0.6696	0.6590
3O1	0.6215	0.6821
3O2	0.7555	0.7829
3O3	0.7073	0.7442
3O4	0.7550	0.6994
420	0.8458	0.8816
42H	0.7553	0.7855
43E	0.8867	0.9105
46X	0.9738	0.9735
46Y	0.9084	0.9223
46Z	0.7307	0.7800
49S	0.7765	0.9105
4FU	0.8255	0.8152
4Q7	0.7797	0.8216
507	0.8828	0.8421
508	0.8143	0.8008
509	0.6937	0.7294
539	0.8871	0.8418
540	0.8231	0.7058
541	0.6970	0.5865

Plan	Pro Factor	Instl Factor
542	0.6576	0.5241
5NJ	0.6982	0.6798
5NK	0.8551	0.8372
5NL	0.7758	0.7162
5NM	0.7720	0.7494
5NN	0.6982	0.6798
5NP	0.8525	0.8372
5NQ	0.7734	0.7162
5NR	0.7687	0.7494
5NS	0.6452	0.7184
5NT	0.6452	0.5949
5NU	0.6452	0.7184
5NV	0.6452	0.5949
5PB	0.6452	0.7184
5PC	0.6452	0.5949
5PD	0.6452	0.7184
5PE	0.6452	0.5949
5PF	0.6452	0.7184
5PG	0.6452	0.5949
5SG	0.9031	0.8374
5SH	0.8179	0.7162
5SJ	0.7424	0.5952
5SK	0.9031	0.8374
5SL	0.8179	0.7162
5SM	0.7424	0.5952
5SN	0.9031	0.8374
5SP	0.8179	0.7162
5SQ	0.7424	0.5952
5SS	0.8179	0.7162
5ST	0.7424	0.8052
5SU	0.9031	0.8374
5SV	0.8179	0.7162
5SW	0.7424	0.5952
60D	0.9311	0.9486
60E	0.7780	0.7892
60F	0.8504	0.8816
643	0.5866	0.8054
645	0.7890	0.8735
64Q	0.7949	0.6341
64R	0.6366	0.6154
67G	0.9084	0.9223
67J	0.7307	0.7800
67K	0.5866	0.6913
67L	0.7890	0.8735
67P	0.9311	0.9486
67Q	0.8504	0.8816
67R	0.7780	0.7892

Plan	Pro Factor	Instl Factor
6DC	0.8890	0.8929
6DD	0.8890	0.8929
6DE	0.7957	0.7430
6DF	0.7957	0.7430
6DG	0.7539	0.7375
6DH	0.7539	0.7375
6DJ	0.6724	0.6590
6DK	0.6724	0.6590
6DL	0.8890	0.8929
6DM	0.8890	0.8929
6DN	0.7957	0.7430
6DP	0.7957	0.7430
6DQ	0.7539	0.7375
6DR	0.7539	0.7375
6DS	0.6724	0.6590
6DT	0.6724	0.6590
6DU	0.7961	0.7829
6DV	0.7961	0.7829
6DW	0.7539	0.7442
6DX	0.7539	0.7442
6DY	0.6724	0.6821
6DZ	0.6724	0.6821
6EB	0.7961	0.7829
6EC	0.7961	0.7829
6ED	0.7539	0.7442
6EE	0.7539	0.7442
6EF	0.6724	0.6821
6EG	0.6724	0.6821
6EK	0.5380	0.4134
6EL	0.5513	0.5829
6EM	0.5849	0.6503
6EN	0.6878	0.7720
6EP	0.8930	1.0046
6EQ	1.0995	1.2129
6ER	0.5380	0.4134
6ES	0.5513	0.5829
6ET	0.5849	0.6503
6EU	0.6878	0.7720
6EV	0.8930	1.0046
6EW	1.0995	1.2129
71Q	0.9390	0.9683
71R	0.7369	0.8351
71V	0.9213	0.9206
71W	0.7565	0.7895
71Y	0.9213	0.9206
71Z	0.7577	0.7872
721	0.7577	0.7872

CALIFORNIA

Provider Participation Agreement – Revised 1.10.25

Participation Physician Group (PPG) Template – DMHC Approved 2008

## Q1 – 2024 BENEFIT PLAN FACTORS

Plan	Pro Factor	Instl Factor
722	0.6261	0.7982
723	0.9808	0.9746
725	0.8363	0.9498
726	0.6760	0.8548
729	0.8396	0.8776
72B	0.9385	0.9446
72K	0.8781	0.9567
72R	0.9277	0.9763
72U	0.8207	0.9746
72V	0.9839	0.9766
72W	0.9836	0.9766
738	0.8217	0.9065
73F	0.9328	0.5995
73G	0.7388	0.5972
73H	0.7388	0.5972
73L	0.8265	0.9775
73M	0.8265	0.9775
74C	0.7553	0.7872
75D	0.9213	0.9206
75E	0.9277	0.9763
75F	0.8207	0.9746
75G	0.9836	0.9766
75H	0.9213	0.9206
75J	0.9213	0.9206
75K	0.7577	0.7872
75L	0.7577	0.7872
75M	0.6261	0.7982
75P	0.8217	0.9065
75Q	0.8396	0.8776
75R	0.9385	0.9446
75S	0.7565	0.7843
75V	0.8781	0.9567
761	0.9328	0.5995
762	0.7388	0.5972
763	0.8265	0.9775
76C	0.9213	0.9206
76D	0.7577	0.7872
76E	0.6261	0.7982
76G	0.9213	0.9206
76H	0.7577	0.7872
76J	0.6261	0.7982
76X	0.9280	0.8435
76Y	0.9280	0.8435
77G	0.9280	0.9761
77H	0.9280	0.9761
77J	1.0469	0.8444
77K	1.0469	0.8444

Plan	Pro Factor	Instl Factor
77L	0.8217	0.9746
77P	0.6576	0.5224
77Z	0.9332	0.9642
78C	0.6695	0.7072
78D	0.8351	0.8978
78E	0.7488	0.8337
78F	0.9363	0.9622
78G	0.6695	0.6835
78H	0.8351	0.8201
78J	0.7488	0.7531
78K	0.9363	0.8868
80W	0.7899	0.8158
80X	0.7089	0.8106
84H	0.7553	0.8568
87E	0.7553	0.7768
87G	0.7899	0.8181
87H	0.7089	0.7497
87Y	0.9151	0.9244
87Z	0.7510	0.7907
881	0.6208	0.6590
883	0.8351	0.9004
884	0.7488	0.8354
885	0.6695	0.7084
888	0.9363	0.9645
88C	0.8351	0.8227
88D	0.7488	0.7557
88E	0.6695	0.6861
88H	0.9363	0.8894
88Q	0.7553	0.7930
97H	0.8871	0.8412
97J	0.8231	0.7063
97K	0.6970	0.5871
97L	0.6576	0.5230
97M	0.7949	0.6347
97N	0.6366	0.6160
97P	0.9363	0.9703
97Q	0.7369	0.7216
983	0.6265	0.7006
984	0.9808	0.9752
985	0.8219	0.8288
986	0.9328	0.6006
987	0.7388	0.5983
988	0.9213	0.9218
989	0.7582	0.7886
98B	0.9277	0.9775
98C	0.8210	0.9758
98D	0.9836	0.9778

Plan	Pro Factor	Instl Factor
98E	0.9328	0.6006
98F	0.7388	0.5983
98G	0.9277	0.9775
98H	0.8210	0.9758
98J	0.9836	0.9778
98K	0.9213	0.9218
98L	0.7582	0.7886
98M	0.6265	0.7006
98P	0.9280	0.7306
993	0.9839	0.9778
994	0.9280	0.9772
995	0.9280	0.9772
997	0.7388	0.5983
9C2	0.6306	0.6567
9C3	0.7899	0.7878
9C4	0.7089	0.7196
9C8	0.7039	0.7231
9DW	0.5380	0.4134
9DX	0.5513	0.5829
9DY	0.5849	0.6503
9DZ	0.6912	0.7738
9EB	0.8930	1.0046
9EC	1.1047	1.2159
9L9	0.8351	0.8435
9M1	0.7488	0.7214
9M2	0.6695	0.4889
9M3	0.9363	0.9645
9M4	0.7899	0.8181
9M5	0.7089	0.7497
9M6	0.8351	0.8227
9M7	0.7488	0.7557
9M8	0.6695	0.6861
9M9	0.9363	0.8894
9MF	0.9003	0.8712
9MG	0.8427	0.8210
9MH	0.8040	0.7716
9MJ	0.7159	0.5565
9MK	0.6483	0.4883
9ML	0.6910	0.6997
9MM	0.6836	0.6656
9MN	0.8554	0.7800
9MP	0.7498	0.5981
9MQ	0.8241	0.8141
9MR	0.9017	0.8903
9MS	0.8441	0.8487
9MT	0.8054	0.8077
9MU	0.7130	0.5565

Plan	Pro Factor	Instl Factor
9MV	0.6478	0.4895
9P3	0.8867	0.9105
9P4	0.7797	0.8216
9S3	0.8635	0.8929
9S4	0.7123	0.7375
9S5	0.6241	0.6590
9S6	0.6241	0.6821
9S7	0.7582	0.7829
9S8	0.7123	0.7442
9S9	0.7577	0.7430
9T3	0.7553	0.7872
AJ2	0.9363	0.9680
AJ3	0.8351	0.9037
AJ4	0.7488	0.8384
AJ5	0.6695	0.7110
AJ6	0.9363	0.8926
AJ7	0.8351	0.8257
AJ8	0.7488	0.7584
AJ9	0.6695	0.6886
AJB	0.8351	0.8466
AJC	0.7488	0.7240
AJD	0.6695	0.4907
AJE	0.8377	0.8245
AJF	0.7488	0.7584
AJG	0.6695	0.6886
AJH	0.9363	0.9680
AKW	0.7925	0.8199
AKX	0.7089	0.7524
AKZ	0.7116	0.7512
AL7	0.8351	0.8466
AL8	0.7488	0.7237
AL9	0.6695	0.4907
ALC	0.8351	0.8256
ALD	0.7488	0.7584
ALE	0.6695	0.6886
ALF	0.9363	0.9680
ALG	0.8351	0.8466
ALH	0.7488	0.7237
ALJ	0.6695	0.4907
ALK	0.9363	0.8926
ALM	0.7488	0.7584
ALN	0.6695	0.6886
ALP	0.7899	0.8211
ALQ	0.7089	0.7524
ALR	0.8351	0.8257
B3J	0.8869	0.8894
B3P	0.7677	0.6004

## Q1 – 2024 BENEFIT PLAN FACTORS

Plan	Pro Factor	Instl Factor
B3Q	0.8427	0.8169
B3R	0.8898	0.8724
B3S	0.8613	0.8239
B3T	0.8224	0.7745
B3U	0.7338	0.5588
B7H	0.8492	0.8842
B7J	0.8102	0.8707
B7K	0.7238	0.7598
B7L	0.6502	0.7465
B7M	0.9316	0.9119
B7N	0.9464	0.9128
B7P	0.8673	0.8851
B7Q	0.8281	0.8715
B7R	0.7419	0.7606
B7S	0.6681	0.7473
B7T	0.7620	0.5995
B7U	0.8121	0.8707
B7V	0.7266	0.7598
B7W	0.6535	0.7465
B7X	0.9328	0.9119
B7Y	0.7799	0.6004
B7Z	0.8570	0.8169
B80	0.9473	0.9128
B81	0.8303	0.8715
B82	0.7412	0.7606
B83	0.6681	0.7473
B85	0.5538	0.9540
B86	0.5710	0.9555
B87	0.5877	1.0325
B88	0.6042	1.0338
B89	0.6912	1.1110
B8B	0.7073	1.1124
B8C	0.8976	1.1895
B8D	0.9181	1.1909
B8E	1.0879	1.2027
B8F	1.1103	1.2039
B9F	0.7825	0.8429
B9G	0.8867	0.9105
B9L	0.8867	0.9105
B9M	0.7825	0.8429
BA4	0.5404	0.4144
BA5	0.5538	0.5847
BA6	0.5875	0.6520
BA7	0.6912	0.7738
BA8	0.8972	1.0070
BA9	1.1047	1.2159
BAB	0.9543	0.9657

Plan	Pro Factor	Instl Factor
BAC	0.8630	0.9022
BAE	0.7832	0.8374
BAF	0.7092	0.7101
BAG	0.9543	0.8900
BAH	0.8630	0.8236
BAJ	0.7832	0.7563
BAK	0.7092	0.6864
BAL	0.8217	0.8190
BAM	0.7460	0.7502
BAP	0.6726	0.6546
BAS	0.8217	0.7895
BAT	0.7460	0.7214
BAU	0.7015	0.6812
BAV	0.8592	0.8392
BAW	0.7794	0.7176
BAX	0.7756	0.7511
BAY	0.6483	0.7205
BAZ	0.6483	0.5963
BB0	0.9074	0.8392
BB1	0.8217	0.7179
BB2	0.7460	0.5963
BB3	0.9543	0.9657
BB4	0.8630	0.8441
BB5	0.7832	0.7228
BB6	0.7092	0.4889
BB7	0.9543	0.8900
BB8	0.8630	0.8236
BB9	0.7832	0.7563
BBB	0.7092	0.6864
BBC	0.8217	0.8190
BBD	0.7460	0.7502
BBE	0.6726	0.6546
BBF	0.8217	0.7895
BBG	0.7460	0.7214
BBH	0.6483	0.7205
BBJ	0.6483	0.5963
BBK	0.9074	0.8392
BBL	0.8217	0.7179
BBM	0.7460	0.5963
BC2	0.8998	0.9125
BC3	0.8066	0.8236
BC4	0.7340	0.7231
BEB	0.7376	0.7247
BEC	0.8095	0.8450
BED	0.8998	0.9125
BEZ	0.7460	0.7502
BF1	0.7460	0.7214

Plan	Pro Factor	Instl Factor
BF2	0.6699	0.6584
BF3	0.8217	0.8190
BF4	0.9543	0.9657
BF5	0.8630	0.8441
BF6	0.7832	0.7219
BF7	0.9543	0.8900
BF8	0.8630	0.8236
BF9	0.7832	0.7563
BFB	0.7092	0.6864
BFC	0.7015	0.6812
bfd	0.8566	0.8392
BFE	0.7773	0.7176
BFF	0.7722	0.7511
BFG	0.6483	0.5963
BFH	0.9074	0.8392
BFJ	0.7460	0.5963
BFK	0.7064	0.4901
BFL	0.6483	0.7205
BFP	1.1047	1.2159
BFQ	0.8972	1.0070
BFR	0.6912	0.7738
BFS	0.5875	0.6520
BFT	0.5538	0.5847
BFU	0.5404	0.4144
BFV	0.8217	0.7895
BFW	0.7460	0.7214
BFX	0.6726	0.6546
BFZ	0.8630	0.8441
BG0	0.7832	0.7228
BG1	0.7064	0.4901
BG2	0.8630	0.8236
BG3	0.7832	0.7563
BG4	0.7092	0.6864
BG5	0.6483	0.7205
BG6	0.6483	0.5963
BG7	0.7460	0.8067
BNE	0.8933	0.8949
BNF	0.7995	0.7447
BNG	0.7574	0.7393
BNH	0.6757	0.6604
BNJ	0.8000	0.7846
BNK	0.7574	0.7459
BNL	0.6757	0.6838
BNN	0.8933	0.8949
BNP	0.7995	0.7447
BNQ	0.7574	0.7393
BNR	0.6757	0.6604

Plan	Pro Factor	Instl Factor
BNS	0.8000	0.7846
BNT	0.7574	0.7459
BNU	0.6757	0.6838
BNY	0.7973	0.7892
BP2	0.7574	0.7459
BP3	0.8933	0.8949
BP4	0.7995	0.7447
BP5	0.7574	0.7393
BP6	0.6757	0.6604
BP7	0.8000	0.7846
BP8	0.6757	0.6838
BPB	0.7933	0.7930
BPC	0.7574	0.7459
BPD	0.8933	0.8949
BPE	0.7995	0.7447
BPF	0.7574	0.7393
BPG	0.6757	0.6604
BPH	0.8000	0.7846
BPJ	0.6757	0.6838
BQQ	0.8217	0.7179
BT2	0.8601	0.7800
BT4	0.7025	0.7014
BT5	0.6884	0.6671
C9R	0.9273	0.9150
C9S	0.8365	0.8535
C9T	0.7574	0.8043
C9U	0.6843	0.7512
C9V	0.6234	0.6582
C9W	0.9452	0.9158
C9X	0.8547	0.8544
C9Y	0.7756	0.8051
C9Z	0.7025	0.7521
CA0	0.6413	0.6591
CA1	0.8360	0.8504
CA2	0.7574	0.8013
CA3	0.6843	0.7485
CA4	0.6196	0.6558
CA5	0.9273	0.9117
CA6	0.9452	0.9125
CA7	0.8539	0.8513
CA8	0.7756	0.8022
CA9	0.7025	0.7494
CAB	0.6375	0.6558
CAC	0.5816	1.1587
CAD	0.8866	1.2286
CAE	1.0743	1.3171
CAF	0.5450	1.0606

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Plan	Pro Factor	Instl Factor
CAG	0.6832	1.1907
CAH	0.6996	1.1919
CAJ	0.9059	1.2299
CAK	1.0951	1.3182
CAL	0.5607	1.0606
CAN	0.5970	1.1601
CAP	0.8360	0.8504
CAR	0.7577	0.8013
CAS	0.6843	0.7485
CAT	0.6234	0.6558
CAU	0.9273	0.9117
CAV	0.9418	0.9125
CAW	0.8539	0.8504
CAX	0.7756	0.8013
CAY	0.7025	0.7485
CAZ	0.6416	0.6567
CB4	0.6884	0.6570
CB6	0.7025	0.6529
CE5	0.9409	0.9703
CE6	0.8391	0.9056
CE7	0.7526	0.8405
CE8	0.6729	0.7127
CE9	0.9409	0.8946
CEB	0.8465	0.8266
CEC	0.7526	0.7601
CED	0.6729	0.6903
CEE	0.8465	0.8472
CEF	0.7598	0.7246
CEG	0.6803	0.4907
CEH	0.8413	0.8245
CEJ	0.7562	0.7590
CEK	0.6772	0.6872
CEL	0.9409	0.9703
CEN	0.7973	0.8199
CEP	0.7122	0.7542
CER	0.7152	0.7512
CEV	0.8465	0.8472
CEW	0.7562	0.7237
CEX	0.6772	0.4895
CEZ	0.8425	0.8245
CF0	0.7562	0.7573
CF1	0.6772	0.6872
CF2	0.9483	0.9692
CF3	0.8465	0.8472
CF4	0.7598	0.7254
CF5	0.6803	0.4907
CF6	0.9437	0.8912

Plan	Pro Factor	Instl Factor
CF7	0.7608	0.7590
CF8	0.6803	0.6889
CFB	0.7197	0.7530
CFC	0.8465	0.8266
CZC	0.9263	0.9164
CZD	0.8360	0.8043
CZE	0.7577	0.6640
CZF	0.6843	0.6246
CZG	0.6234	0.5081
CZH	0.9442	0.9164
CZI	0.8539	0.8043
CZJ	0.7756	0.6640
CZK	0.7025	0.6246
CZL	0.6416	0.5081
D10	0.8623	0.8773
D12	0.8360	0.8013
D13	0.7577	0.6616
D14	0.6843	0.6223
D15	0.6234	0.5062
D16	0.9263	0.9131
D17	0.9442	0.9131
D18	0.8539	0.8013
D19	0.7732	0.6616
D1B	0.7025	0.6223
D1C	0.6416	0.5062
D1D	0.5802	1.0227
D1E	0.8861	1.1907
D1F	1.0731	1.3190
D1G	0.5483	0.8862
D1H	0.6791	1.0670
D1J	0.6996	1.0670
D1K	0.9052	1.1907
D1L	1.0939	1.3190
D1M	0.5643	0.8862
D1N	0.5970	1.0227
D1P	0.8360	0.8013
D1Q	0.7577	0.6616
D1R	0.6843	0.6223
D1S	0.6234	0.5062
D1T	0.9263	0.9131
D1U	0.9442	0.9131
D1V	0.8539	0.8013
D1W	0.7756	0.6616
D1X	0.7025	0.6223
D1Y	0.6416	0.5062
D20	0.6256	0.5978
D22	0.7777	0.7739

Plan	Pro Factor	Instl Factor
EBI	0.9442	0.9164
EBJ	0.9263	0.9164
EBK	0.8539	0.8043
EBL	0.8360	0.8043
EBM	0.7756	0.6640
EBN	0.7550	0.6640
EBO	0.7025	0.6246
EBP	0.6812	0.6246
EBQ	0.6416	0.5081
EBR	0.6234	0.5081
EFH	0.9435	0.9164
EFI	0.9254	0.9164
EFJ	0.8523	0.8043
EFK	0.8343	0.8043
EFL	0.7732	0.6640
EFM	0.7550	0.6640
EFN	0.6994	0.6246
EFO	0.6812	0.6246
FFP	0.5723	0.6472
EFQ	0.5544	0.6472
EG5	0.9442	0.9131
EG6	0.9263	0.9131
EG7	0.8523	0.8013
EG8	0.8360	0.8013
EG9	0.7756	0.6616
EGB	0.7577	0.6616
EGC	0.7025	0.6223
EGD	0.6843	0.6223
EGE	0.5723	0.6472
EGF	0.5544	0.6472
EGG	0.9435	0.9164
EGH	0.9263	0.9164
EGI	0.8523	0.8043
EGJ	0.8360	0.8043
EGK	0.7756	0.6640
EGL	0.7577	0.6640
EGM	0.7025	0.6246
EGN	0.6843	0.6246
EGO	0.5723	0.6472
EGP	0.5544	0.6472
EGQ	0.9435	0.9131
EGR	0.9254	0.9131
EGS	0.8523	0.8013
EGT	0.8343	0.8013
EGU	0.7732	0.6616
EGV	0.7550	0.6616
EGW	0.6994	0.6223

Plan	Pro Factor	Instl Factor
EGX	0.6812	0.6223
EGY	0.5723	0.6472
EGZ	0.5544	0.6472
EH8	0.7777	0.7739
EHD	0.6468	0.7271
EHE	0.8623	0.8782
EHG	0.6643	0.5680
EHI	0.8604	0.8773
EX5	0.7732	0.7486
EX6	0.7550	0.7486
EX7	0.7362	0.5863
EX8	0.7180	0.5863
EX9	0.7732	0.7459
EXB	0.7550	0.7459
EXC	0.7362	0.5842
EXD	0.7180	0.5842
EXE	0.7732	0.7486
EXF	0.7550	0.7486
EXG	0.7362	0.5863
EXH	0.7180	0.5863
EXI	0.7732	0.7459
EXJ	0.7550	0.7459
EXK	0.7362	0.5842
EXL	0.7180	0.5842
EZ9	0.7362	0.5863
EZC	0.7362	0.5842
EZE	0.7362	0.5842
EZG	0.7732	0.7486
EZI	0.7732	0.7459
EZK	0.7732	0.7459
F20	0.6643	0.5680
F21	0.7362	0.5863
F23	0.7362	0.5842
F25	0.7362	0.5842
F27	0.7732	0.7486
F29	0.7732	0.7459
F2C	0.7732	0.7459
F2E	0.7751	0.7739
F2H	0.6468	0.7271
F2U	0.7732	0.6640
F2V	0.7550	0.6640
F2W	0.7732	0.6616
F2X	0.7550	0.6616
F2Y	0.7732	0.6640
F2Z	0.7550	0.6640
F30	0.7732	0.6616
F31	0.7550	0.6616

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Plan	Pro Factor	Instl Factor
F32	0.7362	0.5863
F33	0.7180	0.5863
F34	0.7362	0.5842
F35	0.7180	0.5842
F36	0.7362	0.5863
F37	0.7180	0.5863
F38	0.7362	0.5842
F39	0.7180	0.5842
F3B	0.6994	0.6246
F3C	0.6812	0.6246
F3D	0.6994	0.6223
F3E	0.6812	0.6223
F3F	0.6994	0.6246
F3G	0.6812	0.6246
F3H	0.6994	0.6223
F3I	0.6812	0.6223
F3R	0.9435	0.9164
F3S	0.9254	0.9164
F3T	0.9435	0.9131
F3U	0.9254	0.9131
F3V	0.9435	0.9164
F3W	0.9254	0.9164
F3X	0.9435	0.9131
F3Y	0.9254	0.9131
F3Z	0.8523	0.8043
F40	0.8343	0.8043
F41	0.8523	0.8013
F42	0.8343	0.8013
F43	0.8523	0.8043
F44	0.8343	0.8043
F45	0.8523	0.8013
F46	0.8343	0.8013
F47	0.7732	0.7486
F48	0.7550	0.7486
F49	0.7732	0.7459
F4B	0.7550	0.7459
F4C	0.7732	0.7486
F4D	0.7550	0.7486
F4E	0.7732	0.7459
F4F	0.7550	0.7459
F4G	0.5107	0.5779
F4H	0.4925	0.5779
F4I	0.5107	0.5779
F4J	0.4925	0.5779
F4K	0.5107	0.5779
F4L	0.4925	0.5779
F4M	0.5107	0.5779

Plan	Pro Factor	Instl Factor
F4N	0.4925	0.5779
G21	0.7550	0.6208
G22	0.7732	0.6208
G23	0.7180	0.5863
G24	0.7362	0.5863
G25	0.6812	0.5959
G26	0.6994	0.5959
G27	0.6196	0.5191
G28	0.6375	0.5191
G29	0.9254	0.8877
G2B	0.9435	0.8877
G2C	0.8343	0.8043
G2D	0.8523	0.8043
G2E	0.7550	0.7486
G2F	0.7732	0.7486
G2G	0.4844	0.5753
G2H	0.5026	0.5753
G2Y	0.7550	0.6186
G2Z	0.7732	0.6186
G30	0.7180	0.5842
G31	0.7362	0.5842
G32	0.6812	0.5937
G33	0.6994	0.5937
G34	0.6196	0.5172
G36	0.7570	0.7332
G37	0.7751	0.7240
G38	0.6468	0.7245
G39	0.6643	0.7245
G3B	0.7180	0.5842
G3C	0.7362	0.5842
G3D	0.9254	0.8845
G3E	0.9435	0.8845
G3F	0.8343	0.8013
G3G	0.8523	0.8013
G3H	0.7550	0.7459
G3I	0.7732	0.7459
G3J	0.7550	0.7459
G3K	0.7732	0.7459
G3L	0.4753	0.5753
G3M	0.4933	0.5753
G3N	0.6110	0.5732
G3O	0.6284	0.5732
G3P	0.7550	0.6208
G3Q	0.7732	0.6208
G3R	0.7180	0.5863
G3S	0.7362	0.5863
G3T	0.6812	0.5959

Plan	Pro Factor	Instl Factor
G3U	0.6994	0.5959
G3V	0.6196	0.5191
G3X	0.7180	0.5863
G3Y	0.7362	0.5863
G3Z	0.6464	0.7272
G40	0.6643	0.7272
G41	0.9254	0.8877
G42	0.9435	0.8877
G43	0.8343	0.8043
G44	0.8523	0.8043
G45	0.7550	0.7486
G46	0.7732	0.7486
G47	0.7550	0.7486
G48	0.7732	0.7486
G49	0.4844	0.5753
G4B	0.5026	0.5753
G4C	0.7550	0.6186
G4D	0.7732	0.6186
G4E	0.7180	0.5842
G4F	0.7362	0.5842
G4G	0.6812	0.5937
G4H	0.6994	0.5937
G4I	0.6196	0.5172
G4J	0.6375	0.5172
G4K	0.7180	0.5842
G4L	0.7362	0.5842
G4M	0.9254	0.8845
G4N	0.9435	0.8845
G4O	0.8343	0.8013
G4P	0.8523	0.8013
G4Q	0.7550	0.7459
G4R	0.7732	0.7459
G4S	0.7550	0.7459
G4T	0.7732	0.7459
G4U	0.4753	0.5753
G4V	0.4933	0.5753
GQT	0.7550	0.6208
GQU	0.7732	0.6208
GQV	0.7180	0.5863
GQW	0.7362	0.5863
GQX	0.6812	0.5202
GQY	0.6994	0.5202
GQZ	0.6196	0.4089
GR0	0.6375	0.3973
GR1	1.0357	0.7066
GR3	0.9254	0.8750
GR4	0.9435	0.8750

Plan	Pro Factor	Instl Factor
GR5	0.8343	0.7973
GR6	0.8523	0.7973
GR7	0.7550	0.7077
GR8	0.7732	0.7020
GR9	0.4844	0.5727
GRB	0.5026	0.5727
GRT	0.7550	0.6186
GRU	0.7732	0.6186
GRV	0.7180	0.5842
GRW	0.7362	0.5842
GRX	0.6812	0.5183
GRY	0.6994	0.5183
GRZ	0.6196	0.4075
GS0	0.6375	0.3959
GS1	0.7550	0.6544
GS3	0.6445	0.7242
GS5	0.7180	0.5842
GS7	1.0386	0.7040
GS8	1.0536	0.7040
GS9	0.9254	0.8718
GSB	0.9435	0.8718
GSC	0.8343	0.7944
GSD	0.8523	0.7944
GSE	0.7550	0.6994
GSF	0.7732	0.6994
GSG	0.7550	0.6994
GSH	0.7732	0.6994
GSI	1.0386	0.7040
GSJ	1.0565	0.7040
GSK	0.4753	0.5706
GSL	0.4933	0.5727
GSM	0.5207	0.5706
GSO	0.7550	0.6208
GSP	0.7732	0.6208
GSQ	0.7180	0.5863
GSR	0.7362	0.5863
GSS	0.6812	0.5202
GST	0.6994	0.5202
GSU	0.6196	0.3973
GSW	0.7180	0.5863
GSY	0.6445	0.7269
GT0	1.0386	0.7066
GT1	1.0565	0.7066
GT2	0.9254	0.8750
GT3	0.9435	0.8750
GT4	0.8343	0.7973
GT5	0.8523	0.7973

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Plan	Pro Factor	Instl Factor
GT6	0.7550	0.7020
GT7	0.7732	0.7077
GT8	0.7550	0.7077
GTB	1.0386	0.7066
GTD	0.4844	0.5727
GTE	0.5026	0.5727
GTF	0.7550	0.6186
GTG	0.7732	0.6186
GTH	0.7180	0.5842
GTI	0.7362	0.5842
GTJ	0.6812	0.5183
GTK	0.6994	0.5183
GTL	0.6196	0.3347
GTN	0.7180	0.5842
GTP	1.0357	0.7040
GTR	0.9254	0.8718
GTS	0.9435	0.8718
GTT	0.8343	0.7944
GTU	0.8523	0.7944
GTV	0.7550	0.6994
GTW	0.7732	0.6994
GTX	0.7550	0.6994
GTZ	1.0352	0.7040
GU1	0.4753	0.5706
GU2	0.4933	0.5706
H9R	0.8867	0.9105
H9S	0.7825	0.8429
H9T	0.7825	0.8429
H9V	0.9437	0.9669
H9X	0.9437	0.8912
H9Z	0.8425	0.8669
HA1	0.8425	0.8245
HA3	0.7973	0.8199
HA4	0.7562	0.7657
HA5	0.7562	0.7657
HA6	0.7562	0.7573
HA7	0.7562	0.7573
HA9	0.7164	0.7512
HAB	0.6772	0.5756
HAC	0.6772	0.5756
HAD	0.6772	0.6872
HAE	0.6772	0.6872
HB7	0.9437	0.9669
HB9	0.9437	0.8912
HBC	0.8425	0.8669
HBD	0.8425	0.8245
HBE	0.8425	0.8245

Plan	Pro Factor	Instl Factor
HBG	0.7562	0.7666
HBI	0.7572	0.7573
HBJ	0.7164	0.7512
HBM	0.6772	0.5756
HBO	0.6772	0.6872
HN2	0.7550	0.6208
HN3	0.7732	0.6208
HN4	0.7180	0.5220
HN5	0.7362	0.5220
HN6	0.6812	0.4556
HN7	0.6994	0.4556
HN8	0.6196	0.3916
HN9	0.6375	0.3916
HNB	1.0386	0.7066
HNC	1.0565	0.7066
HND	0.9254	0.8750
HNE	0.9435	0.8750
HNF	0.8343	0.7973
HNG	0.8523	0.7973
HNH	0.7550	0.6646
HNJ	0.7732	0.6646
HNK	0.4844	0.5727
HNM	0.5026	0.5727
HO5	0.7550	0.6186
HO6	0.7732	0.6186
HO7	0.7180	0.5201
HO8	0.7362	0.5201
HO9	0.6812	0.4540
HOB	0.6994	0.4540
HOC	0.6196	0.3731
HOD	0.6375	0.3731
HOE	0.7550	0.6186
HOF	0.7732	0.6186
HOG	0.6812	0.4540
HOH	0.6994	0.4540
HOI	0.7180	0.5198
HOJ	0.7362	0.5198
HOK	1.0386	0.7040
HOL	1.0536	0.7040
HOM	0.9254	0.8718
HON	0.9435	0.8718
HOO	0.8343	0.7944
HOP	0.8523	0.7944
HOQ	0.7550	0.6622
HOR	0.7732	0.6622
HOS	0.7550	0.6622
HOT	0.7732	0.6622

Plan	Pro Factor	Instl Factor
HOU	1.0386	0.7040
HOV	1.0565	0.7040
HOW	0.4753	0.5706
HOX	0.4933	0.5706
HOY	0.5202	0.5706
HOZ	0.5382	0.5706
HP0	0.7550	0.6208
HP1	0.7732	0.6208
HP2	0.7180	0.5220
HP3	0.7362	0.5220
HP4	0.6812	0.4556
HP5	0.6994	0.4556
HP6	0.6196	0.3745
HP7	0.6375	0.3745
HP8	0.7180	0.5217
HP9	0.7362	0.5217
HPB	0.6812	0.4556
HPC	0.6994	0.4556
HPD	0.7550	0.6208
HPE	0.7732	0.6208
HPF	1.0386	0.7066
HPG	1.0565	0.7066
HPH	0.9254	0.8750
HPI	0.9435	0.8750
HPJ	0.8343	0.7973
HPK	0.8523	0.7973
HPL	0.7550	0.6646
HPM	0.7732	0.6646
HPN	0.7550	0.6646
HPO	0.7732	0.6646
HPP	1.0386	0.7066
HPQ	1.0565	0.7066
HPR	0.4844	0.5727
HPS	0.5026	0.5727
HPT	0.7550	0.6186
HPU	0.7732	0.6186
HPV	0.7180	0.5201
HPW	0.7362	0.5201
HPX	0.6812	0.4540
HPY	0.6994	0.4540
HPZ	0.6196	0.3731
HQ0	0.6375	0.3731
HQ1	0.7180	0.5198
HQ2	0.7362	0.5198
HQ3	1.0386	0.7040
HQ4	1.0565	0.7040
HQ5	0.9254	0.8718

Plan	Pro Factor	Instl Factor
HQ6	0.9435	0.8718
HQ7	0.8343	0.7944
HQ8	0.8523	0.7944
HQ9	0.7550	0.6622
HQB	0.7732	0.6622
HQC	0.7550	0.6622
HQD	0.7732	0.6622
HQE	1.0386	0.7040
HQF	1.0565	0.7040
HQG	0.4753	0.5706
HQH	0.4933	0.5706
HQM	0.8867	0.9105
HQN	0.7851	0.8429
HQO	0.9437	0.9669
HQP	0.9437	0.8912
HQQ	0.8425	0.8669
HQR	0.8425	0.8245
HQS	0.7562	0.7666
HQT	0.7562	0.7573
HQU	0.7164	0.7512
HQV	0.6772	0.5756
HQW	0.6772	0.6872
HRR	0.9437	0.9669
HRS	0.9437	0.8912
HRT	0.8425	0.8669
HRU	0.8425	0.8245
HRV	0.7973	0.8199
HRW	0.7562	0.7657
HRX	0.7562	0.7573
HRY	0.7164	0.7512
HRZ	0.6772	0.5756
HS0	0.6772	0.6872
JF6	0.9402	0.9669
JF7	0.9402	0.8912
JF8	0.8403	0.8669
JF9	0.8403	0.8245
JFB	0.7957	0.8199
JFC	0.7553	0.7657
JFD	0.7553	0.7573
JFE	0.7161	0.7512
JFF	0.6772	0.5756
JFG	0.6772	0.6872
JFH	0.8871	0.9105
JFI	0.7868	0.8429
JFJ	0.9402	0.9669
JFK	0.9402	0.8912
JFL	0.8403	0.8669

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## Q1 – 2024 BENEFIT PLAN FACTORS

Plan	Pro Factor	Instl Factor
JFM	0.8403	0.8245
JFN	0.7553	0.7666
JFO	0.7553	0.7573
JFP	0.7161	0.7512
JFQ	0.6772	0.5756
JFR	0.6772	0.6872
JG0	0.755	0.5565
JG1	0.7732	0.5565
JG2	0.718	0.5185
JG3	0.7362	0.5185
JG4	0.6812	0.4521
JG5	0.6994	0.4521
JG6	0.6196	0.371
JG7	0.6375	0.371
JG8	0.718	0.5185
JGB	0.6812	0.4521
JGD	1.0386	0.7066
JGE	1.0565	0.7066
JGF	0.9254	0.875
JGG	0.9435	0.875
JGH	0.8343	0.7973
JGI	0.8523	0.7973
JGJ	0.755	0.6646
JGK	0.7732	0.6646
JGL	1.0386	0.7066
JGN	0.755	0.6646
JGP	0.4835	0.5643
JGQ	0.5014	0.5643
JHS	0.755	0.5544
JHT	0.7732	0.5544
JHU	0.718	0.5166
JHV	0.7362	0.5166
JHW	0.6812	0.4505
JHX	0.6994	0.4505
JHY	0.6196	0.3696
JHZ	0.6375	0.3696
JIO	0.755	0.5544
JI3	0.6812	0.4505
JI5	0.718	0.5166
JI7	1.0386	0.704
JI8	1.0565	0.7040
JI9	0.9254	0.8718
JIB	0.9435	0.8718
JIC	0.8343	0.7944
JID	0.8523	0.7944
JIE	0.755	0.6622
JIF	0.7732	0.6622

Plan	Pro Factor	Instl Factor
JIG	0.755	0.6622
JII	1.0386	0.704
JIK	0.4741	0.5622
JIL	0.4923	0.5622
JIM	0.4741	0.5622
JIO	0.755	0.5565
JIP	0.7732	0.5565
JIQ	0.718	0.5185
JIR	0.7362	0.5185
JIS	0.6812	0.4521
JIT	0.6994	0.4521
JIU	0.6196	0.371
JIW	0.718	0.5185
JIY	0.6812	0.4521
JJO	0.755	0.5565
JJ2	1.0386	0.7066
JJ3	1.0565	0.7066
JJ4	0.9254	0.875
JJ5	0.9435	0.875
JJ6	0.8343	0.7973
JJ7	0.8523	0.7973
JJ8	0.755	0.6646
JJ9	0.7732	0.6646
JJB	0.755	0.6646
JJD	1.0386	0.7066
JJF	0.4835	0.5643
JJG	0.5014	0.5643
JJH	0.4835	0.5643
JJJ	0.755	0.5544
JJK	0.7732	0.5544
JJL	0.718	0.5166
JJM	0.7362	0.5166
JJN	0.6812	0.4505
JJO	0.6994	0.4505
JJP	0.6196	0.3696
JJQ	0.6375	0.3696
JJR	0.718	0.5166
JJT	1.0386	0.704
JJV	0.9254	0.8718
JJW	0.9435	0.8718
JJX	0.8343	0.7944
JJY	0.8523	0.7944
JJZ	0.755	0.6622
JK0	0.7732	0.6622
JK1	0.755	0.6622
JK3	1.0386	0.704
JK5	0.4741	0.5622

Plan	Pro Factor	Instl Factor
JK6	0.4923	0.5622
K70	0.7550	0.5541
K71	0.7732	0.5541
K72	0.7180	0.5197
K74	0.6812	0.4498
K75	0.6994	0.4498
K76	0.6196	0.3687
K77	0.6375	0.3687
K7F	1.0386	0.7031
K7G	1.0565	0.7031
K7H	0.9254	0.8764
K7J	0.8343	0.7988
K7K	0.8523	0.7988
K7L	0.7550	0.6660
K7T	0.4775	0.5637
K7U	0.4954	0.5637
K8Q	0.7550	0.5521
K8S	0.7180	0.5178
K8U	0.6812	0.4482
K8V	0.6994	0.4482
K8W	0.6196	0.3673
K8Y	0.6172	0.3667
K96	1.0386	0.7017
K98	0.9254	0.8733
K99	0.9435	0.8733
K9B	0.8343	0.7959
K9C	0.8523	0.7959
K9D	0.7550	0.6636
K9E	0.7732	0.6636
K9F	0.7180	0.6518
K9L	0.4682	0.5617
K9P	0.7550	0.5541
K9Q	0.7732	0.5541
K9R	0.7180	0.5197
K9T	0.6812	0.4498
K9U	0.6994	0.4498
K9V	0.6196	0.3687
KA5	1.0386	0.7031
KA7	0.9254	0.8764
KA8	0.9435	0.8764
KA9	0.8343	0.7988
KAB	0.8523	0.7988
KAC	0.7550	0.6660
KAK	0.4775	0.5637
KAW	0.7550	0.5521
KAX	0.7732	0.5521
KAY	0.7180	0.5178

Plan	Pro Factor	Instl Factor
KAZ	0.7362	0.5178
KB0	0.6812	0.4482
KB2	0.6196	0.3673
KB4	0.6172	0.3667
KB8	1.0386	0.7006
KBB	0.9254	0.8733
KBC	0.9435	0.8733
KBD	0.8343	0.7959
KBE	0.8523	0.7959
KBF	0.7550	0.6636
KBG	0.7732	0.6636
KBN	0.4682	0.5617
KBO	0.4863	0.5617
KC5	0.9402	0.9669
KC7	0.8403	0.8669
KC8	0.8403	0.8245
KC9	0.7553	0.7666
KCB	0.7553	0.7573
KCD	0.6772	0.5756
KCE	0.6772	0.6872
KCH	0.8871	0.9105
KCI	0.7868	0.8429
KCJ	0.9402	0.9669
KCL	0.8403	0.8669
KCM	0.8403	0.8245
KCP	0.7553	0.7573
KCQ	0.7161	0.7512
KCR	0.6772	0.5756
KCS	0.6772	0.6872
Q7A	0.8255	0.8152
QHA	0.9793	0.9706
QIA	0.8900	0.9472
QJA	0.9311	0.9700
S28	0.8231	0.7058
S29	0.6576	0.5241
S30	0.7949	0.6341
S31	0.6366	0.6154
S3R	0.6695	0.7072
S3S	0.8351	0.8978
S3T	0.7488	0.8337
S3U	0.9363	0.9622
S3V	0.6695	0.6835
S3W	0.8351	0.8201
S3X	0.7488	0.7081
S3Y	0.9363	0.8776
S41	0.8351	0.9004
S42	0.7488	0.8354

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**Q1 – 2024 BENEFIT PLAN FACTORS**

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Plan	Pro Factor	Instl Factor
S43	0.9363	0.9645
S44	0.6695	0.7084
S45	0.7488	0.7557
S46	0.9363	0.8894
S47	0.8351	0.8227
S48	0.6695	0.6861
S4X	0.8231	0.7063
S4Y	0.6576	0.5230

Plan	Pro Factor	Instl Factor
S4Z	0.7949	0.6347
S51	0.6366	0.6160
S5Y	0.7899	0.8181
S5Z	0.7089	0.7497
S6E	0.8351	0.8435
S6F	0.7488	0.7202
S6G	0.9363	0.9645
S6H	0.6695	0.4889

Plan	Pro Factor	Instl Factor
S6J	0.7488	0.7557
S6L	0.8351	0.8227
S6M	0.6695	0.6861
S87	0.6215	0.6821
S88	0.7653	0.8926
S89	0.7097	0.6991
S91	0.6215	0.6590
S92	0.7555	0.7829

Plan	Pro Factor	Instl Factor
S93	0.7082	0.7442
S94	0.7550	0.7043
V1A	0.9786	0.9766
V2A	0.9086	0.9310
V3A	0.7856	0.8201
V4A	0.7968	0.7361
V5A	0.9856	0.9726
V7A	0.8828	0.8767

**Q1 – 2024 BENEFIT PLAN FACTORS**

Ambetter HMO

Plan	Pro Factor	Instl Factor
9KH	1.1437	1.1437
9KJ	1.3032	1.3032
9KK	1.0000	1.0000
9KL	1.3984	1.3984
9KM	1.2913	1.2913
9KN	1.0754	1.0754
9KP	1.4599	1.4599
9KQ	1.4599	1.4599
9KR	1.4599	1.4599
9KT	1.1437	1.1437
9KU	1.3032	1.3032
9KV	1.0000	1.0000
BV7	1.1437	1.1437
BV8	1.3032	1.3032
BV9	1.0000	1.0000
BVB	1.3984	1.3984
BVC	1.2913	1.2913
BVD	1.0754	1.0754
BVE	1.4599	1.4599
BVF	1.4599	1.4599
BVG	1.4599	1.4599
BVH	1.1437	1.1437
BVJ	1.3032	1.3032
BVK	1.0000	1.0000
CKS	1.3032	1.3032

Plan	Pro Factor	Instl Factor
CKT	1.1437	1.1437
CKU	1.0000	1.0000
CL0	1.0754	1.0754
CL1	1.2913	1.2913
CL2	1.3984	1.3984
CR5	1.0000	1.0000
CR6	1.1437	1.1437
CR7	1.3032	1.3032
CRE	1.4599	1.4599
DKQ	1.3032	1.3032
DKR	1.1437	1.1437
DKS	1.0000	1.0000
DKT	1.0000	1.0000
DKU	1.1437	1.1437
DKV	1.3032	1.3032
DKW	1.0754	1.0754
DKX	1.2913	1.2913
DKY	1.3984	1.3984
DKZ	1.4599	1.4599
E8I	1.3032	1.3032
E8J	1.1437	1.1437
E8K	1.0000	1.0000
EDM	1.0000	1.0000
EDN	1.0000	1.0000
EDO	1.1437	1.1437

Plan	Pro Factor	Instl Factor
EDP	1.3032	1.3032
EDQ	1.3032	1.3032
EDR	1.1437	1.1437
EDS	1.0000	1.0000
EDT	1.0754	1.0754
EDU	1.2913	1.2913
EDV	1.3984	1.3984
EDW	1.4599	1.4599
FAD	1.1437	1.1437
FAE	1.0000	1.0000
FAH	1.0000	1.0000
FAI	1.1437	1.1437
FAK	1.0754	1.0754
FAL	1.2913	1.2913
FAN	1.3984	1.3984
FAO	1.4599	1.4599
GBG	1.3032	1.3032
GBH	1.1437	1.1437
GBI	1.0000	1.0000
GBJ	1.3032	1.3032
GBK	1.0000	1.0000
GBL	1.1437	1.1437
GBM	1.0754	1.0754
GBN	1.2913	1.2913
GBO	1.3984	1.3984

Plan	Pro Factor	Instl Factor
GBP	1.4599	1.4599
H7B	1.3032	1.3032
H7C	1.1437	1.1437
H7D	1.0000	1.0000
H7E	1.0000	1.0000
H7F	1.1437	1.1437
H7G	1.3032	1.3032
H7K	1.0754	1.0754
H7L	1.2913	1.2913
H7M	1.3984	1.3984
H7N	1.4599	1.4599
KNN	1.3032	1.3032
KNO	1.1437	1.1437
KNP	1.0000	1.0000
KNQ	0.7713	0.7713
KNS	1.1437	1.1437
KNT	1.0000	1.0000
KNU	0.7713	0.7713
KNV	0.6103	0.6103
KNW	1.3032	1.3032
KPS	1.3984	1.3984
KPT	1.4599	1.4599
KPU	1.4599	1.4599
KPV	1.0754	1.0754
KPW	1.2913	1.2913

## Q1 – 2024 BENEFIT PLAN FACTORS

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### Medicare COB HMO

<b>Plan</b>	<b>Prof Factor</b>
Medicare Conversion Plan J	1.2018
Medicare COB \$0 Copay	1.1169
Medicare COB \$5 and up Copay	0.6326

### Medicare COB POS

<b>Plan</b>	<b>Prof Factor</b>
POS Medicare COB \$0 Copay	1.1169
POS Medicare COB \$5 and up Copay	0.6326

**Q1 – 2024 BENEFIT PLAN FACTORS**

**A.4 Benefit Plan Factors for Standard POS Capitation and Standard POS Shared Risk Budgets**

Standard POS

Plan	Pro Factor	Instl Factor
10H	0.8981	0.9138
10K	0.9913	0.8780
10L	0.9583	0.8780
10N	0.9485	0.9337
10Q	0.9485	0.9337
110	0.9994	0.9363
111	0.9354	0.8780
114	0.9072	0.8800
11L	0.8981	0.9094
11N	0.9538	0.9337
11P	0.9748	0.8716
11Q	0.9330	0.8064
120	0.9963	0.9140
12N	0.8556	0.8780
12Q	0.9485	0.9176
12T	0.9015	0.9168
130	0.9605	0.8931
136	0.9278	0.8237
137	0.9278	0.8237
139	0.8129	0.7024
13L	0.9493	0.8797
13M	0.9493	0.8915
13Y	1.1105	0.9210
141	0.8518	0.8780
144	0.8998	0.8770
145	0.9022	0.8779
148	0.8508	0.8780
149	0.9485	0.9350
14K	0.9994	0.9131
15H	0.8129	0.7381
15J	0.9015	0.8495
167	0.9485	0.9337
168	0.9593	0.9099
169	0.8981	0.9323
16B	0.9452	0.9151
16C	0.9485	0.8495
16D	0.9485	0.8275
16E	0.9015	0.8481
16F	0.9015	0.8262
16G	0.9015	0.8264
16H	0.9015	0.8044
16J	0.8563	0.8233
16K	0.8563	0.8014

Plan	Pro Factor	Instl Factor
16L	0.9347	0.7923
16M	0.9347	0.8166
16N	0.8508	0.7721
16P	0.8418	0.7445
16R	0.8563	0.9075
16U	0.9015	0.9323
16W	0.9015	0.9106
17P	0.8559	0.8233
181	0.9865	0.9883
1A1	0.8563	0.8233
1A2	0.9485	0.8495
1A3	0.9015	0.8481
1A4	0.9015	0.8262
1A5	0.9015	0.8264
1A6	0.9015	0.8044
1A7	0.8291	0.8560
1A8	0.9015	0.9123
1A9	0.9015	0.9352
1B1	0.9493	0.8797
1B2	0.8566	0.9329
1B3	0.9015	0.9337
1B4	0.9015	0.9143
1B5	0.9015	0.9323
1B6	0.9015	0.9159
1B7	0.9015	0.8285
1B8	0.9485	0.9316
1B9	0.9485	0.9138
1C1	0.8184	0.8060
1C2	0.9966	0.9140
1C3	0.9225	0.9143
1C4	0.9569	0.9144
1C5	0.9485	0.9176
1C6	0.9485	0.9337
1C7	0.9015	0.9329
1C8	0.9999	0.9363
1C9	0.9485	0.9154
1D2	0.8599	0.8789
1D4	0.8563	0.9075
1D5	0.9015	0.9303
1E1	0.7835	0.7523
1E6	0.8563	0.8233
1E7	0.8563	0.8233
1E8	0.8563	0.8014

Plan	Pro Factor	Instl Factor
1E9	0.9015	0.9094
1F1	0.9015	0.9094
1F2	0.9015	0.9106
1G2	0.8136	0.8780
1I4	0.8437	0.7959
1TV	0.7572	0.7721
1TW	0.8506	0.8780
1TX	0.8535	0.7721
1TY	0.8045	0.8780
1TZ	0.8045	0.7721
1UB	0.8045	0.7086
1UC	0.7546	0.8780
1UD	0.7546	0.7086
1UG	0.7572	0.5423
1UH	0.7572	0.7523
1UJ	0.6736	0.7523
1UK	0.6736	0.6968
1UL	0.6232	0.7523
1UM	0.6232	0.6968
1WR	0.7572	0.7721
1WT	0.8045	0.8780
1WU	0.8045	0.7086
1WV	0.7572	0.8780
1WW	0.7572	0.7086
1WX	0.7572	0.5423
1WY	0.7572	0.7523
1WZ	0.6736	0.7523
1XB	0.6736	0.6968
1XC	0.6232	0.6968
1YN	0.7832	0.7721
1YP	0.8689	0.8780
1YQ	0.8719	0.7721
1YR	0.8270	0.8780
1YS	0.8270	0.7721
1YT	0.8270	0.7086
1YU	0.7805	0.8780
1YV	0.7805	0.7086
1YW	0.7068	0.6143
1YX	0.6624	0.6143
1YY	0.7832	0.5423
1YZ	0.7832	0.7523
1ZB	0.7068	0.7523
1ZC	0.7068	0.6968

Plan	Pro Factor	Instl Factor
1ZD	0.6624	0.7523
1ZE	0.6624	0.6968
208	0.8442	0.8942
20X	0.7933	0.8780
24P	0.8826	0.8780
24R	0.7085	0.7498
24S	0.8387	0.7861
25P	0.7321	0.6602
25Q	0.7964	0.7057
26N	0.8843	0.8807
271	0.9012	0.9323
27L	0.8752	0.8780
27R	0.7823	0.7721
283	0.8917	0.8789
28R	0.9845	0.7990
28S	0.9015	0.7976
28T	0.9015	0.7759
294	0.9015	0.8925
29J	1.0049	0.9363
2BX	0.7859	0.7721
2BY	0.8733	0.8780
2BZ	0.8719	0.7721
2CB	0.8289	0.8780
2CC	0.8270	0.7721
2CD	0.8289	0.7086
2CE	0.7859	0.8780
2CF	0.7859	0.7086
2CG	0.7109	0.6143
2CH	0.6676	0.6143
2CJ	0.7859	0.5423
2CK	0.7859	0.7523
2CL	0.7109	0.7523
2CM	0.7109	0.6968
2CN	0.6676	0.7523
2CP	0.6676	0.6968
2D4	0.8138	0.8906
2EE	0.8291	0.8560
2HT	0.9015	0.9123
2HW	0.8563	0.6604
2HX	0.8563	0.7023
2HY	0.9015	0.8033
2JB	0.8535	0.6580
2JD	0.8535	0.7523

## Q1 – 2024 BENEFIT PLAN FACTORS

Plan	Pro Factor	Instl Factor
2JE	0.7572	0.6968
2JH	0.8317	0.8780
2JJ	0.8537	0.8780
2JX	0.9485	0.9316
2L4	0.8384	0.8780
2L5	0.8384	0.7721
2L6	0.8384	0.6580
2L7	0.8384	0.7086
2L8	0.8384	0.5423
2L9	0.8384	0.7523
2M1	0.8384	0.6968
2M2	0.7904	0.8780
2M3	0.7904	0.7721
2M4	0.7904	0.6580
2M5	0.7904	0.7086
2M6	0.7904	0.4919
2M7	0.7904	0.7523
2M8	0.7904	0.6968
2M9	0.7436	0.8780
2MP	0.8621	0.8560
2N1	0.7436	0.7721
2N2	0.7436	0.6580
2N3	0.7436	0.7086
2N4	0.7436	0.5423
2N5	0.7436	0.7523
2N6	0.7436	0.6968
2RE	0.9164	0.9123
2RG	0.9586	0.9138
2RH	0.8754	0.6604
2RJ	0.8754	0.7023
2RQ	0.8719	0.7523
2RR	0.7832	0.6968
2RS	0.8523	0.8780
2RT	0.8523	0.6675
2RU	0.8523	0.8780
2Z3	0.5523	0.6143
30E	0.8654	0.8275
30F	0.9015	0.8923
30S	0.8776	0.8537
311	0.8508	0.8780
312	0.9015	0.9329
314	0.9094	0.8780
31B	0.9557	0.7974
31C	0.8637	0.8245
31F	0.9485	0.8495
31L	0.9994	0.9363
32P	0.9015	0.9323

Plan	Pro Factor	Instl Factor
32Q	0.9015	0.9106
32R	0.8563	0.8233
32S	0.8563	0.7728
32T	0.8776	0.8780
32U	0.8776	0.7721
32V	0.8776	0.7086
32W	0.8776	0.6580
32X	0.8508	0.8780
32Y	0.8508	0.7721
32Z	0.8508	0.7086
330	0.8508	0.6580
331	0.8248	0.8780
332	0.8248	0.7721
333	0.8248	0.7086
334	0.8248	0.6675
335	0.8248	0.6143
336	0.8248	0.5423
337	0.7615	0.7721
338	0.7615	0.7086
339	0.7615	0.6675
33B	0.7615	0.6143
33C	0.7615	0.5423
33D	0.7374	0.7721
33E	0.7374	0.7086
33F	0.7374	0.6675
33G	0.7374	0.6143
33H	0.7374	0.5423
341	0.6301	0.5907
34T	0.6748	0.6906
359	0.8721	0.8780
35B	0.8272	0.8780
35F	0.9352	0.6985
35M	0.8332	0.7721
35N	0.9306	0.8495
366	0.9512	0.8755
37D	0.9512	0.9331
37G	0.8248	0.7523
37Y	0.8508	0.6143
39J	0.9540	0.8902
39K	0.9015	0.9338
39M	0.8986	0.8634
3A3	0.9015	0.9329
3A8	0.6977	0.5599
3A9	0.6977	0.6791
3AN	0.8188	0.7523
3BK	0.9485	0.9337
3BN	0.9586	0.9337

Plan	Pro Factor	Instl Factor
3BR	0.9164	0.8221
3BW	0.8523	0.8780
3C3	0.8721	0.8780
3C7	0.7059	0.7523
3CS	0.9015	0.7724
3CT	0.8917	0.7389
3CV	0.7572	0.6580
3CW	0.8568	0.8780
3CX	0.6963	0.4919
3CY	0.8537	0.5423
3CZ	0.8267	0.8780
3D6	0.8086	0.8245
3DB	0.8267	0.7721
3DD	0.8568	0.7721
3EN	0.9164	0.9106
3EP	0.7832	0.6580
3EQ	0.8752	0.8780
3ER	0.7278	0.4919
3ES	0.8719	0.5423
3ET	0.8475	0.8780
3EU	0.8475	0.7721
3EV	0.7278	0.6482
3FX	0.9970	0.9363
3G7	0.8473	0.8780
3GC	0.8045	0.7523
3GD	0.7637	0.7086
3GE	0.8317	0.7523
3GF	0.8537	0.7721
3GG	0.7572	0.7086
3GH	0.8568	0.8780
3HC	0.8754	0.6850
3HE	0.8270	0.5423
3HF	0.8270	0.7523
3HK	0.7835	0.7086
3HL	0.8752	0.8780
3HW	0.7214	0.7061
3HX	0.7214	0.6005
3KL	0.7536	0.6322
3ZP	0.9072	0.8800
3ZR	0.8563	0.7023
3ZS	0.9015	0.8221
3ZX	0.9015	0.9323
3ZY	0.9485	0.9151
3ZZ	0.9485	0.8235
40L	0.9645	0.8586
40M	1.0157	0.8781
40N	0.9485	0.8495

Plan	Pro Factor	Instl Factor
40P	0.9485	0.8275
40Q	0.9015	0.8481
40R	0.9015	0.8262
40S	0.9015	0.8264
40T	0.9015	0.8044
40U	0.8563	0.8233
40V	0.8563	0.8014
415	0.8129	0.7445
41Y	0.8508	0.8780
42P	0.8981	0.9094
42S	0.8291	0.8560
431	0.8248	0.7721
454	0.8838	0.8680
455	0.8981	0.9094
456	0.9347	0.9150
468	0.9832	0.9150
46E	0.9051	0.8348
46H	0.9237	0.8780
46L	0.9313	0.8166
46Q	0.8903	0.9255
46V	0.9681	0.8781
471	0.9485	0.6985
472	0.8563	0.7350
47E	0.9015	0.9123
47F	0.7617	0.8245
47G	0.7617	0.8245
47Q	0.8621	0.8902
47T	0.8981	0.9106
47W	0.9182	0.8985
48K	0.9015	0.9352
4AL	0.9015	0.9323
4AM	0.5592	0.6143
4AN	0.8425	0.8780
4AS	0.8568	0.7721
4AU	0.8045	0.6968
4AW	0.8267	0.7086
4CJ	0.6736	0.7445
4CM	0.8274	0.7396
4EZ	0.8389	0.6869
4I1	0.8418	0.7721
4I5	0.7591	0.8780
4L3	0.8384	0.8780
4L4	0.7500	0.7721
4L5	0.6691	0.7086
4L6	0.7952	0.7721
4L7	0.6203	0.6143
4L8	0.8637	0.8240

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## Q1 – 2024 BENEFIT PLAN FACTORS

Plan	Pro Factor	Instl Factor
4N6	0.8222	0.7713
4NC	0.8754	0.7023
4ND	0.9164	0.8221
4NJ	0.9164	0.9323
4NK	0.9586	0.9151
4NL	0.9586	0.8235
4NM	0.9164	0.9106
4NY	0.8986	0.8680
4NZ	0.9452	0.8166
4P2	0.8707	0.7648
4PD	0.8270	0.6968
4R8	0.8470	0.8780
4R9	0.9225	0.9143
4UB	0.9015	0.9106
4UJ	0.7197	0.7086
4UK	0.8960	0.7721
4UZ	0.8986	0.8780
4VB	0.7897	0.8780
4VC	0.7348	0.8780
4VD	0.8523	0.8780
4VE	0.8752	0.8780
4VJ	0.7969	0.8290
4VL	0.8301	0.7721
4VU	0.8626	0.6869
4VX	0.8637	0.8240
4WC	0.9164	0.7560
4WG	0.9164	0.8033
4WZ	0.9015	0.9323
4XX	0.8626	0.6869
4YF	0.9600	0.8697
4Z8	0.7811	0.8874
4ZL	0.7832	0.7721
4ZQ	0.7400	0.6143
4ZT	0.7835	0.7086
4ZU	0.9065	0.7389
505	0.8239	0.7381
506	0.8654	0.7886
50L	0.8759	0.8780
50Q	0.9072	0.8800
50R	0.8508	0.8780
50U	0.9493	0.8797
51Q	0.8566	0.9329
527	0.9452	0.9300
52B	0.8248	0.8780
53C	0.8563	0.8233
53K	0.9593	0.8930
53R	0.9015	0.9337

Plan	Pro Factor	Instl Factor
55A	0.7811	0.7721
561	0.9237	0.8780
56U	0.9015	0.9138
56V	0.9015	0.9143
56W	0.9865	0.8218
56X	0.9347	0.8166
56Y	0.9015	0.9323
56Z	0.9015	0.9094
57B	0.9015	0.9094
57C	0.9015	0.9094
58X	0.9015	0.9106
58Y	0.9485	0.9151
58Z	0.9015	0.9106
591	0.9015	0.9323
592	0.9015	0.9323
593	0.9015	0.9337
594	0.9485	0.9316
595	0.9015	0.9323
596	0.9485	0.9151
597	0.9485	0.9115
598	0.9485	0.9176
599	0.8563	0.8233
59B	0.9015	0.9094
59C	0.9015	0.9159
59D	0.9485	0.9128
59E	0.9485	0.8285
59F	0.9485	0.9206
59G	0.9015	0.8285
59H	0.9485	0.9316
59J	0.9485	0.9346
59K	0.9485	0.9138
5AT	0.8826	0.8780
5AY	0.9015	0.9094
5AZ	0.9419	0.9337
5BB	0.7271	0.6322
5BC	0.8826	0.8780
5BD	0.8317	0.7721
5BE	0.7637	0.7721
5BW	0.9015	0.8221
5BZ	0.7832	0.7523
5C6	0.8418	0.8780
5DM	0.9485	0.9176
5DV	0.8315	0.7721
5DW	0.7725	0.8780
5GK	0.9519	0.9337
5GL	0.7536	0.6322
5HF	0.9164	0.8221

Plan	Pro Factor	Instl Factor
5HG	0.9164	0.7560
5JT	1.0145	0.9337
5L7	0.7811	0.8874
5LC	1.0047	0.9363
5LY	0.8270	0.7086
5M8	0.9015	0.8221
5M9	0.9485	0.9337
5MQ	0.9164	0.9323
5MV	0.7085	0.7498
5MW	0.8119	0.7861
5ND	0.6624	0.6968
5PU	0.7068	0.7523
5TT	0.8689	0.8780
5UF	0.7835	0.4919
5WJ	0.9586	0.9337
5WK	0.8752	0.8780
5WM	0.8752	0.8780
5WT	0.7805	0.7086
5XN	0.7682	0.6143
5XV	0.8473	0.8780
5YX	0.6624	0.6031
5YZ	0.6624	0.6031
5ZE	0.6679	0.6143
5ZS	0.8523	0.7086
5ZV	0.6748	0.6906
5ZW	0.6748	0.6492
5ZZ	0.7988	0.8245
604	0.9330	0.8744
605	0.8786	0.8634
60B	0.8411	0.8780
60Y	0.8563	0.6850
60Z	0.9419	0.9337
61N	0.8329	0.7396
628	0.9337	0.9074
62V	0.9015	0.9303
632	0.9419	0.8848
662	0.9010	0.8348
664	0.8329	0.7396
66D	0.7047	0.5962
66G	0.9072	0.8800
66J	0.8329	0.7645
66U	0.8637	0.8245
67Z	0.8444	0.8780
680	0.8487	0.6813
681	0.8444	0.7721
682	0.8444	0.7086
683	0.8444	0.5423

Plan	Pro Factor	Instl Factor
684	0.8150	0.8780
685	0.8150	0.7721
686	0.8150	0.7086
687	0.8150	0.4919
688	0.7489	0.7086
689	0.7489	0.4919
68B	0.6846	0.6482
68C	0.6846	0.4919
68D	0.8064	0.9337
68E	0.8917	0.7759
68F	0.8434	0.6869
68G	0.7247	0.8893
691	0.8418	0.8780
6A4	0.7832	0.7721
6JM	0.9335	0.9337
6KB	0.6977	0.6791
6KC	0.6977	0.5599
6KN	0.8719	0.8780
6KS	0.9012	0.9323
6LS	0.7969	0.7393
6MY	0.8188	0.7523
6T4	0.8291	0.8560
6T5	0.9970	0.9363
6T6	0.8222	0.7713
6T9	1.0092	0.9337
6U1	0.9994	0.9363
6U9	0.9072	0.8800
6V4	1.0725	0.8898
6V5	0.8563	0.7023
6V6	0.9485	0.8235
6V7	0.9015	0.8221
6V8	0.9015	0.8033
6V9	0.9015	0.9123
6W3	0.9485	0.9138
6W4	0.9485	0.9176
6W5	0.9485	0.9337
6W6	0.9485	0.9154
6W7	0.8563	0.6604
6W9	0.8563	0.7023
6X1	0.8563	0.7023
6X2	0.8563	0.6850
6X3	0.9015	0.9094
6X4	0.9015	0.7724
6X6	0.9378	0.6985
6Y2	0.9419	0.9337
6Y3	0.8917	0.7389
6Y4	0.8434	0.6869

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## Q1 – 2024 BENEFIT PLAN FACTORS

Plan	Pro Factor	Instl Factor
6Y5	0.7271	0.6322
6Y9	0.9015	0.9323
6Z1	0.9485	0.9151
6Z4	0.9485	0.8235
6Z5	0.9015	0.8221
6Z7	0.9015	0.8033
6Z9	0.9015	0.9106
6ZC	0.8752	0.7721
6ZF	0.8477	0.8780
6ZL	0.8755	0.7721
6ZM	0.9559	0.8235
70B	0.8184	0.8060
70F	0.8150	0.9140
70J	0.8475	0.8848
70N	0.8566	0.8634
711	0.7266	0.5423
712	0.8165	0.8780
713	0.7326	0.7523
714	0.7500	0.7721
72C	0.8138	0.7496
72E	0.9146	0.8599
72F	0.9146	0.8599
72G	0.8131	0.8599
72H	0.9679	0.8694
72J	0.8628	0.8693
72M	0.9149	0.8599
734	0.9681	0.8801
73B	0.9146	0.7364
73N	0.8138	0.8693
73V	0.9153	0.8801
73W	0.9151	0.8437
73X	0.9151	0.8240
73Y	0.9151	0.8146
744	0.9149	0.8801
74F	0.7171	0.6673
751	0.6846	0.7086
770	0.6824	0.6968
772	0.9493	0.8743
776	0.8289	0.6695
7C1	0.9015	0.7560
7C2	0.9015	0.9323
7C3	0.9015	0.9106
7K6	0.5592	0.6143
7K7	0.8425	0.8780
7L1	0.8568	0.8780
7L4	0.7572	0.7721
7L5	0.8535	0.8780

Plan	Pro Factor	Instl Factor
7L7	0.8045	0.8780
7L9	0.8045	0.7086
7M1	0.7572	0.8780
7M2	0.7572	0.7086
7M3	0.6736	0.6143
7M4	0.6232	0.6143
7M5	0.7572	0.5423
7M6	0.7572	0.7523
7M7	0.6736	0.7523
7M8	0.6736	0.6968
7M9	0.6232	0.7523
7N1	0.6232	0.6968
7N2	0.7572	0.7721
7N3	0.8506	0.8780
7N4	0.8535	0.7721
7N5	0.8045	0.8780
7N6	0.8045	0.7721
7N7	0.8045	0.7086
7N8	0.7546	0.8780
7N9	0.7546	0.7086
7P1	0.6736	0.6143
7P2	0.6232	0.6143
7P3	0.7572	0.5423
7P4	0.7572	0.7523
7P5	0.6736	0.7523
7P6	0.6736	0.6968
7P7	0.6232	0.7523
7P8	0.6232	0.6968
7R8	0.8838	0.8680
7R9	0.9347	0.8166
7S1	0.8568	0.7721
7S2	0.7985	0.7523
7S3	0.8289	0.8780
7S5	0.8535	0.8780
7S6	0.8535	0.7721
7S7	0.8535	0.6580
7S8	0.8535	0.7086
7S9	0.8535	0.5423
7T1	0.8535	0.7523
7T2	0.8045	0.8780
7T3	0.8045	0.7721
7T4	0.8045	0.6580
7T5	0.8045	0.7086
7T6	0.8045	0.5423
7T7	0.8045	0.7523
7T8	0.8045	0.6968
7T9	0.7572	0.8780

Plan	Pro Factor	Instl Factor
7U1	0.7572	0.7721
7U2	0.7572	0.6580
7U3	0.7572	0.7086
7U4	0.7572	0.5423
7U5	0.7572	0.7523
7U6	0.7572	0.6968
7U7	0.8826	0.8780
7U8	0.8568	0.8780
7U9	0.8317	0.8780
7V1	0.8317	0.7721
7V2	0.8317	0.7086
7V3	0.8317	0.6675
7V4	0.7637	0.7721
7V5	0.7637	0.7086
7V9	0.7400	0.6143
7W2	0.8317	0.7523
7W3	0.8568	0.8780
7W4	0.8315	0.7721
7W5	0.7725	0.8780
7W6	0.8079	0.7721
7W8	0.8317	0.8780
7W9	0.8537	0.8780
7X1	0.6963	0.4919
7X2	0.8537	0.7721
7X4	0.8537	0.5423
7X5	0.8267	0.8780
7X6	0.8267	0.7721
7X7	0.8267	0.7086
7X8	0.7572	0.7086
7X9	0.7572	0.4919
7Y1	0.8267	0.5423
7Y2	0.6963	0.6482
7Y5	0.8568	0.8780
7Y6	0.8568	0.7721
7Z9	0.8535	0.6968
81F	0.8384	0.7721
82H	0.8470	0.8780
82P	0.9225	0.9143
83P	0.9569	0.9144
846	0.8219	0.8938
84J	0.6619	0.7459
8A2	0.6289	0.6143
8G8	0.8081	0.7721
8J5	0.6736	0.7445
8K3	0.8274	0.7396
8M6	0.8239	0.7599
8N3	0.9500	0.8697

Plan	Pro Factor	Instl Factor
8U1	0.9485	0.9316
906	0.8384	0.8780
907	0.7787	0.7721
90B	0.9309	0.8599
91Q	0.7013	0.5962
91R	0.6846	0.4919
927	0.8384	0.7721
928	0.8384	0.7086
929	0.8384	0.5423
92B	0.8117	0.8780
92C	0.8117	0.7721
92D	0.8117	0.7086
92E	0.7438	0.7086
92F	0.7438	0.4919
92N	0.9419	0.9337
92Q	0.8117	0.4919
92R	0.6846	0.6482
92S	0.8917	0.7759
92T	0.8434	0.7247
92U	0.7271	0.8893
93Q	0.8384	0.7721
95E	0.6846	0.7086
95F	0.6619	0.7445
95M	0.9512	0.8517
95N	0.8329	0.7366
95P	0.9309	0.8599
97V	1.0092	0.9337
97Y	0.8903	0.9255
97Z	0.9182	0.8977
98Q	0.9306	0.8599
98R	0.8838	0.8680
98S	0.9347	0.9150
98T	0.9347	0.8166
98U	0.9347	0.8166
98V	0.8838	0.7533
99D	0.9485	0.9337
99E	0.9015	0.8925
99F	0.9020	0.9323
99G	0.9485	0.9316
99H	0.9015	0.9323
99J	0.9485	0.9151
99K	0.9485	0.9115
99L	0.9485	0.9176
99M	0.9493	0.8743
99N	0.9485	0.8495
99P	0.9015	0.8481
99Q	0.9015	0.8262

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Plan	Pro Factor	Instl Factor
99R	0.9015	0.8264
99S	0.9015	0.9323
99T	0.9015	0.9106
99U	0.9485	0.7990
99V	0.9015	0.7976
99W	0.9015	0.7759
99X	0.9994	0.9363
99Y	0.9015	0.9323
99Z	0.9015	0.9106
9A2	0.8267	0.8780
9A3	0.7102	0.7086
9CD	0.8986	0.8780
9CE	0.8303	0.8780
9CF	0.7350	0.8780
9CG	0.8523	0.8780
9CH	0.8752	0.8780
9CY	0.9602	0.8697
9FL	0.7988	0.8245
9FN	0.7297	0.6069
9G1	0.8389	0.6869
9HH	0.9337	0.9337
9KE	0.6626	0.6968
9TY	0.7896	0.7746
9UB	0.8760	0.7746
9UC	0.8328	0.8808
9UD	0.8308	0.7746
9UE	0.8310	0.7110
9UF	0.7896	0.8808
9UG	0.7896	0.7109
9UH	0.7142	0.6163
9UJ	0.6707	0.6163
9UK	0.7896	0.5441
9UL	0.7896	0.7547
9UM	0.7142	0.7547
9UN	0.7142	0.6991
9UP	0.6707	0.7547
9UQ	0.6707	0.6991
9UR	0.6655	0.6051
9US	0.7868	0.7746
9UT	0.8729	0.8808
9UU	0.8762	0.7745
9UV	0.8308	0.8808
9UW	0.8308	0.7746
9UX	0.8310	0.7110
9UY	0.7841	0.8808
9UZ	0.7841	0.7109
9VB	0.7101	0.6163

Plan	Pro Factor	Instl Factor
9VC	0.6655	0.6163
9VD	0.7868	0.5441
9VE	0.7835	0.7523
9VF	0.7101	0.7547
9VG	0.7101	0.6991
9VH	0.6624	0.7530
9VJ	0.6624	0.6974
9VK	0.6655	0.6051
9VL	0.7572	0.7728
9VM	0.8506	0.8780
9VP	0.8045	0.7728
9VR	0.7572	0.8788
9VS	0.7546	0.7086
9VT	0.7572	0.5428
9VU	0.7572	0.7530
9VV	0.6736	0.7530
9VW	0.6736	0.6974
9XE	0.6590	0.6525
9XF	0.5919	0.5210
9XK	0.8721	0.8780
A7N	0.7331	0.7072
A7P	0.6738	0.6410
A7Q	0.6275	0.5720
A7R	0.7971	0.7411
A7S	0.8546	0.6577
A7T	0.7109	0.5456
A7U	0.6526	0.4154
A7W	0.8183	0.6692
A7X	0.6967	0.6028
A7Z	0.6137	0.7184
A81	0.8138	0.5420
A82	0.7351	0.8100
A83	0.8303	0.8780
A84	0.7350	0.8780
A85	0.8523	0.8780
A86	0.8752	0.8780
A88	0.8755	0.7721
A89	0.8752	0.8780
A8B	0.7823	0.7728
A8C	0.8677	0.8294
A8F	0.6937	0.8212
A8G	0.8986	0.8780
A8H	0.8086	0.8245
A8K	0.7572	0.6994
A8L	0.7873	0.7009
A8P	0.6963	0.5443
A8Q	0.8267	0.8812

Plan	Pro Factor	Instl Factor
A8R	0.7873	0.6619
A8S	0.7312	0.4948
A8U	0.7572	0.7112
A8W	0.7871	0.7128
A8X	0.8793	0.8800
A93	0.8537	0.8812
A95	0.8267	0.7749
A97	0.8514	0.7767
A9C	0.8826	0.8780
A9F	0.8308	0.7102
A9J	0.8912	0.8831
A9L	0.7971	0.6619
A9M	0.7534	0.5456
A9N	0.7109	0.5456
A9P	0.6760	0.8052
A9Q	0.6526	0.7781
A9R	0.6137	0.7184
A9T	0.7971	0.7411
A9U	0.7109	0.6735
A9V	0.6526	0.6064
A9W	0.5444	0.5335
A9X	0.7331	0.7072
A9Y	0.6738	0.6410
A9Z	0.6275	0.5720
AAA	0.9452	0.9300
AAZ	0.9545	0.9084
AAZ	0.8684	0.7000
AB0	0.9660	0.8737
AB1	0.9633	0.8287
AB2	1.0080	0.9400
AB3	0.9043	0.9361
AB4	0.9013	0.9333
AB6	0.8676	0.6917
AB7	0.9657	0.9193
AB9	0.9236	0.8274
ABA	1.0126	0.8625
ABC	0.8804	0.7047
ABD	0.7579	0.6367
ABE	0.8804	0.6873
ABF	0.9419	0.9371
ABK	0.9660	0.9396
ABL	0.8687	0.8613
ABM	0.9232	0.9178
ABN	0.9657	0.9206
ABP	0.8804	0.6627
ABR	0.9485	0.9184
ABT	0.9015	0.9331

Plan	Pro Factor	Instl Factor
ABU	0.9015	0.9114
ABV	0.9164	0.9331
ABY	0.9015	0.8228
ACA	0.9512	0.9182
AEA	0.9015	0.9011
AFA	0.9485	0.9030
AGA	0.8981	0.9255
AH2	0.8317	0.8780
AI9	0.8226	0.7541
AIH	0.8226	0.7541
AJA	0.8981	0.9242
ANA	0.8981	0.8182
ANM	0.8291	0.8560
AOA	0.9994	0.9260
APD	0.8563	0.7023
APH	0.8274	0.7396
AQM	0.8795	0.8799
ASA	1.0697	0.8830
ATA	1.0092	0.9261
AUA	0.8623	0.8943
AVA	0.9493	0.8671
AVB	0.8563	0.7023
AWA	0.9452	0.9325
AWH	0.9236	0.7608
AX2	0.8602	0.7721
AX3	0.9165	0.7724
AXA	0.9015	0.9006
AYA	0.8903	0.9405
AYM	0.7934	0.7739
AZA	0.9015	0.9068
AZF	0.7092	0.7547
AZG	0.9660	0.9396
B15	0.8760	0.7739
B1F	1.0070	0.9370
B5D	0.7331	0.5947
B8W	0.8026	0.8272
B9C	0.8310	0.7568
B9D	0.7104	0.7541
B9Q	0.5833	0.4247
B9R	0.6621	0.5998
BBN	0.8762	0.8799
BBU	0.8026	0.8799
BCA	0.9485	0.9234
BDA	0.9485	0.9489
BFA	0.8981	0.9475
BGA	0.8981	0.9356
BHA	0.9485	0.9486

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Plan	Pro Factor	Instl Factor
BJA	0.9485	0.9228
BJV	0.7883	0.7721
BJW	0.8769	0.8780
BJZ	0.8358	0.7738
BK2	0.7873	0.7104
BK3	0.7104	0.6158
BK5	0.7921	0.5436
BK6	0.7921	0.7541
BK7	0.7104	0.7541
BK8	0.7104	0.6983
BK9	0.6705	0.7547
BKA	0.9966	0.9261
BKB	0.6705	0.6990
BKC	0.6657	0.6048
BLA	0.9966	0.9515
BMA	0.9932	0.9287
BMN	0.7921	0.7738
BMS	0.8310	0.7738
BMU	0.7921	0.8799
BMV	0.7934	0.7127
BMW	0.7176	0.6178
BMX	0.7873	0.5436
BMZ	0.7921	0.7541
BN0	0.7176	0.7565
BN1	0.7176	0.7006
BN2	0.6705	0.7541
BN3	0.6705	0.6983
BN4	0.6686	0.6063
BNA	0.8981	0.9370
BPQ	0.8762	0.7766
BR1	0.6232	0.6968
BSA	0.9485	0.8420
BSS	0.7176	0.7006
BSX	0.8310	0.8807
BSY	0.8762	0.8807
BTA	0.9015	0.8421
BUA	0.9485	0.9017
BVA	0.9270	0.9285
BVW	0.7906	0.7763
BVX	0.8762	0.8799
BVY	0.8762	0.7745
BVZ	0.8310	0.8799
BW0	0.8346	0.7763
BW1	0.8358	0.7110
BW2	0.7879	0.8827
BW3	0.7879	0.7127
BW4	0.7135	0.6178

Plan	Pro Factor	Instl Factor
BW5	0.6657	0.6158
BW6	0.7906	0.5454
BW7	0.7873	0.7541
BW8	0.7135	0.7565
BW9	0.7135	0.7006
BWB	0.6657	0.7547
BWC	0.6657	0.6990
BWD	0.6686	0.6063
BWL	0.7934	0.7763
BWN	0.8801	0.7763
BWP	0.8366	0.8827
BWQ	0.8358	0.7738
BWS	0.7934	0.8827
BWT	0.7934	0.7127
BWU	0.7176	0.6178
BWV	0.6657	0.6158
BWW	0.7934	0.5454
BWX	0.7934	0.7565
BWY	0.7176	0.7565
BWZ	0.7176	0.7006
BX0	0.6738	0.7565
BX1	0.6738	0.7006
BX2	0.6686	0.6063
BXA	0.9452	0.9014
BYP	0.8274	0.7396
BZ7	0.8912	0.8799
BZ8	0.7971	0.7411
BZ9	0.7109	0.5456
BZA	0.9452	0.9332
BZB	0.7109	0.6735
BZW	0.7109	0.5456
BZX	0.7109	0.6735
C3L	0.8795	0.8799
C3M	0.8563	0.8799
C3N	0.7386	0.8799
C3P	0.8344	0.8799
C3Q	0.9029	0.8799
C3R	0.8795	0.7738
C3S	1.0084	0.9403
C3U	0.8795	0.8799
C3V	0.9633	0.8287
C3W	0.8795	0.7738
C3X	0.8793	0.8800
C4F	0.9235	0.8737
C4T	0.7861	0.7745
C5E	0.7921	0.7110
C5F	0.7949	0.7739

Plan	Pro Factor	Instl Factor
C5Q	0.7921	0.6619
C5R	0.7362	0.5456
C5S	0.8843	0.8799
C60	0.7594	0.6374
C62	0.8862	0.6633
C6G	0.8960	0.8799
C6H	0.7379	0.7072
C6J	0.6786	0.6410
C6K	0.6323	0.5720
C6L	0.8019	0.7411
C6M	0.8597	0.6577
C6N	0.7156	0.5456
C6P	0.6574	0.4154
C6R	0.7156	0.6735
C6S	0.7018	0.6028
C6U	0.6184	0.7184
C6V	0.8439	0.6604
C6W	0.8190	0.5420
C6X	0.6808	0.4947
C6Y	0.8960	0.8831
C6Z	0.8477	0.6619
C70	0.8019	0.6619
C71	0.7582	0.5456
C72	0.7156	0.5456
C73	0.6808	0.8052
C74	0.6574	0.7781
C75	0.6184	0.7184
C76	0.8960	0.8064
C77	0.8019	0.7411
C78	0.7156	0.6735
C79	0.6574	0.6064
C7B	0.5492	0.5372
C7C	0.7379	0.7072
C7D	0.6786	0.6410
C7E	0.6323	0.5720
C8J	0.7348	0.5957
C95	0.8614	0.7738
C98	0.8843	0.8799
CAA	0.9832	0.9336
CBA	0.9865	0.9336
CBJ	0.6657	0.5998
CDA	0.9865	0.9443
CEA	0.9313	0.8335
CFA	0.9347	0.8336
CHA	0.9347	0.8437
CIA	0.8807	0.7689
CJA	0.8838	0.7687

Plan	Pro Factor	Instl Factor
CKG	0.6127	0.7163
CKH	0.6127	0.7157
CLA	0.8838	0.7786
CMZ	0.7620	0.7112
CN1	0.8301	0.7749
CN2	0.7620	0.7728
CN3	0.8571	0.8788
CN8	0.6784	0.7530
CNH	0.9060	0.9115
CNL	0.9060	0.8221
CNN	0.8609	0.7023
CNW	0.5761	0.3915
CNZ	0.5761	0.3911
CQA	0.8776	0.8625
CRA	0.8508	0.8614
CSA	0.8989	0.8589
CTA	0.8508	0.8614
CUQ	0.9261	0.7793
CUR	0.8692	0.7738
CZ1	0.9450	0.9378
CZA	1.0092	0.9267
DA2	0.7921	0.7738
DA3	0.8809	0.8799
DA4	0.8358	0.7738
DA5	0.7921	0.7104
DA6	0.7152	0.6158
DA7	0.7921	0.5436
DA8	0.7921	0.7541
DA9	0.7152	0.7541
DAA	0.9452	0.9214
DAB	0.7152	0.6983
DAC	0.6705	0.7547
DAD	0.6705	0.6990
DAE	0.6705	0.6048
DAF	0.6175	0.7163
DAG	0.5809	0.3915
DBA	0.9485	0.9234
DCA	0.9452	0.9376
DCH	0.7921	0.7738
DCI	0.8358	0.7738
DCJ	0.7934	0.7104
DCK	0.7176	0.6158
DCL	0.7921	0.7541
DCM	0.7152	0.7541
DCN	0.7176	0.6983
DCO	0.6705	0.7541
DCP	0.6705	0.6983

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Plan	Pro Factor	Instl Factor
DCQ	0.6705	0.6043
DCS	0.6175	0.7157
DCT	0.5809	0.3911
DDA	0.8981	0.9356
DEA	0.9452	0.9049
DFA	0.9452	0.8753
DFG	0.7921	0.7541
DFH	0.7152	0.7541
DFI	0.7152	0.6983
DFJ	0.6705	0.7547
DFK	0.6705	0.6990
DFL	0.6705	0.6048
DFM	0.7921	0.7738
DFN	0.8809	0.8799
DFO	0.8358	0.7738
DFP	0.7921	0.7104
DFR	0.7921	0.5436
DGA	0.8981	0.8993
DGQ	0.7934	0.7541
DGR	0.7152	0.7541
DGS	0.7152	0.6983
DGT	0.6738	0.7541
DGU	0.6738	0.6983
DGV	0.6705	0.6043
DGW	0.7934	0.7738
DGY	0.7921	0.7104
DGZ	0.7176	0.6158
DHA	0.9452	0.9214
DIA	0.9452	0.9189
DJA	0.8981	0.9139
DKA	0.8981	0.9158
DLA	0.9452	0.9042
DMA	0.8981	0.7753
DN8	0.7921	0.8807
DNA	0.8530	0.7045
DNQ	0.7934	0.5436
DQA	0.9631	0.9242
DRA	0.9485	0.8680
DS8	0.7921	0.8799
DSA	0.9485	0.9264
DSC	0.7934	0.8799
DTA	0.9015	0.9364
DTP	0.7152	0.6158
DTQ	0.7118	0.6968
DTS	0.6674	0.6036
DTV	0.8809	0.8799
DU1	0.7921	0.6619

Plan	Pro Factor	Instl Factor
DU3	0.8843	0.8799
DUA	0.9015	0.9482
DV8	0.9672	0.8277
DV9	0.8843	0.7738
DVB	0.8843	0.8799
DVD	1.0145	0.9383
DVY	0.9273	0.8254
DW2	0.8862	0.6871
DWA	0.9485	0.9234
DWB	0.7176	0.6983
DWC	0.7156	0.5456
DWD	0.7156	0.6735
DXE	0.8809	0.7745
DXF	0.8358	0.8799
DYA	0.9452	0.9189
DYO	0.8809	0.7738
DYU	0.7921	0.5436
DZA	0.9600	0.9101
DZB	0.7921	0.7745
E5Y	0.8626	0.7031
E7C	0.9225	0.9162
E7E	0.8862	0.6633
E7G	0.9698	0.9186
E7M	0.6657	0.5998
E8W	0.7608	0.6374
E9H	0.9450	0.9367
E9X	0.8614	0.7738
EA8	0.8358	0.7568
EEP	0.5809	0.3874
ENO	0.6280	0.6968
EWP	0.6705	0.6983
EXM	0.6705	0.6990
EXW	0.8614	0.7738
FDX	0.8657	0.8799
FDY	0.8604	0.7738
FDZ	0.8215	0.7738
FE0	0.7785	0.7384
FE1	0.7785	0.7738
FE2	0.7785	0.7104
FE3	0.7785	0.5436
FE4	0.7032	0.7384
FE5	0.7032	0.6800
FE6	0.7032	0.6158
FE7	0.6602	0.7391
FE8	0.6602	0.6807
FE9	0.6602	0.5935
FEB	0.6091	0.7163

Plan	Pro Factor	Instl Factor
FEF	0.5740	0.3719
FGP	0.8215	0.7738
FGQ	0.7785	0.7384
FGR	0.7785	0.7738
FGS	0.7785	0.7104
FGT	0.7032	0.7384
FGU	0.7032	0.6800
FGV	0.7032	0.6158
FGW	0.6602	0.7384
FGX	0.6600	0.6800
FGY	0.6602	0.5930
FGZ	0.6091	0.7157
FH0	0.5859	0.3851
FH6	0.8657	0.7738
FH8	0.7785	0.7541
FH9	0.7785	0.7738
FHB	0.7032	0.7541
FHC	0.7032	0.6983
FHD	0.6602	0.6983
FHI	0.8657	0.8799
FHJ	0.8692	0.8799
FHK	0.8215	0.8799
FHL	0.7785	0.7541
FHM	0.7785	0.7738
FHN	0.7785	0.7104
FHO	0.7785	0.5436
FHP	0.7032	0.7541
FHQ	0.7032	0.6983
FHR	0.6999	0.6968
FHS	0.6602	0.6990
FMO	0.9698	0.9186
FMP	0.9273	0.9162
FMR	0.8862	0.6871
FNA	0.9571	0.9002
FNN	1.0164	0.9391
FO8	0.7484	0.7728
FOA	0.9571	0.9244
FOF	0.8165	0.8780
FOZ	0.7785	0.7745
FPA	0.9084	0.8246
FPI	0.6602	0.6983
FPJ	0.8692	0.7738
FPK	0.8692	0.8799
FPL	0.9672	0.8267
FQA	0.9084	0.8233
FQJ	0.6602	0.6048
FRA	0.9548	0.9002

Plan	Pro Factor	Instl Factor
FS9	0.9450	0.9367
FSA	0.9373	0.9015
FTN	1.0118	0.8866
FTP	0.8649	0.7738
FTW	0.8690	0.8799
FUD	0.8215	0.7480
FUF	0.7023	0.6983
FWA	0.9419	0.9174
FYA	0.9137	0.8725
FZA	0.9141	0.9149
G4W	0.8618	0.8799
G4X	0.8422	0.7738
G4Y	0.8184	0.7738
G50	0.7758	0.7384
G51	0.7758	0.7738
G52	0.7758	0.7104
G53	0.7758	0.5436
G54	0.7020	0.7384
G56	0.7020	0.6800
G57	0.7020	0.7104
G58	0.7020	0.6158
G59	0.6600	0.7391
G5B	0.6600	0.6807
G5C	0.6600	0.5935
G5D	0.6600	0.6158
G5E	0.6086	0.7163
G5I	0.8184	0.7738
G5J	0.7460	0.7157
G5K	0.7758	0.7384
G5L	0.7758	0.7738
G5M	0.7758	0.7104
G5N	0.7020	0.7384
G5P	0.7020	0.7104
G5Q	0.7020	0.6158
G5R	0.6600	0.7384
G5S	0.6598	0.6800
G5T	0.6600	0.5930
G5U	0.6600	0.6158
G5V	0.6086	0.4154
G5Y	0.7020	0.6800
G6W	0.8026	0.8272
G7K	0.6602	0.6990
GBA	0.8981	0.9380
GEA	0.8981	0.8981
GEG	0.8384	0.8812
GEJ	0.7785	0.7738
GFA	0.9485	0.9130

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Plan	Pro Factor	Instl Factor
GGD	0.7436	0.7523
GGE	0.7020	0.4377
GGF	0.6600	0.3086
GGH	0.7020	0.4377
GGI	0.6600	0.3083
GHA	0.9485	0.9197
GI9	0.7763	0.7738
GIA	0.8981	0.9030
GIJ	1.0164	0.9391
GLA	0.9485	0.9229
GLL	0.8690	0.8799
GMA	0.9452	0.8822
GN0	1.0118	0.8866
GN2	0.6927	0.5222
GN4	0.6927	0.5222
GNI	0.6602	0.6990
GNM	0.6753	0.6158
GNO	0.6753	0.6158
GNQ	0.8649	0.7738
GOB	0.8186	0.7480
GOE	0.7023	0.6983
GOH	0.8019	0.8807
GQA	0.8981	0.8981
GSA	0.9999	0.9489
GU5	0.7763	0.7738
GUA	0.8981	0.8981
GUB	0.9244	0.9162
GUC	0.9665	0.9177
GVA	0.8981	0.9157
GW0	1.0123	0.9391
GXA	0.9956	0.9228
GYA	0.9392	0.8940
GZ1	0.8540	0.8799
GZ2	0.8540	0.7738
GZ3	0.8095	0.7738
GZ4	0.793	0.4154
GZ5	0.6507	0.6800
GZ6	0.6507	0.5930
GZ7	0.6507	0.6158
GZ8	0.5871	0.4154
GZ9	0.6254	0.4154
GZA	0.9624	0.9239
GZD	0.7668	0.7384
GZE	0.7668	0.7738
GZF	0.7668	0.7104
GZG	0.7668	0.5436
GZH	0.6927	0.7384

Plan	Pro Factor	Instl Factor
GZJ	0.6927	0.6800
GZK	0.6927	0.7104
GZL	0.6927	0.6158
GZM	0.6507	0.7391
GZN	0.6925	0.4377
GZO	0.6504	0.3086
GZQ	0.7641	0.6466
GZR	0.6927	0.5222
GZS	0.8709	0.7738
GZT	0.8095	0.7738
GZU	0.7930	0.4154
GZV	0.7668	0.7384
GZW	0.7668	0.7738
GZX	0.7668	0.7104
GZY	0.6927	0.7384
GZZ	0.6927	0.7104
H00	0.6927	0.6158
H01	0.6492	0.7384
H02	0.6507	0.6800
H03	0.6507	0.5930
H04	0.6507	0.6158
H05	0.5871	0.4154
H0B	0.6927	0.6800
H0C	0.6927	0.4377
H0D	0.6504	0.3083
H0F	0.7641	0.6466
H0G	0.6927	0.5222
H6O	0.8657	0.8799
H77	0.8351	0.8812
H7H	0.8838	0.6871
H7I	0.9244	0.9162
HDM	0.7763	0.7738
HFV	0.7414	0.7523
HFV	0.7763	0.7738
HHQ	0.8136	0.8780
HHT	0.6753	0.6158
HHV	0.6753	0.6158
HHZ	0.8800	0.9509
HI7	0.9421	0.9367
HI9	0.8649	0.7738
HJO	1.0118	0.8866
HJX	0.8186	0.7480
HK0	0.7023	0.6983
HT8	0.8540	0.8799
HTB	0.8540	0.7738
HTD	0.8095	0.7738
HTE	0.7930	0.4154

Plan	Pro Factor	Instl Factor
HTF	0.7668	0.7384
HTG	0.7668	0.7738
HTH	0.7641	0.6455
HTI	0.7668	0.7104
HTJ	0.7668	0.5436
HTK	0.6927	0.7384
HTL	0.6927	0.671
HTM	0.6927	0.7104
HTN	0.6927	0.5222
HTO	0.6927	0.6158
HTP	0.6925	0.4307
HTR	0.6507	0.7391
HTS	0.6507	0.6710
HTT	0.6507	0.5930
HTU	0.6507	0.6158
HTV	0.6254	0.4154
HTW	0.6504	0.3086
HTX	0.5871	0.4154
HTZ	0.5518	0.2526
HVB	0.8838	0.6871
HVY	0.854	0.7738
HW0	0.8095	0.7738
HW1	0.793	0.4154
HW1	0.793	0.4154
HW2	0.7668	0.7384
HW3	0.7668	0.7738
HW4	0.7641	0.6455
HW5	0.7668	0.7104
HW6	0.6927	0.7384
HW7	0.6927	0.6710
HW8	0.6927	0.7104
HWB	0.6927	0.6158
HWC	0.6927	0.4307
HWD	0.6717	0.6602
HWE	0.6492	0.7384
HWF	0.6507	0.6710
HWG	0.6507	0.5930
HWI	0.6254	0.4154
HWJ	0.6504	0.3083
HWK	0.5871	0.4154
HWL	0.5788	0.3715
HZP	0.8019	0.8807
J86	1.0123	0.9391
J9L	0.6602	0.699
JAM	0.8384	0.8812
JAW	0.7763	0.7738
JAZ	0.7763	0.7738

Plan	Pro Factor	Instl Factor
JB4	0.7763	0.7738
JB6	0.8657	0.8799
JC2	0.7414	0.7523
JD5	0.8136	0.8780
JDB	0.9421	0.9367
JDD	0.8649	0.7738
JDI	0.8186	0.7480
JDL	0.7023	0.6983
JDX	1.0118	0.8866
JDY	0.8657	0.8799
JNJ	0.854	0.7738
JNL	0.8095	0.7738
JNM	0.793	0.4154
JNN	0.7668	0.8799
JNO	0.7668	0.7384
JNP	0.7641	0.6455
JNQ	0.7668	0.7104
JNS	0.7254	0.6595
JNT	0.6927	0.7384
JNU	0.6927	0.671
JNV	0.6927	0.7104
JNW	0.6927	0.5222
JNX	0.6927	0.6158
JNY	0.6925	0.4307
JNZ	0.6925	0.3938
JO1	0.6507	0.671
JO2	0.6507	0.593
JO3	0.6507	0.6158
JO4	0.6254	0.4154
JO5	0.6504	0.3086
JO6	0.5871	0.4154
JO7	0.5773	0.3719
JR4	0.854	0.7738
JR6	0.8095	0.7738
JR7	0.793	0.4154
JR8	0.7668	0.8799
JR9	0.7668	0.7384
JRB	0.7641	0.6455
JRC	0.7668	0.7104
JRE	0.7254	0.6595
JRF	0.6927	0.7384
JRG	0.6927	0.671
JRH	0.6927	0.7104
JRJ	0.6927	0.6158
JRK	0.6927	0.4307
JRM	0.6717	0.6602
JRN	0.6507	0.671

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Plan	Pro Factor	Instl Factor
JRO	0.6507	0.593
JRQ	0.6254	0.4154
JRR	0.6504	0.3083
JRS	0.5871	0.4154
JW5	0.8019	0.8807
JZ3	0.6602	0.6990
K1P	0.8384	0.8812
K1P	0.8384	0.8812
K1R	0.7414	0.7523
K1R	0.7414	0.7523
K22	1.0123	0.9391
K23	0.7763	0.7738
K2B	0.8657	0.8799
K2W	0.7763	0.7738
K4C	0.8649	0.7738
K4S	0.9421	0.9367
K5O	0.8186	0.7480
K5R	0.7023	0.6983
K5Y	1.0118	0.8866
K61	0.8657	0.8799
KBA	0.9493	0.9022

Plan	Pro Factor	Instl Factor
KCA	0.9581	0.8407
KCY	0.6492	0.7384
KD0	0.8136	0.8780
KDA	0.9528	0.9032
KHO	0.8542	0.7738
KHQ	0.8098	0.7738
KHS	0.7668	0.8799
KHT	0.7668	0.7384
KHV	0.7641	0.6455
KHW	0.7668	0.7104
KI2	0.6927	0.7384
KI5	0.6927	0.7104
KI8	0.6927	0.4307
KIC	0.6507	0.6710
KID	0.6507	0.5930
KIG	0.6507	0.3086
KIH	0.5874	0.4154
KII	0.5778	0.3626
KIJ	0.8542	0.7738
KIO	0.7670	0.7384
KIQ	0.7641	0.6455

Plan	Pro Factor	Instl Factor
KIW	0.6927	0.6710
KJ1	0.6927	0.4307
KJ4	0.6507	0.6710
KJ5	0.6507	0.5930
KJ8	0.6507	0.3083
KKO	0.8052	0.8807
KKY	0.8838	0.6871
KQ1	0.6602	0.699
KQ9	0.8384	0.8812
KQD	0.7414	0.7523
KQG	0.8654	0.8799
KQS	1.0126	0.9391
KRZ	0.7763	0.7738
KSD	0.7763	0.7738
MLA	0.8735	0.8639
NAA	0.8776	0.8773
NFA	0.8704	0.8780
NGA	0.8508	0.7710
NHA	0.8508	0.7075
NKA	0.8248	0.7086
OBA	0.9452	0.9276

Plan	Pro Factor	Instl Factor
OCA	0.9452	0.8420
ODA	0.9015	0.8376
OGA	0.9378	0.9028
OHA	0.9452	0.9069
OIA	0.9645	0.8704
OKA	0.8981	0.8420
OLA	0.9452	0.9500
OMA	0.9452	0.9468
OUA	0.9411	0.9370
PEA	0.9454	0.9466
PNA	0.9452	0.9498
POA	0.9485	0.9303
PVA	0.8981	0.8314
PXA	0.9452	0.9037
XGA	1.0486	0.9224
XHA	0.9485	0.8722
XIA	1.0680	0.9201
XKA	0.9485	0.8170
XMA	0.9450	0.9021
XRA	0.8186	0.8863

**Q1 – 2024 BENEFIT PLAN FACTORS**

**A.5 Benefit Plan Factors for Small Group POS Capitation and Small Group POS Shared Risk Budgets**

Small Group POS

Plan	Pro Factor	Instl Factor
10G	0.9485	0.9100
13D	0.7644	0.9593
17I	0.9366	0.8444
1AK	0.9404	0.8723
1AL	0.8348	0.6538
1AM	0.7472	0.5388
1AN	0.6667	0.4117
1AP	0.9404	0.7964
1AQ	0.8348	0.7323
1AR	0.7472	0.6652
1AS	0.6667	0.5992
1AT	0.9428	0.9020
1AU	0.8506	0.6965
1CF	0.9356	0.8723
1CG	0.8312	0.6538
1CH	0.7419	0.5388
1CJ	0.6597	0.4117
1CK	0.9323	0.7964
1CL	0.8312	0.7323
1CM	0.7419	0.6652
1CN	0.6597	0.5992
1DX	0.7871	0.7270
1DZ	0.7051	0.6605
1EB	0.7003	0.6605
1ES	0.9515	0.8723
1ET	0.8562	0.6538
1EU	0.7756	0.5388
1EV	0.7006	0.4117
1EW	0.9515	0.7964
1EX	0.8562	0.7323
1EY	0.7756	0.6652
1EZ	0.7006	0.5992
1FB	0.9502	0.9020
1FC	0.8696	0.6965
1GN	0.9466	0.8723
1GP	0.8525	0.6538
1GQ	0.7701	0.5388
1GR	0.6932	0.4117
1GS	0.9433	0.7964
1GT	0.8525	0.7323
1GU	0.7701	0.6652
1GV	0.6932	0.5992
1HM	0.7617	0.7053
1JF	0.8125	0.7270
1JG	0.8083	0.7270

Plan	Pro Factor	Instl Factor
1JH	0.7361	0.6605
1JJ	0.7311	0.6605
1KC	0.6554	0.5648
1KD	0.8097	0.6983
1KE	0.7311	0.6333
1KG	0.6554	0.5648
1KH	0.8083	0.6983
1KJ	0.7311	0.6333
1KZ	0.8480	0.6965
1LQ	0.9323	0.8723
1LR	0.8312	0.6538
1LS	0.7410	0.5388
1LT	0.6597	0.4117
1LZ	0.8291	0.7323
1MB	0.7419	0.6652
1MC	0.6597	0.5992
1MH	0.9323	0.8723
1MJ	0.8291	0.6538
1MK	0.7410	0.5388
1MW	0.8291	0.7323
1NJ	0.8097	0.6983
1NK	0.7314	0.6333
1PC	0.8102	0.7053
1PQ	0.9490	0.9020
1PR	0.8672	0.6965
1QT	0.8097	0.6983
1QU	0.7314	0.6333
1QV	0.6554	0.5648
1QZ	0.9433	0.8723
1RB	0.8525	0.6538
1RC	0.7692	0.5388
1RD	0.6932	0.7778
1RK	0.8503	0.7323
1RL	0.7701	0.6652
1RM	0.6932	0.5992
1RS	0.9433	0.8723
1RT	0.8503	0.6538
1RU	0.7692	0.5388
1RV	0.6932	0.4117
1SJ	0.9433	0.7964
1SK	0.8503	0.7323
1SL	0.8142	0.6652
1SM	0.6932	0.5992
289	0.8341	0.7824
2ZT	0.6597	0.4117

Plan	Pro Factor	Instl Factor
2ZW	0.6597	0.5992
3AH	0.9414	0.9020
42Q	0.8551	0.7041
4WY	0.7617	0.7053
50B	0.7491	0.6123
50C	0.9485	0.9100
50D	0.9015	0.8931
50E	0.8566	0.8672
52X	0.7670	0.5388
545	0.9368	0.7671
546	0.8382	0.7041
547	0.7472	0.7053
548	0.7517	0.6104
549	0.9481	0.8675
550	0.8561	0.8080
551	0.7703	0.7325
5NW	0.6296	0.5271
5NX	0.6296	0.7184
5NZ	0.6296	0.7487
5PK	0.6296	0.5271
5PL	0.6296	0.7184
5PM	0.6296	0.5271
5TB	0.8984	0.6538
5TC	0.8097	0.5388
5TD	0.7314	0.8052
5TE	0.8984	0.6538
5TF	0.8097	0.5388
5TG	0.7314	0.8052
5TH	0.8984	0.6538
5TJ	0.8097	0.8337
5TK	0.7314	0.8052
5TN	0.7314	0.8052
60G	0.8678	0.9014
60K	0.9366	0.8193
67H	0.7668	0.7041
67S	0.8551	0.7041
67T	0.8461	0.7639
6CL	0.8102	0.6983
6CM	0.8102	0.6983
6CN	0.8102	0.5733
6CP	0.8102	0.5733
6CQ	0.6937	0.8212
6CR	0.6937	0.8212
6CU	0.8102	0.6983
6CV	0.8102	0.6983

Plan	Pro Factor	Instl Factor
6CW	0.8102	0.5733
6CX	0.8102	0.5733
6CY	0.6937	0.8212
6CZ	0.6937	0.8212
76W	0.9149	0.8570
77R	0.9146	0.8570
783	0.6667	0.4117
784	0.8348	0.6538
785	0.7472	0.5388
786	0.9404	0.8723
787	0.6667	0.5992
788	0.8348	0.7323
789	0.7472	0.6652
78B	0.9404	0.7964
78Q	0.8506	0.6965
78R	0.9457	0.9020
7J7	0.9356	0.8723
7J8	0.8312	0.6538
7J9	0.7419	0.5388
7K1	0.6597	0.4117
7K2	0.9323	0.7964
7K3	0.8312	0.7323
7K4	0.7419	0.6652
7K5	0.6597	0.5992
80Y	0.7813	0.7270
80Z	0.7051	0.6605
86Z	0.9404	0.8723
871	0.8348	0.6538
872	0.7472	0.5388
873	0.6667	0.4117
874	0.9404	0.7964
875	0.8348	0.7323
876	0.7472	0.6652
877	0.6667	0.5992
878	0.7668	0.6104
879	0.7871	0.7270
87B	0.7051	0.6605
87C	0.9428	0.9020
87D	0.8506	0.6965
8M8	0.7453	0.7053
92H	0.7453	0.7053
96X	0.8379	0.7671
96Y	0.9368	0.7671
96Z	0.8382	0.7041
971	0.7517	0.6104

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Plan	Pro Factor	Instl Factor
972	0.9368	0.8723
97E	0.9485	0.8675
97F	0.8566	0.8080
97G	0.7703	0.7325
981	0.9309	0.8605
982	0.9309	0.8605
999	0.7453	0.7053
9C5	0.6191	0.5648
9C6	0.7844	0.6983
9C7	0.7003	0.6333
9C9	0.6191	0.5648
9D1	0.7830	0.6983
9D2	0.7003	0.6333
9D7	0.9323	0.8723
9D8	0.8291	0.7323
9F2	0.9414	0.9020
9F4	0.8480	0.6965
9F6	0.8291	0.6538
9G9	0.7928	0.7053
9H7	0.7410	0.5388
9H8	0.6597	0.4117
9H9	0.9323	0.7964
9J1	0.7844	0.6652
9J2	0.6597	0.5992
9J4	0.7003	0.6605
9P5	0.9323	0.8723
9P7	0.7410	0.5388
9Q1	0.8291	0.7323
9Q2	0.7419	0.6652
9Q3	0.6597	0.5992
9T6	0.7003	0.6605
9T7	0.7830	0.7270
AJK	0.9356	0.8755
AJL	0.8312	0.6562
AJM	0.7419	0.5408
AJN	0.6597	0.4132
AJP	0.9323	0.7993
AJQ	0.8312	0.7350
AJR	0.7419	0.6676
AJS	0.6597	0.6014
AJX	0.9359	0.8755
AJY	0.8312	0.6561
AJZ	0.7410	0.5388
AK0	0.6597	0.4117
AK2	0.8291	0.7323
AK3	0.7419	0.6676
AK4	0.6597	0.5992

Plan	Pro Factor	Instl Factor
AK9	0.9404	0.8755
AKB	0.8348	0.6562
AKC	0.7472	0.5408
AKD	0.6667	0.4132
AKE	0.9404	0.7993
AKF	0.8348	0.7350
AKG	0.7472	0.6676
AKH	0.6667	0.6014
AKJ	0.7871	0.7296
AKK	0.7051	0.6629
AKL	0.9323	0.8723
AKM	0.8291	0.6562
AKN	0.7410	0.5388
AKP	0.8291	0.7350
AL0	0.9428	0.9053
AL1	0.8506	0.6990
AL2	0.8480	0.6990
BBZ	0.9546	0.9041
BC0	0.8736	0.6981
BCT	0.9561	0.8743
BCU	0.8603	0.6552
BCV	0.7792	0.5401
BCW	0.7039	0.4127
BCX	0.9561	0.7983
BCY	0.8603	0.7338
BCZ	0.7792	0.6667
BD0	0.7039	0.6004
BD1	0.8138	0.7288
BD2	0.7397	0.6619
BD3	0.6585	0.5663
BD4	0.8138	0.7001
BD5	0.7350	0.6346
BD6	0.6325	0.5281
BD7	0.6325	0.7199
BD8	0.9027	0.6552
BD9	0.8138	0.5401
BDB	0.7350	0.8067
BEF	0.9512	0.8743
BEH	0.8566	0.6552
BEJ	0.7737	0.5401
BEK	0.6965	0.4127
BEL	0.9512	0.7983
BEM	0.8566	0.7338
BEN	0.7737	0.6667
BEP	0.6965	0.6004
BER	0.6585	0.5663
BES	0.8138	0.7001

Plan	Pro Factor	Instl Factor
BET	0.7350	0.6346
BEU	0.6325	0.5281
BEV	0.6325	0.7199
BEW	0.9027	0.6552
BEX	0.8138	0.8357
BEY	0.7350	0.8067
BFM	0.8712	0.6981
BFN	0.9534	0.9041
BGQ	0.8180	0.6667
BGR	0.8138	0.7001
BGS	0.7350	0.6346
BGT	0.9512	0.8743
BGU	0.8566	0.6552
BGV	0.7737	0.5401
BGW	0.6965	0.4127
BGX	0.9512	0.7983
BGY	0.8566	0.7338
BGZ	0.6965	0.6004
BH0	0.9027	0.6552
BH1	0.8138	0.5401
BH2	0.6585	0.5663
BH3	0.8566	0.6552
BH4	0.7737	0.5401
BH5	0.6965	0.7797
BH6	0.8566	0.7338
BH7	0.7737	0.6667
BH9	0.7350	0.8067
BNB	0.6970	0.8227
BNC	0.8140	0.7001
BND	0.8140	0.5745
BNV	0.8140	0.7001
BNW	0.8140	0.5745
BNX	0.6970	0.8227
BNZ	0.8140	0.7001
BPO	0.8140	0.5745
BP1	0.6970	0.8227
BPK	0.8140	0.7001
BPL	0.8140	0.5745
BQR	0.6325	0.7503
C22	0.6970	0.8227
CDD	0.9404	0.8755
CDE	0.8363	0.6561
CDF	0.7467	0.5408
CDG	0.6645	0.4132
CDH	0.9404	0.7992
CDJ	0.8363	0.7350
CDK	0.7467	0.6676

Plan	Pro Factor	Instl Factor
CDL	0.6645	0.6013
CDN	0.7054	0.6629
CDP	0.9404	0.8755
CDQ	0.8363	0.6561
CDR	0.7467	0.5388
CDS	0.8363	0.7350
CDT	0.6645	0.4132
CDU	0.9404	0.7992
CDV	0.7491	0.6676
CDW	0.6645	0.6013
CFD	0.9404	0.8755
CFE	0.8363	0.6561
CFF	0.7467	0.5408
CFG	0.6645	0.4132
CFH	0.9404	0.7992
CFJ	0.7467	0.6676
CFK	0.6645	0.6013
CFM	0.8348	0.6561
CFN	0.7467	0.5408
CFP	0.6645	0.4132
CFR	0.8363	0.7350
CFS	0.7467	0.6676
CFT	0.6633	0.5992
CFW	0.8363	0.7350
E97	0.9521	0.9041
E98	0.8532	0.6981
FAS	0.9521	0.9041
FAU	0.8532	0.6981
FBD	0.9414	0.8755
FBE	0.8379	0.6561
FBF	0.7467	0.5408
FBG	0.6676	0.4132
FBH	0.9418	0.7992
FBI	0.7491	0.6676
FBJ	0.6676	0.6013
FBL	0.8348	0.6561
FBM	0.7467	0.5408
FBN	0.6645	0.4132
FBQ	0.7467	0.6676
FBR	0.6664	0.5992
FBS	0.8379	0.7350
FBT	0.9414	0.8755
FBU	0.8379	0.6561
FBV	0.7491	0.5408
FBW	0.6676	0.4132
FBX	0.9418	0.7992
FBY	0.8379	0.7350

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**Q1 – 2024 BENEFIT PLAN FACTORS**

Plan	Pro Factor	Instl Factor
FBZ	0.7491	0.6676
FC0	0.6676	0.6013
FC2	0.7082	0.6629
FC4	0.8379	0.6561
FC5	0.7491	0.5408
FC6	0.8363	0.7350
FC7	0.6645	0.4132
FC8	0.9404	0.7992
FC9	0.7491	0.6676
FCB	0.6645	0.6013
H94	0.9418	0.8755
H96	0.9418	0.7992
H97	0.8386	0.7066
H98	0.8386	0.7066
H9B	0.8386	0.7350
H9C	0.7503	0.6126
H9D	0.7503	0.6126
H9F	0.7503	0.6676
H9H	0.7082	0.6629
H9J	0.6691	0.4905
H9L	0.6676	0.6013

Plan	Pro Factor	Instl Factor
H9N	0.9521	0.9041
H9P	0.8532	0.7386
HAQ	0.9414	0.8755
HAR	0.9414	0.7992
HAT	0.8379	0.7066
HAV	0.8379	0.7350
HAX	0.7467	0.6126
HAZ	0.7491	0.6676
HB1	0.6676	0.4905
HB3	0.6676	0.6013
HQK	0.9521	0.9041
HQL	0.8532	0.7386
HQX	0.9414	0.8755
HQY	0.9414	0.7992
HQZ	0.8379	0.7066
HR0	0.8379	0.7350
HR1	0.7467	0.6126
HR2	0.7491	0.6676
HR3	0.6676	0.4905
HR4	0.6676	0.6013
HR7	0.9418	0.8755

Plan	Pro Factor	Instl Factor
HR8	0.9418	0.7992
HR9	0.8386	0.7066
HRB	0.8386	0.7350
HRC	0.7503	0.6126
HRD	0.7503	0.6676
HRE	0.7082	0.6629
HRF	0.6691	0.4905
HRG	0.6676	0.6013
JEV	0.938	0.8755
JEW	0.938	0.7992
JEX	0.8355	0.7066
JEY	0.8355	0.735
JEZ	0.7481	0.6126
JF0	0.7481	0.6676
JF1	0.7092	0.6629
JF2	0.6676	0.4905
JF3	0.6676	0.6013
JF4	0.9488	0.9041
JF5	0.8511	0.7386
JFS	0.938	0.8755
JFU	0.8355	0.7066

Plan	Pro Factor	Instl Factor
JFV	0.8355	0.735
JFW	0.7457	0.6126
JFX	0.7481	0.6676
JFY	0.6676	0.4905
JFZ	0.6676	0.6013
KBP	0.9380	0.8755
KBR	0.8355	0.7066
KBS	0.8355	0.7350
KBT	0.7481	0.6126
KBU	0.7481	0.6676
KBW	0.6676	0.4905
KC2	0.7481	0.6676
KCF	0.9488	0.9041
MBA	0.8102	0.8434
QFA	0.9330	0.8269
QGA	0.9834	0.9321
QKA	0.8255	0.8527
QRA	0.9485	0.8822
QSA	0.9015	0.8563

**EXHIBIT A-3**

**DIVISION OF FINANCIAL RESPONSIBILITY  
MATRIX OF HEALTH NET, PPG, AND HOSPITAL CAPITATED SERVICES  
COMMERCIAL HMO AND POINT OF SERVICE BENEFIT PROGRAMS**

The following matrix outlines the Division of Financial Responsibility between Health Net and PPG. The matrix is intended only as a summary guide. The DOFR applies only to Covered Services and does not address any supplement or rider a Beneficiary may have. The applicable Benefit Program shall determine Covered Services. Unless otherwise stated as Out of Area in this matrix, all services are intended as In Area (within the Service Area).

**NOTE TO NEGOTIATOR: THE AIDS CATEGORIES OF SERVICE HAVE BEEN REMOVED FROM THE DOFR. IF YOUR CONTRACT STILL HAS AIDS REINSURANCE, IT MUST BE REMOVED AS WELL.**

<b>CATEGORY OF SERVICE</b>	<b>PPG CAPITATED SERVICES</b>	<b>HEALTH NET RISK SERVICES</b>	<b>IHA AMP HMO/ SHARED RISK/HOSPITAL CAPITATED SERVICES</b>
<b>ALLERGY IMMUNOTHERAPY</b>	X		
<b>ALLERGY TESTING</b>	X		
<b>ALPHA-FETOPROTEIN</b>	X		
<b>AMBULANCE</b> - In Area (30 Mile Radius) - Out of Area			X X
<b>ANESTHESIOLOGY</b>	X		
<b>BIOFEEDBACK</b>	X		
<b>BLOOD / BLOOD PRODUCTS</b> - Blood Bank - Hemophilia related Blood Factors - Storage and Collection of Blood - Transfusion Autologous/Homologous			X X X X
<b>CHEMICAL DEPENDENCY DETOX</b> - Inpatient Detox Facility Component - Inpatient Detox Professional Component	X		X
<b>CHEMICAL DEPENDENCY REHAB</b> - Inpatient Facility Component - Inpatient Professional Component - Outpatient Facility Component - Outpatient Professional Component		X X X X	
<b>CHEMOTHERAPY</b> - Drugs, including Epogen, Neupogen and adjunctive therapies - Outpatient - Facility Component - Inpatient including Drugs - Facility Component - Outpatient - Professional Component	X  X		X X
<b>CHIROPRACTIC</b>	X		

<b>CATEGORY OF SERVICE</b>	<b>PPG CAPITATED SERVICES</b>	<b>HEALTH NET RISK SERVICES</b>	<b>IHA AMP HMO/ SHARED RISK/HOSPITAL CAPITATED SERVICES</b>
<b>CLINIC VISITS</b> Non-urgent, Outpatient, Facility & Professional (includes Telehealth)	X		
<b>COLOSTOMY SUPPLIES</b>			X
<b>CONSULTATIONS</b>	X		
<b>COSMETIC SURGERY (Medically Necessary)</b> - Facility Component - Professional Component	X		X
<b>CRITICAL CARE VISITS</b>	X		
<b>DENTAL SERVICES</b> - Facility Component - Professional Component	X		X
<b>DIAGNOSTIC TESTING – Outpatient Facility or Home</b> - Facility Component - Professional Component	X X		
<b>DURABLE MEDICAL EQUIPMENT</b> - Outpatient (includes home) - Surgically Implanted			X X
<b>EMERGENCY ROOM ADMISSIONS – In-Area</b> - Facility Component - Professional Component	X		X
<b>EMERGENCY ROOM ADMISSIONS – Out of Area</b> - Facility Component - Professional Component			X X
<b>EMERGENCY ROOM VISITS – In Area</b> - Facility Component - Professional Component	X		X
<b>EMERGENCY ROOM VISITS – Out-of-Area</b> - Facility Component - Professional Component			X X
<b>EXTENDED CARE/SKILLED NURSING FACILITY</b> - Facility Component - Professional Component	X		X
<b>GROWTH HORMONES</b>			X
<b>HEARING AIDS</b>	X		
<b>HEMODIALYSIS</b> - Facility Component includes ESRD related drugs, supplies, and laboratory - Professional Component	X		X
<b>HOME HEALTH</b>			X
<b>HOME VISITS</b>	X		

CATEGORY OF SERVICE	PPG CAPITATED SERVICES	HEALTH NET RISK SERVICES	IHA AMP HMO/ SHARED RISK/HOSPITAL CAPITATED SERVICES
<b>HOSPICE</b> - Facility Component - Professional Component	X		X
<b>HOSPITAL BASED PHYSICIANS</b> - Inpatient, Ambulatory Surgery or Emergency Room Admissions - Professional Component - Technical Component	X		X
<b>HYPERBARIC OXYGEN THERAPY, OUTPATIENT</b> - Facility Component			X
<b>HYPERBARIC OXYGEN THERAPY, OUTPATIENT</b> - Professional Component	X		
<b>IMMUNIZATIONS</b> , Pediatric – COVID-19	X		
<b>IMMUNIZATIONS</b> , Pediatric not subject to H&S Code 1367.36 (1)	X		
<b>IMMUNIZATIONS</b> , Pediatric subject to H&S Code 1367.36 unless PPG has accepted risk as shown below		X	
<b>IMMUNIZATIONS</b> , Pediatric - Meningococcal vaccine - 1 <sup>st</sup> and 2 <sup>nd</sup> Doses (e.g., Menactra®, Menveo®, Bexsero®)	X		
<b>IMMUNIZATIONS</b> , Pediatric – Tdap (e.g., Boostrix® Adacel®)	X		
<b>IMMUNIZATIONS</b> , Pediatric - Rotavirus vaccine (e.g., Rota Teq® and Rotarix®)		X	
<b>IMMUNIZATIONS</b> , Pediatric - Human Papilloma Virus Vaccine (e.g., Gardasil®, Cervarix®)		X	
<b>IMMUNIZATIONS</b> , Pediatric - Varicella Virus -1st & 2nd Doses (e.g., Varivax ®)	X		
<b>IMMUNIZATIONS</b> , Pediatric – Influenza Vaccines Ages 5 – 17	X		
<b>IMMUNIZATIONS</b> , Adult	X		
<b>IMMUNIZATIONS</b> , Adult – COVID-19	X		
<b>IMMUNIZATIONS</b> , Adult – Human Papilloma Virus Vaccine (e.g., Gardasil®, Cervarix®)	X		
<b>INFANT APNEA MONITOR</b>			X
<b>INFERTILITY TREATMENTS</b> <b>IVF, GIFT, ZIFT &amp; AI</b> - Facility Component - Professional Component	X		X

<b>CATEGORY OF SERVICE</b>	<b>PPG CAPITATED SERVICES</b>	<b>HEALTH NET RISK SERVICES</b>	<b>IHA AMP HMO/ SHARED RISK/HOSPITAL CAPITATED SERVICES</b>
<b>INFUSION THERAPY ADMINISTRATION,</b> Outpatient Facility, excluding drugs			X
<b>INHALATION DRUGS,</b> Office or Clinic	X		
<b>INJECTABLES, SELF ADMINISTERED</b>	X		
<b>INPATIENT VISITS, Professional</b>	X		
<b>LITHOTRIPSY</b> - Facility Component - Professional Component	X		X
<b>MATERNITY – Deliveries and Non-Deliveries</b> - Facility Component - Professional Component	X		X
<b>MEDICAL ADMISSIONS In Area and Non-Emergency Out of Area</b> - Facility Component - Professional Component	X		X
<b>MENTAL HEALTH – Inpatient</b> - Facility Component - Professional Component		X X	
<b>MENTAL HEALTH – Outpatient</b> - Facility Component - Professional Component		X X	
<b>OBSERVATION CARE, DIRECT ADMISSION – Outpatient Facility (2)</b> - Facility Component - Professional Component	X		X
<b>OFFICE VISITS (includes Telehealth)</b>	X		
<b>OUTPATIENT FACILITY SERVICES / TECHNICAL COMPONENT</b> Not listed elsewhere on DOFR			X
<b>PATHOLOGY – Inpatient, Ambulatory Surgery or Emergency Room</b> - Professional Component - Technical Component	X		X
<b>PATHOLOGY &amp; LABORATORY SERVICES</b> - Mobile (including in the home)	X		
<b>PATHOLOGY &amp; LABORATORY SERVICES</b> - Office	X		
<b>PATHOLOGY &amp; LABORATORY SERVICES, Outpatient (Includes Pre-Admission Tests within 72 hrs. of related admission)</b> - Professional Component - Technical Component	X X		

<b>CATEGORY OF SERVICE</b>	<b>PPG CAPITATED SERVICES</b>	<b>HEALTH NET RISK SERVICES</b>	<b>IHA AMP HMO/ SHARED RISK/HOSPITAL CAPITATED SERVICES</b>
<b>PATHOLOGY &amp; LABORATORY SERVICES,</b> Outpatient, Office, Mobile, Home (COVID-19 testing, including specimen collection) ** - Professional Component - Technical Component	X X		
<b>PATIENT EDUCATION</b>	X		
<b>PERIODIC EXAMS</b>	X		
<b>PROFESSIONAL SERVICE / TECHNICAL &amp; PROFESSIONAL COMPONENT</b> Not listed elsewhere on DOFR	X		
<b>PROSTHETIC/ORTHOTIC DEVICES</b> - Outpatient Dispensed (including Home) - Surgically Implanted			X X
<b>RADIATION THERAPY -OUTPATIENT/ OFFICE</b> - Technical Component	X		
<b>RADIATION THERAPY</b> - Professional Component	X		
<b>RADIOLOGY – Inpatient, Ambulatory Surgery or Emergency Room</b> - Professional Component - Technical Component	X		X
<b>RADIOLOGY-Mobile (including in the home)</b>	X		
<b>RADIOLOGY – Office</b>	X		
<b>RADIOLOGY – Outpatient (Includes Pre-Admission Tests within 72 hrs. of related admission)</b> - Professional Component - Technical Component	X X		
<b>SPEECH AND HEARING EXAMS</b>	X		
<b>SUPPLIES- Medical, Surgical</b> - Related to a Hospital Stay - Related to Outpatient, Office & Home	X		X
<b>SUPPLIES, DIABETIC</b> - Chem. Strips, Lancet, Needles, Syringes - Glucometer			X X
<b>SURGERY – Inpatient</b> - Facility Component - Professional Component	X		X
<b>SURGERY – Office</b>	X		
<b>SURGERY – Outpatient</b> - Facility Component - Professional Component	X		X

CATEGORY OF SERVICE	PPG CAPITATED SERVICES	HEALTH NET RISK SERVICES	IHA AMP HMO/ SHARED RISK/HOSPITAL CAPITATED SERVICES
<b>THERAPEUTIC INJECTABLE AND IMPLANTABLE MEDICATION</b> - Equal or less than \$250.00 cost per dose - More than \$250.00 cost per dose	X X		
<b>THERAPY/REHABILITATION:</b> includes Physical, Occupational, Respiratory, Speech, and Cardiac Rehab - Inpatient - Outpatient/Office	X		X
<b>TRANSGENDER, INJECTABLE, AND IMPLANTABLE MEDICATION</b> - Hormones (Pre & Post Op)		X	
<b>TRANSGENDER SERVICES</b> - Non-Medical Cosmetic Procedures - Pre-Op MD Consults - Psychiatric Pre-Op Evaluation - Voice Therapy, Professional		X X X X	
<b>TRANSGENDER SURGERY</b> – Complete and Partial InterSex Reassignment Procedures - Facility Component Inpatient & Outpatient (includes preadmission testing at the same facility within 72 hours of admission) - Professional Component		X X	
<b>TRANSPLANTS</b> (Non-experimental) - Drugs (Immunosuppressive, stem cell mobilizers, G-CSF) - Facility Component - Organ Procurement - Professional Component		X X X X	
<b>TRANSPLANT EVALUATIONS</b> - Facility Component - Professional Component		X X	
<b>URGENT CARE VISITS</b> – In-Area	X		
<b>URGENT CARE VISITS</b> – Out-of-Area			X
<b>VISION CARE</b> - Exams and Medically Necessary Care - Implanted Intraocular Lenses - Lenses and Frames (Non-Cataract)	X	X	X

(1) Except where a pediatric immunization which is not subject to H & S 1367.36 is otherwise specifically described elsewhere in the DOFR.

(2) Observation Care shall be consistent with CMS guidelines related to payment for hospital Outpatient Prospective Payment for Direct to Observation admissions and InterQual criteria. Observation Care is a well-defined set of specific, clinically appropriate

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services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation Services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. When direct admission to Observation is ordered for patients who do not present through the emergency department the same purpose is applied that the member require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. The Observation Services of short-term treatment, assessment and reassessment in an outpatient facility unit must be reasonable and necessary and meet the minimum severity and purpose described under CMS guidelines to be covered. All direct to observation admissions must have PPG authorization and on-going care management. Any service such as laboratory, radiology or diagnostic testing that can safely be performed in an outpatient facility or office, in absence of the observation component, are excluded from the observation category under this Agreement. Any direct to observation admissions that do not meet CMS guidelines will be classified under the DOFR as the applicable DOFR category within the PPG's PPA, e.g., diagnostic testing, lab or radiology and have the corresponding financial risk owner. The decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient should usually be made in less than 24 hours. For any direct to observation admission greater than 24 hours, PPG must notify Health Net consistent with the notification requirements for an inpatient admission. For the purposes of the DOFR, Observation Care, Direct Admission, Outpatient Facility does not include the care performed within an emergency area or emergency related holding unit or post-operative care and should not be used for services that should be performed in an inpatient setting.

**NOTE TO NEGOTIATOR – PLEASE ENSURE THAT RADIOLOGY AND PATHOLOGY HAVE THE SAME RISK.**

**\*\* NOTE TO NEGOTIATOR – FOR PATHOLOGY/LABORATORY SERVICES COVID-19, DO NOT AGREE TO FURTHER DEFINE COVID TESTING TO PCR/DIAGNOSTIC VS ANTIBODY, IT SHOULD BE ALL COVID-19 TESTING.**

**\*\* NOTE TO NEGOTIATOR – FOR PATHOLOGY/LABORATORY SERVICES COVID-19, RISK SHOULD NOT SHIFT TO HN, X's WILL REMAIN IN THE PPG COLUMN.**

## EXHIBIT A-4

### **COMMERCIAL BENEFIT PROGRAMS PPG FEE-FOR-SERVICE PROGRAM PROVISIONS**

**I. Applicability.** This Addendum and accompanying exhibits apply to Covered Services delivered to Beneficiaries covered by commercial Benefit Programs that include but are not limited, to HMO, PPO, EPO, POS, Medicare COB and any leased networks. All Covered Services delivered to a Beneficiary covered by a commercial Benefit Program shall be paid in accordance with this Addendum regardless of product specific name unless otherwise specifically agreed by the parties and set forth in a separate rate exhibit.

**II. Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Point of Service (POS), Leased PPO Benefit Programs, and Payor Disclosures.** PPG understands and agrees that Health Net may sell, lease, transfer or convey a list, including PPG, to Payors.

Payors shall actively encourage subscribers to use the list of contracted providers when obtaining medical care. Active encouragement includes offering subscribers direct financial incentives to use the list of contracted providers when obtaining medical care (such as reduced Copayments, Coinsurance and Deductibles), or providing or causing the provision of information to subscribers advising such subscribers of the existence of a list of contracted providers through a variety of advertising or marketing approaches that supply the names, addresses and telephone numbers of contracted providers to subscribers in advance of their selection of a health care provider. Nothing in this Addendum shall be construed to require a Payor to actively encourage such Payor's subscribers to use the list of contracted PPGs, including PPG, when obtaining medical care in the event of an Emergency.

Health Net shall not permit Payors to access this Agreement and pay PPG's contracted rate for the Benefit Programs covered by this Addendum unless Payor, or Health Net on Payor's behalf, has actively encouraged Payor's subscribers to use the list of contracted providers in obtaining medical care.

PPG agrees that the following commercial Benefit Program Payors are eligible to pay PPG's contracted rate under this Addendum as of the Effective Date of this Agreement:

#### **NO PAYORS**

Health Net may modify the above list periodically. PPG may request in writing, and Health Net shall have thirty (30) days from the date of such request, to provide PPG with an updated listing of Payors.

PPG understands and agrees that any Health Net subsidiary or affiliate, including, but not limited to, Health Net Life Insurance Company, are not Payors under this Addendum A but shall access this Agreement as Health Net.

**III. Compensation.** PPG and Professional Providers shall render Covered Services for which Capitation is not paid under this Addendum and for which PPG has no financial responsibility under the DOFR. Health Net shall compensate such services on a FFS basis at the rates set forth in Exhibit A-5, subject to the payment conditions set forth in Addendum E. PPG and Professional Providers shall submit claims for such services in accordance with the terms of this Agreement and applicable State and federal law. Notwithstanding any other provision in this Agreement, the parties acknowledge that each Payor is solely responsible for paying PPG for Covered Services rendered to those individuals for whom Payor provides health care coverage. For self-insured Payors, Health Net shall not be obligated to pay all or any portion of any PPG claim on a Payor's behalf unless and

until Health Net has received sufficient funds from the applicable Payor to cover such claim. In the event such Payor fails to provide funds to Health Net, PPG may seek payment from Member up to the rates specified in Exhibit A-5, unless prohibited by applicable law.

**EXHIBIT A-5**

**COMMERCIAL BENEFIT PROGRAMS  
PPG FEE-FOR-SERVICE RATE EXHIBIT**

Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Addendum E, Health Net or Payor shall pay and PPG or Professional Provider shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered under commercial Benefit Programs pursuant to this Addendum, the lesser of: (i) the rates listed below, or (ii) 65% - 100% of PPG's Allowable Charges.

<b>Category of Service</b>	<b>Compensation</b>
Covered Services delivered or arranged by PPG, excluding Laboratory services	___ % of CMS Allowable
Anesthesia Services when provided by an Anesthesiologist or Certified Registered Nurse Anesthetist (American Society of Anesthesiology (ASA) unit scale)	\$ ___ / ASA unit
Medical/Surgical Services by an Anesthesiologist or Certified Registered Nurse Anesthetist	___ % of CMS Allowable
Laboratory Services performed in PPG or Professional Provider office	___ % of CMS Allowable
Pharmaceuticals	
- With an established Medicare Value	the lesser of 100% of PPG's Allowable Charges or XXX% of Medicare allowable
- Without an established Medicare Value	the lesser of 100% of PPG's Allowable Charges or X% of AWP
OB Services	NTN: Choose One Option
	___ % of CMS Allowable
	or
- CPT 59400: Global Obstetric care with vaginal delivery	\$0000.00/
- CPT 59510: Global Obstetric care with cesarean delivery	\$0000.00/
- CPT 59610: Vaginal Delivery after previous cesarean delivery	\$0000.00/
- CPT 59618: Attempted vaginal delivery, resulting in cesarean	\$0000.00/
Immunizations	
- With an established Medicare Value	the lesser of 100% of PPG's Allowable Charges or XXX% of Medicare allowable

<p>- Without an established Medicare Value</p>	<p>the lesser of 100% of PPG's Allowable Charges or X% of AWP</p>
<p>By Report (BR) Covered Services, Covered Services not listed and Covered Services with relativities not established.</p>	<p>65-100 % of Allowable Charges for Covered Services</p>

## **ADDENDUM B**

### **MEDICARE ADVANTAGE BENEFIT PROGRAMS**

This Addendum B applies to Medicare Advantage Benefit Programs. All Covered Services delivered to Beneficiaries covered by Medicare Advantage Benefit Programs shall be paid in accordance with this Addendum regardless of product specific name unless otherwise specifically agreed by the parties and set forth in a separate rate exhibit.

This Addendum includes each of the following with respect to the Medicare Advantage Benefit Programs: (i) Exhibit B-1, which covers Medicare Advantage Benefit Program capitation provisions for Capitated Services rendered under this Addendum; (ii) Exhibit B-2, outlines the Division of Financial Responsibility (DOFR); (iii) Exhibit B-3, which is the FFS rate exhibit for non-capitated Covered Services rendered under this Addendum; (iv) Exhibit B-4, Medicare Advantage Compensation for Quality.

The Capitation provisions set forth herein shall be applicable to only those Beneficiaries listed on the applicable Capitation eligibility roster lists provided to PPG under the terms of this Agreement.

## **EXHIBIT B-1**

### **MEDICARE ADVANTAGE BENEFIT PROGRAM PROVISIONS**

#### **I. DEFINITIONS**

For purposes of this Addendum B only, the following additional definitions included herein shall have the meaning required by law applicable to Medicare Advantage HMO Benefit Programs.

**1.1. Delegation.** Delegation to a PPG of a certain contractual obligation of Health Net under Health Net's contract with CMS.

**1.2. Contract Period.** The term of the contract between Health Net and CMS.

**1.3. Centers for Medicare & Medicaid Services (CMS).** The Centers for Medicare and Medicaid Services which is the agency of the federal government responsible for administration of the Medicare Advantage Benefit program.

**1.4. Medicare Advantage (MA).** The statutory name applicable to the federal program of prepaid health care services for Medicare Beneficiaries established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

**1.5. MA Benefit Program.** A Health Net Medicare Advantage Benefit Program that provides coverage for certain health care services.

**1.6. MAPD Benefit Program.** An MA Benefit Program that includes Medicare Part D prescription drug coverage.

**1.7. Medicare Advantage (MA) Beneficiary or Member.** A Beneficiary who has elected to enroll in and receive coverage through a Health Net MA or MAPD Benefit Program, under the terms and conditions of the Benefit Program's MA or MAPD Evidence of Coverage, and whose enrollment has been confirmed by the Centers for Medicare and Medicaid Services ("CMS"), an agency of the U.S. Department of Health and Human Services ("HHS") that administers the Medicare Advantage Program.

**1.8. MA/MAPD Evidence of Coverage.** A legally binding statement of coverage, revised annually, between a Medicare Member and Health Net under which a Medicare Member is entitled to receive coverage for certain hospital, medical and other associated health care services.

**1.9. Medicare Enrollment Area.** The area approved by CMS and the State regulatory agency as the area in which Health Net may market and enroll Medicare HMO Beneficiaries. At any given time during the term of the Agreement, the Medicare Enrollment Area consists of the list of zip codes currently approved by CMS and/or the State regulatory agency as the Medicare Enrollment Area. (This is not the area for which PPG shall be responsible for "in-area" services.)

**1.10. Medicare HMO Beneficiary.** A Beneficiary who has enrolled in or elected coverage in a Health Net Medicare HMO Benefit Program.

**1.11. Monthly Membership Report (MMR).** The CMS Membership Monthly Report. CMS Monthly Membership report field numbers may change should CMS modify the MMR format.

**1.12. Net Monthly CMS Payment.** The monthly payment received by Health Net from CMS (Field 65 of the MMR) for delivering Part A and Part B Medicare services, minus /excluding rebates for other Supplementary Benefits (Fields 57 and 58 of the MMR), minus/excluding Rebate D Supplementary Benefits (Fields 61 and 62 of the MMR) as determined by CMS. CMS fields as listed above from the Membership Monthly Report (MMR) are subject to change and would follow the successor equivalent field.

Net Monthly CMS payment can be reduced for the actual financial cost to Health Net for any excise or premium tax, fee, or cost imposed by any Governmental Authority, including Sequestration, on Health Net and excludes the following:

- All rebate amounts allocated for Mandatory Supplemental Benefits,
- All Part D CMS premium and subsidy payments, and
- All rebate amounts allocated to Part D supplemental benefits

\*CMS Monthly Membership Report field numbers may change should CMS modify the MMR format.

**1.13. In-Network Services.** Covered Services provided or arranged for through a Beneficiary's selected or assigned PCP or Provider.

**1.14. Medicare Regulations.** PPG shall assume the financial responsibility for any failure to comply with Medicare Regulations, including, but not limited to, failure to provide records when requested and failure to provide or document Notice(s) of Non-Coverage to Beneficiaries.

**1.15. Withhold Fund.** A fund established by Health Net by withholding from PPG's monthly capitation an amount deemed necessary by Health Net to cover the cost of any Covered Services rendered to a Beneficiary by a referral specialist or emergency physician and may include amounts required to service any debt or deficits owed to Health Net by PPG. The amount of the monthly withhold shall be adjusted based upon Health Net's quarterly review of the actual referral experience of PPG. The withhold shall be administered by Health Net.

## II. MEDICARE HMO BENEFIT PROGRAMS PROFESSIONAL CAPITATION RATES

**2.1. HMO Benefit Program.** The Medicare HMO Benefit Program shall apply to Medicare HMO Beneficiaries; any PMPM or any percent of Net Monthly CMS Payment calculation under Addendum B shall be based on Medicare HMO Beneficiaries.

### OPTION I: Applicable to Shared Risk Program Only

*Note to Negotiator: If Provider does not accept risk for Epogen, Neupogen and Facility component under Hemodialysis and Health Net does not give them a higher percentage for monthly capitation revenue, then these DOFR items must be adjusted accordingly and moved to Shared Risk Services.*

**2.2. Capitation: Capitated Services.** As compensation for rendering Capitated Services as defined herein, Health Net shall pay PPG as set forth below for each Medicare HMO Beneficiary eligible to receive such services from PPG during any particular month.

**A. Specified End Stage Renal Disease (ESRD) Medicare HMO Beneficiaries:**

\_\_\_\_\_ percent (\_\_\_\_%) of Net Monthly CMS Payment applies to Medicare HMO Beneficiaries identified on the CMS published Monthly Medicare Report (MMR) with an ESRD indicator

of “Yes” and risk adjustment factor type codes D, ED and/or default risk factor code “2” as defined below. Should CMS change such coding, the replacement codes would apply here as well.

- i. D = Dialysis (ESRD)
- ii. ED = New Enrollee Dialysis (ESRD)
- iii. 2 = Default Enrollee—ESRD Dialysis

**B. All other Medicare HMO Beneficiaries not identified in Section A above:**  
\_\_\_\_\_ percent ( \_\_\_\_\_ %) of Net Monthly CMS Payment

Capitation shall be computed on the basis of the most current information available and shall be paid by Health Net by wire transfer on or before the fifteenth (15<sup>th</sup>) day of each month or the first business day following the fifteenth (15<sup>th</sup>) if the fifteenth (15<sup>th</sup>) is a holiday or on a weekend or within two (2) days of CMS’s payment to Health Net, whichever is later. Each Capitation payment shall be accompanied by a remittance summary. The remittance summary identifies the total Capitation payable and those Medicare HMO Beneficiaries for whom Capitation is being paid. In the event of a Capitation error, resulting in an overpayment or underpayment to PPG, Health Net shall adjust subsequent Capitation to offset such error.

**OPTION II: APPLICABLE TO DUAL RISK PROGRAM ONLY**

**(Option I can be used in a Dual Risk arrangement only with Finance approval.)**

***Note to Negotiator: Please remember to move Hemodialysis Epogen and Neupogen and Facility components to Hospital Capitated Services for the Dual Risk Program.***

**2.2. Capitation: Capitated Services.** As compensation for rendering Capitated Services as defined herein, Health Net shall pay PPG Capitation at \_\_\_\_\_ percent ( \_\_\_\_\_ %) of Net Monthly CMS Payment for each Medicare HMO Beneficiary eligible to receive such services from PPG during any particular month. Capitation shall be computed on the basis of the most current information available and shall be paid by Health Net by wire transfer on or before the fifteenth (15<sup>th</sup>) day of each month or the first business day following the fifteenth (15<sup>th</sup>) if the fifteenth (15<sup>th</sup>) is a holiday or on a weekend or within two (2) days of CMS’s payment to Health Net, whichever is later. Each Capitation payment shall be accompanied by a remittance summary. The remittance summary identifies the total Capitation payable and those Medicare HMO Beneficiaries for whom Capitation is being paid. In the event of a Capitation error, resulting in an overpayment or underpayment to PPG, Health Net shall adjust subsequent Capitation to offset such error.

- ***Negotiator Note: Only applicable to add the language below for capped MA deals to ensure HN shares in vendor costs that work to enhance how much revenue comes in, which also benefits PPGs..***

**2.3. Risk Adjustment Costs.** Should CMS Risk Adjustment activity retroactively increase or decrease payments, including Risk Adjustment Data Validation (RADV), or should CMS adjust Health Net’s monthly payments based upon changes in eligibility, Capitation payments to PPG shall be retroactively adjusted on a proportional basis. Any vendor or third-party fees resulting from premium enhancing activities will be charged back to PPG by deducting these costs from the PPG’s Capitation payment upon disbursement of the Risk Adjustment Score final run. If PPG disagrees with the adjustment, PPG may contest in writing to Health Net in accordance with Health Net’s policies and procedures within 30 days of the notice of adjustment. The parties will then meet and confer pursuant to Section 7.5 of the Agreement to resolve the dispute. Failure by PPG to formally contest the adjustment within 30 days shall be deemed acceptance by PPG of the adjustment.

### III. PROFESSIONAL STOP LOSS PROGRAM

#### SELECT OPTION ONE OR OPTION TWO

**OPTION ONE:** PPG elects not to participate in the Professional Stop Loss Program. PPG shall provide Health Net with proof of Professional Stop Loss coverage.

**OPTION TWO:** PPG's Professional Stop Loss threshold shall be \$ [REDACTED] per Medicare HMO Beneficiary during the calendar year. The cost to PPG for the Professional Stop Loss Program shall be [REDACTED] percent ([REDACTED]%) of the applicable Medicare HMO Beneficiary's CMS payment and county premium, if any, which shall be deducted from PPG's Capitation. PPG shall report potential stop loss claims and receive payment for such claims in accordance with procedures set forth in the Health Net Policies.

### IV. SHARED (DUAL) RISK PROGRAM

#### NOTE TO NEGOTIATOR:

#### CHOOSE ONE:

(1) If PPG has SHARED RISK arrangements with Health Net, then use SHARED RISK introductory paragraph and remainder of Section IV. Title Section IV SHARED RISK PROGRAM.

#### SHARED RISK introductory paragraph

PPG shall participate in an incentive program for Shared Risk Services that shall reward PPG for coordinating such care. Under this program, a budget shall be established for Shared Risk Services, and the actual cost of such services shall be compared to the budget.

(2) If PPG has DUAL RISK arrangements with Health Net, then use DUAL RISK introductory paragraph and delete remainder of Section IV; Title Section IV DUAL RISK PROGRAM.

#### DUAL RISK introductory paragraph.

PPG shall establish a Hospital Capitated Services incentive arrangement with the Primary Hospital which is (name, address). Hospital Capitated Services for Medicare HMO Beneficiaries who have selected PPG are the financial responsibility of the Primary Hospital. PPG shall provide Health Net with a written description of such incentive arrangement and any changes thereto within sixty (60) days of its establishment, or any amendment. Except in the case of an Emergency, all such services must be authorized by PPG and be provided or coordinated through the Primary Hospital.

**4.1 Shared Risk Budget.** Each month, Health Net shall fund the Shared Risk Budget for each eligible Medicare HMO Beneficiary assigned to PPG at [REDACTED] percent ([REDACTED]%) of Net Monthly CMS Payment.

**4.2 Shared Risk Administration.** The Shared Risk Budget calculations shall be based only on applicable Net Monthly CMS Payment and any adjustments to Monthly Review applicable to the Reconciliation Period that is received by Health Net no later than March 31<sup>st</sup> of the year following the Reconciliation Period.

Each Reconciliation Period, Health Net shall calculate Shared Risk Claims in accordance with the Health Net Policies and compare such claims to the corresponding Shared Risk Budget.

Health Net shall perform both an interim and final settlement. In the event any amounts remain in the Withhold Fund following the reconciliation of any shared risk program, those excess funds shall be paid to PPG by April 30 of the following year. In the event that such claims are less than the Shared Risk Budget for the Interim Period, PPG's share of the settlement shall be **fifty percent (50%)**, subject to the terms of this Agreement. Shared Risk Claims with dates of service within the Reconciliation Period and paid by March 31st of the following year shall be used in the calculation. Shared Risk Services incurred within the Reconciliation Period but paid after March 31 of the following year will be included in the next Reconciliation Period calculation.

**4.3 Withhold Fund and Determination of Maximum Downside Shared Risk Deficits.** As a contingency for any PPG liability under the Shared Risk Program, Health Net shall deduct  percent (%) of PPG's Capitation and place such amount in the Withhold Fund as described in the Agreement.

**4.4 Shared Risk Budget Surplus.** In the event of a Shared Risk Budget surplus, PPG's share of the surplus shall be limited to the lesser of (i) **fifty percent (50%)** of the Shared Risk Budget surplus, or (ii) an amount not to exceed **twenty percent (20%)** of the annual gross PPG Capitation.

**4.5 Shared Risk Budget Deficit.** In the event of a Shared Risk Budget deficit, PPG's share of the deficit shall be limited to the lesser of (i) **fifty percent (50%)** of the Shared Risk Budget deficit, or (ii) an amount not to exceed **twenty percent (20%)** of the annual gross PPG Capitation. Subject to the terms of this Agreement, any amounts payable by PPG shall be offset against the Withhold Fund and any other amounts payable by Health Net.

In the event a deficit remains in the Shared Risk Program after such offset, such deficit shall be carried forward to be applied against future years Shared Risk Program surpluses and withhold funds.

## V. PAYMENT FOR NON-CAPITATED COVERED SERVICES

**5.1.** PPG and Professional Providers shall render Covered Services for which Capitation is not paid under this Addendum and for which PPG has no financial responsibility under the DOFR. Health Net shall compensate such services on a FFS basis at the rates set forth in Exhibit B-3, and subject to the applicable payment conditions set forth in Addendum E. PPG and Professional Providers shall submit claims for such services in accordance with the terms of this Agreement and applicable State and federal law.

**5.2.** Health Net and PPG agree to: (i) Process contracted PPG claims received at Health Net within 60 calendar days of receipt, and (ii) Process non-contracted provider clean claims received by PPG within 30 calendar days and 60 calendar days for all other claims.

## VI. REGULATORY OBLIGATIONS

**NOTE TO NEGOTIATOR: ALL LANGUAGE UNDER THE REGULATORY OBLIGATIONS SECTION IS NON-NEGOTIABLE AND MUST REMAIN IN THE CONTRACT OR AMENDMENT AS IS.**

**6.1.** Health Net and PPG agree, and PPG shall require its subcontractors to agree to the following:

(a) HHS, CMS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems, including medical records and documentation of PPG and any PPG subcontractor, involving transactions related to CMS' contract with Health Net through ten (10) years from the final CALIFORNIA

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date of the final Contract Period of the contract entered into between CMS and Health Net or from the date of completion of any audit, whichever is later. This right can be exercised directly with any first tier, downstream, or related entity. For records subject to review under this provision, except in exceptional circumstances, CMS will provide notification to Health Net that a direct request for information has been initiated. [\*See 42 CFR §§422.504(i)(2)(i-iv); Ch. 11. §100.4, Medicare Managed Care Manual, “MMCM”]

**(b)** Cooperate in, assist in, and provide information as requested for audits, evaluations and inspections performed under Section 6.1(a) above. [\*See Ch. 11. §100.4, MMCM]

**(c)** Safeguard each MA Beneficiary’s privacy and comply with the confidentiality and MA Beneficiary record accuracy requirements, including: 1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records , or other health and enrollment information, 2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by MA Beneficiaries to the records and information that pertain to them. [\*See 42 CFR §422.504(a)(13); 42 CFR §422.118; Ch. 11. §100.4, MMCM].

**(d)** Contracts or other written agreements between PPG and PPG subcontractors must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. [\*See 42 CFR §422.520(b)(1); Ch. 11, §100.4, MMCM].

**(e)** Hold each MA Beneficiary harmless for payment of any fees that are the legal obligation of Health Net in the event of, but not limited to, insolvency of, breach by or billing of PPG by Health Net. [\*See 42 CFR §§422.504(g)(1)(i) and (i)(3)(i); Ch. 11 §100.4 MMCM].

**(f)** Comply with all applicable Medicare laws, regulations, reporting requirements and CMS instructions. [\*See 42 CFR §422.504(i)(4)(v)]

**(g)** Perform each service or other activity under this Agreement in a manner consistent and in compliance with Health Net’s contractual obligations to CMS. [\*See 42 CFR §422.504(i)(3)(iii)]

**(h)** Maintain all records relating to this contract for a minimum of ten (10) years from the final date of the Contract Period or the date of the completion of any audit, whichever is later. [\*See Ch. 11. §110.4.3, MMCM]

**(i)** Health Net oversees and is ultimately responsible to CMS for any functions and responsibilities described in the Medicare Advantage regulations. PPG understands that this accountability provision also applies to this Addendum. [\*See 42 CFR §422.504 (i)(4)(iii); Ch.11 §100.4 MMCM].

**(j)** Comply with Health Net Policies. [\*See Ch. 11. §100.4, MMCM]

**(k)** For all MA Beneficiaries eligible for both Medicare and Medicaid (includes Medi-Cal), such MA Beneficiaries will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. PPG will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. PPG and PPG subcontractors may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. PPG will: (1) accept Health Net payment as payment in full, or (2) bill the appropriate State source. [\*See 42 CFR §§422.504(g)(1)(i) and (iii); 42 C.F.R. §422.504(i)(3)(i)]

## **6.2. PPG and Health Net agree:**

(a) Health Net is obligated to pay PPG promptly under the terms of the Agreement between Health Net and the PPG, as well as in accordance with Health Net Policies and Section 5 of this Addendum. [\*See 42 CFR §§422.520(b)(1) and (2); Ch. 11. §100.4, MMCM]

**6.3. PPG and its subcontractors further agree to the following:**

- (a) To direct access to mammography screening and influenza vaccinations.
- (b) To direct access to in-network women's health specialist for women for routine and preventative services.
- (c) To have approved procedures to identify, assess and establish a treatment plan for Beneficiaries with complex or serious medical conditions.
- (d) To provide access to benefits in a manner described by CMS.
- (e) To protect Beneficiaries who are hospitalized from loss of benefits through the period of time CMS premiums are paid.
- (f) To work with Health Net in conducting a health assessment of all new Beneficiaries within ninety (90) days of the effective date of enrollment.
- (g) That PPG must notify any Professional Provider being terminated, in writing, of the reason(s) for denial, suspension or termination determinations.
- (h) To not employ or contract with individuals excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act.
- (i) To adhere to Medicare's appeals, expedited appeals and expedited review procedures for Medicare HMO Beneficiaries, including gathering and forwarding information on appeals to Health Net, as necessary.
- (j) That Medicare Beneficiaries' health services are being paid for with Federal funds, and as such, payments for such services are subject to laws applicable to individuals or entities receiving Federal funds.
- (k) To submit to Health Net all data, including medical records, necessary to characterize the content and purpose of each encounter with Beneficiary.
- (l) To not collect any co-payment or other cost sharing for influenza vaccine and pneumococcal vaccines.
- (m) For purposes of Medicare Beneficiaries, retroactive eligibility changes shall be limited to thirty-six (36) months or as otherwise required by CMS.

**NOTE TO NEGOTIATOR: If no delegation for claims payments, delete items n, o, and p below.**

- (n) To pay for emergency and urgently needed services consistent with federal regulations if such services are PPG's liability.
- (o) To pay for renal dialysis services for Beneficiaries temporarily outside the service area if such services are PPG's liability.
- (p) To submit and certify the completeness and truthfulness of all encounter data.

## VII. DELEGATION

1. If any of Health Net's activities or responsibilities under its contract with CMS have been Delegated in the underlying agreement, Health Net and PPG must enter into a written Delegation instrument that shall adhere to the following Delegation requirements: The Delegation instrument must (a) specify the Delegated activities, (b) specify PPG's reporting requirements, (c) either provide for revocation by CMS and/or Health net of the Delegated activities and reporting requirements, or specify other remedies if CMS and/or Health Net determines that the PPG has not performed satisfactorily, and (d) specify that Health Net monitors the PPG's performance on an ongoing basis. [\*See 42 CFR §422.504(i)(4); Ch. 11, §§100.4 and 110.2, MMCM]
2. In the event Health Net Delegates credentialing to PPG, the parties agree that Health Net will review and approve the credentialing process and shall audit the credentialing process on an ongoing basis. If Health Net delegates the selection of providers, contractors or subcontractors, the Health Net retains the right to approve, suspend, or terminate any such arrangement. [\*See 42 CFR §422.504(i)(4)(iv)]

## VIII. Compensation for PPG Capitated Services for Unidentified Medi-Medi HMO Beneficiaries

Unidentified Medi-Medi HMO Beneficiaries shall be defined as Medicare HMO Beneficiaries not identified by Health Net as Beneficiaries eligible for both Medicare and Medi-Cal coverage on or after the date of this Agreement but are Medicare HMO Beneficiaries who qualify for Medi-Cal Risk Adjustment status on or after the date of this Agreement, due to outreach of a Health Net vendor. Compensation for rendering PPG Capitated Services to Unidentified Medi-Medi HMO Beneficiaries shall be the same percent of Net Monthly CMS Payment set forth in Section II of this Addendum minus the PPG's proportional share of the vendor fee (calculated as the actual vendor fee multiplied times PPG's percent of Net Monthly CMS Payment as set forth in Section II of this Addendum of this Agreement). The vendor fee is the amount paid to the vendor for identifying and qualifying an Unidentified Medi-Medi HMO Beneficiary for the Medi-Cal Risk Adjustment status, herein after referred to as "Enhanced Benefits" (such as Specified Low-Income Medicare Beneficiaries and Qualified Medicare Beneficiary Program, as determined by CMS and/or State and Federal laws).

The effective date of payment for PPG Capitated Services pursuant to this Section for an Unidentified Medi-Medi HMO Beneficiary shall be the date the Unidentified Medi-Medi HMO Beneficiary qualified for Medicaid status as determined by CMS. Health Net shall pay the enhanced revenue to PPG for an Unidentified Medi-Medi HMO Beneficiary as set forth herein only after Health Net is paid for Enhanced Benefits by CMS for such Beneficiary. CMS may retroactively qualify an Unidentified Medi-Medi HMO Beneficiary. In such case, payment to PPG shall be based on the percent of Net Monthly CMS Payment for each month of retroactive CMS payment.

Except for the additional amount set forth above, Capitation for an Unidentified Medi-Medi HMO Beneficiary shall be paid in accordance with this Addendum, and all provisions of this Addendum applicable to the payment of Capitation shall apply to the Capitation payment for Unidentified Medi-Medi HMO Beneficiaries. In the event of a Capitation error for Unidentified Medi-Medi HMO Beneficiaries resulting in an overpayment or underpayment to PPG, Health Net shall adjust subsequent Capitation to offset such error.

**EXHIBIT B-2**

**DIVISION OF FINANCIAL RESPONSIBILITY**

**MATRIX OF HEALTH NET, PPG, AND SHARED RISK/HOSPITAL CAPITATED SERVICES  
MEDICARE ADVANTAGE BENEFIT PROGRAMS**

The following matrix outlines the Division of Financial Responsibility between Health Net and PPG. The matrix is intended only as a summary guide. The DOFR applies only to Covered Services and does not address any supplement or rider a Beneficiary may have. The applicable Benefit Program shall determine Covered Services. Unless otherwise stated as Out of Area in this matrix, all services are intended as In Area (within the Service Area).

***NOTE TO NEGOTIATOR: THE AIDS CATEGORIES OF SERVICE HAVE BEEN REMOVED FROM THE DOFR. IF YOUR CONTRACT STILL HAS AIDS REINSURANCE, IT MUST BE REMOVED AS WELL.***

<b>CATEGORY OF SERVICE</b>	<b>PPG CAPITATED SERVICES</b>	<b>HEALTH NET RISK SERVICES</b>	<b>SHARED RISK/HOSPITAL CAPITATED SERVICES</b>
<b>ALLERGY IMMUNOTHERAPY</b>	X		
<b>ALLERGY TESTING</b>	X		
<b>ALPHA-FETOPROTEIN</b>	X		
<b>AMBULANCE</b> - In Area (30 Mile Radius) - Out of Area		X	X
<b>ANESTHESIOLOGY</b>	X		
<b>BIOFEEDBACK</b>	X		
<b>BLOOD / BLOOD PRODUCTS</b> - Blood Bank - Hemophilia related Blood Factors - Storage and Collection of Blood - Transfusion Autologous/Homologous			X X X X
<b>CHEMICAL DEPENDENCY DETOX</b> - Inpatient Detox Facility Component - Inpatient Detox Professional Component	X		<u>X</u>
<b>CHEMICAL DEPENDENCY REHAB</b> - Inpatient Facility Component - Inpatient Professional Component - Outpatient Facility Component - Outpatient Professional Component		X X X X	
<b>CHEMOTHERAPY</b> - Drugs, including Epogen, Neupogen and adjunctive therapies - Outpatient - Facility Component – Inpatient including Drugs - Facility Component - Outpatient - Professional Component	X  X		X X
<b>CHIROPRACTIC</b>	X		
<b>CLINIC VISITS</b> – Non-urgent, Outpatient, Facility & Professional (includes Telehealth)	X		

CATEGORY OF SERVICE	PPG CAPITATED SERVICES	HEALTH NET RISK SERVICES	SHARED RISK/HOSPITAL CAPITATED SERVICES
<b>COLOSTOMY SUPPLIES</b>			X
<b>CONSULTATIONS</b>	X		
<b>COSMETIC SURGERY</b> (Medically Necessary) - Facility Component - Professional Component	X		X
<b>CRITICAL CARE VISITS</b>	X		
<b>DENTAL SERVICES</b> - Facility Component - Professional Component	X		X
<b>DIAGNOSTIC TESTING</b> – Outpatient Facility or Home - Facility Component - Professional Component	X X		
<b>DURABLE MEDICAL EQUIPMENT</b> - Outpatient (includes home) - Surgically Implanted			X X
<b>EMERGENCY ROOM ADMISSIONS</b> – In-Area - Facility Component - Professional Component	X		X
<b>EMERGENCY ROOM ADMISSIONS</b> – Out of Area - Facility Component - Professional Component		X X	
<b>EMERGENCY ROOM VISITS</b> – In Area - Facility Component - Professional Component	X		X
<b>EMERGENCY ROOM VISITS</b> – Out-of-Area - Facility Component - Professional Component		X X	
<b>EXTENDED CARE/SKILLED NURSING FACILITY</b> - Facility Component - Professional Component	X		X
<b>GROWTH HORMONES</b>			X
<b>HEARING AIDS</b>		X	
<b>HEMODIALYSIS</b> - Facility Component includes ESRD related drugs, supplies, and laboratory - Professional Component	X		X
<b>HOME HEALTH</b>			X
<b>HOME VISITS</b>	X		
<b>HOSPICE</b> - Facility Component - Professional Component	CMS responsible for Medicare Certified (elected) Hospice		
<b>HOSPITAL BASED PHYSICIANS</b> - Inpatient, Ambulatory Surgery or Emergency Room Admissions - Professional Component - Technical Component	X		X

CATEGORY OF SERVICE	PPG CAPITATED SERVICES	HEALTH NET RISK SERVICES	SHARED RISK/HOSPITAL CAPITATED SERVICES
<b>HYPERBARIC OXYGEN THERAPY, OUTPATIENT</b> - Facility Component - Professional Component	X		X
<b>IMMUNIZATIONS</b>	X		
<b>INFANT APNEA MONITOR</b>			X
<b>INFERTILITY TREATMENTS IVE, GIFT, ZIFT &amp; AI</b> - Facility Component - Professional Component	X		X
<b>INFUSION THERAPY ADMINISTRATION, Outpatient Facility, excluding drugs</b>			X
<b>INHALATION DRUGS, Office or Clinic</b>	X		
<b>INJECTABLES, SELF ADMINISTERED</b>	X		
<b>INPATIENT VISITS, Professional</b>	X		
<b>LITHOTRIPSY</b> - Facility Component - Professional Component	X		X
<b>MATERNITY – Deliveries and Non-Deliveries</b> - Facility Component - Professional Component	X		X
<b>MEDICAL ADMISSIONS In Area and Non-Emergency Out of Area</b> - Facility Component - Professional Component	X		X
<b>MENTAL HEALTH – Inpatient</b> - Facility Component - Professional Component		X X	
<b>MENTAL HEALTH – Outpatient</b> - Facility Component - Professional Component		X X	
<b>OBSERVATION CARE, DIRECT ADMISSION – Outpatient Facility (1)</b> - Facility Component - Professional Component	X		X
<b>OFFICE VISITS (includes Telehealth)</b>	X		
<b>OUTPATIENT FACILITY SERVICES / TECHNICAL COMPONENT</b> Not listed elsewhere on DOFR			X
<b>PATHOLOGY – Inpatient, Ambulatory Surgery or Emergency Room</b> - Professional Component - Technical Component	X		X
<b>PATHOLOGY &amp; LABORATORY SERVICES</b> - Mobile (including in the home)	X		
<b>PATHOLOGY &amp; LABORATORY SERVICES</b> - Office	X		
<b>PATHOLOGY &amp; LABORATORY SERVICES</b>			

<b>CATEGORY OF SERVICE</b>	<b>PPG CAPITATED SERVICES</b>	<b>HEALTH NET RISK SERVICES</b>	<b>SHARED RISK/HOSPITAL CAPITATED SERVICES</b>
- Outpatient (Includes Pre-Admission Tests within 72 hrs. of related admission) - Professional Component - Technical Component	X X		
<b>PATIENT EDUCATION</b>	X		
<b>PERIODIC EXAMS</b>	X		
<b>PROFESSIONAL SERVICE / TECHNICAL &amp; PROFESSIONAL COMPONENT</b> Not listed elsewhere on DOFR	X		
<b>PROSTHETICS/ORTHOTICS DEVICES</b> - Outpatient Dispensed (including home) - Surgically Implanted			X X
<b>RADIATION THERAPY -OUTPATIENT/ OFFICE</b> - Technical Component	X		
<b>RADIATION THERAPY</b> - Professional Component	X		
<b>RADIOLOGY</b> – Inpatient, Ambulatory Surgery or Emergency Room - Professional Component -Technical Component	X		X
<b>RADIOLOGY</b> -Mobile (including in the home)	X		
<b>RADIOLOGY</b> – Office	X		
<b>RADIOLOGY</b> – Outpatient (Includes Pre-Admission Tests within 72 hrs. of related admission) - Professional Component - Technical Component	X X		
<b>SPEECH AND HEARING EXAMS</b>	X		
<b>SUPPLIES</b> - Medical, Surgical - Related to a Hospital Stay - Related to Outpatient, Office & Home	X		X
<b>SUPPLIES, DIABETIC</b> - Chem. Strips, Lancet, Needles, Syringes - Glucometer			X X
<b>SURGERY</b> – Inpatient - Facility Component - Professional Component	X		X
<b>SURGERY</b> – Office	X		
<b>SURGERY</b> – Outpatient - Facility Component - Professional Component	X		X
<b>THERAPEUTIC INJECTABLE AND IMPLANTABLE MEDICATION</b>	X		
<b>THERAPY/REHABILITATION:</b> includes Physical, Occupational, Respiratory, Speech, and Cardiac Rehab) - Inpatient - Outpatient/Office	X		X

CATEGORY OF SERVICE	PPG CAPITATED SERVICES	HEALTH NET RISK SERVICES	SHARED RISK/HOSPITAL CAPITATED SERVICES
<b>TRANSGENDER, INJECTABLE, AND IMPLANTABLE MEDICATION</b> - Hormones (Pre & Post Op)		X	
<b>TRANSGENDER SERVICES</b> - Non-Medical Cosmetic Procedures - Pre-Op MD Consults - Psychiatric Pre-Op Evaluation - Voice Therapy, Professional		X X X X	
<b>TRANSGENDER SURGERY</b> – Complete and Partial InterSex Reassignment Procedures - Facility Component Inpatient & Outpatient (includes preadmission testing at the same facility within 72 hours of admission) - Professional Component		X X	
<b>TRANSPLANTS (Non-experimental)</b> - Drugs (Immunosuppressive, stem cell mobilizers, G-CSF) - Facility Component - Organ Procurement - Professional Component		X X X X	
<b>TRANSPLANT EVALUATIONS</b> - Facility Component - Professional Component		X X	
<b>URGENT CARE VISITS</b> – In-Area	X		
<b>URGENT CARE VISITS</b> – Out-of-Area		X	
<b>VISION CARE</b> - Exams and Medically Necessary Care - Implanted Intraocular Lenses - Lenses and Frames (Non-Cataract)	X	X	X

(I) Observation Care shall be consistent with CMS guidelines related to payment for hospital Outpatient Prospective Payment for Direct to Observation admissions and InterQual criteria. Observation Care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation Services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. When direct admission to Observation is ordered for patients who do not present through the emergency department the same purpose is applied that the member require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. The Observation Services of short-term treatment, assessment and reassessment in an outpatient facility unit must be reasonable and necessary and meet the minimum severity and purpose described under CMS guidelines to be covered. All direct to observation admissions must have PPG authorization and on-going care management. Any service such as laboratory, radiology or diagnostic testing that can safely be performed in an outpatient facility or office, in absence of the observation component, are excluded from the observation category under this Agreement. Any direct to observation admissions that do not meet CMS guidelines will be classified under the DOFR as the applicable DOFR category within the PPG's PPA, e.g., diagnostic testing, lab or radiology and have the corresponding financial risk owner. The decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient should usually be made in less than 24 hours. For any direct to observation admission greater than 24 hours, PPG must notify Health Net consistent with the notification requirements for an inpatient admission. For the purposes of the DOFR, Observation Care, Direct Admission, OP Facility does not include the care performed within an emergency area or emergency related holding unit or post-operative care and should not be used for services that should be performed in an inpatient setting.

**NOTE TO NEGOTIATOR - PLEASE ENSURE THAT RADIOLOGY AND PATHOLOGY HAVE THE SAME RISK**

**EXHIBIT B-3**

**MEDICARE ADVANTAGE BENEFIT PROGRAMS  
PPG FEE-FOR-SERVICE RATE EXHIBIT**

**NTN: Configure Categories of Service as applicable**

Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Addendum E, Health Net or Payor shall pay and PPG or Professional Provider shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered under Medicare Advantage Benefit Program pursuant to this Addendum, the lesser of: (i) the rates listed below, or (ii) **65% - 100%** of PPG's Allowable Charges.

<b>Category of Service</b>	<b>Compensation</b>
Covered Services delivered or arranged by PPG, excluding Laboratory services	___ % of CMS Allowable
Anesthesia Services when provided by an Anesthesiologist or Certified Registered Nurse Anesthetist (American Society of Anesthesiology (ASA) unit scale)	\$ / ASA unit
Medical/Surgical Services by an Anesthesiologist or Certified Registered Nurse Anesthetist	___ % of CMS Allowable
Laboratory Services performed in PPG or Professional Provider office	___ % of CMS Allowable
Pharmaceuticals	
- With an established Medicare Value	the lesser of 100% of PPG's Allowable Charges or <b>XXX%</b> of Medicare allowable
- Without an established Medicare Value	the lesser of 100% of PPG's Allowable Charges or <b>X%</b> of AWP
OB Services	<b>NTN: Choose One Option</b>
	<b>___ % of CMS Allowable</b>
	<b>or</b>
- CPT 59400: Global Obstetric care with vaginal delivery	<b>\$0000.00/</b>
- CPT 59510: Global Obstetric care with cesarean delivery	<b>\$0000.00/</b>
- CPT 59610: Vaginal Delivery after previous cesarean delivery	<b>\$0000.00/</b>
- CPT 59618: Attempted vaginal delivery, resulting in cesarean	<b>\$0000.00/</b>
Immunizations	
- With an established Medicare Value	the lesser of 100% of

<p>- Without an established Medicare Value</p>	<p>provider's Allowable Charges or <b>XXX</b>% of Medicare allowable</p> <p>the lesser of 100% of PPG's Allowable Charges or <b>X</b>% of AWP</p>
<p>By Report (BR) Covered Services, Covered Services not listed and Covered Services with relativities not established.</p>	<p><b>65-100</b>% of Allowable Charges for Covered Services</p>

## EXHIBIT B-4

### MEDICARE ADVANTAGE

### COMPENSATION FOR QUALITY

**Note to negotiator:** Add as exhibit to specific addendum or as a standalone addendum and reference which product it applies to.

**Note to Negotiator:** offer this MACQ version 1 first and if the PPG is unwilling, then can follow with MACQ template version 2.0. The score for the mock CAHPS survey is a “gate” for the MACQ bonus; in order to get the bonus the PPG has to meet the CAHPS score threshold.

**Note to Negotiator:** For bracketed content you will need to reach out to the following individuals:

- Specific Value Input/Redlines pertaining to rate adjustments, STARs rating, tiering – Truong-Son Vinh
- Specific Value Input/Redlines pertaining to survey measure tiering, percentile requirements – Truong-Son Vinh

**NOTE TO NEGOTIATOR:** This exhibit references the Net Medicare Revenue payment method. Please ensure that the payment method used in this exhibit aligns with the payment method used in Exhibit B-1 (Net Medicare Revenue or Net Monthly CMS Payment).

#### I. MEDICARE ADVANTAGE QUALITY ADJUSTMENTS YEAR 1

**1.1** Quality Adjustments – year one (1), dates of service 1/1/[XX]-12/31/[XX]. The percent of Net Medicare Revenue for the Capitation payment shall be adjusted annually as follows (the “Quality Adjustment”):

1.1.1 After CMS publishes each year’s final Star cut points, Health Net shall determine [Plan or PPG]’s overall Part C and Part D Star Rating.

1.1.2 On or about November of each year during the term of this Agreement, if [Plan or PPG] does not meet or exceed a [X.X] overall Part C and Part D Star Rating, [Plan or PPG]’s Capitation rate shall be decreased by [X.XXX] percent and applied retroactively to January 1st of the measurement calendar year.

1.1.3 On or about November of each year during the term of this Agreement, if [Plan or PPG] meets or exceeds a [X.X] overall Part C and Part D Star Rating, [Plan or PPG]’s Capitation rate shall be increased by [X.XX] percent and applied retroactively to January 1st of the measurement calendar year. On or about November of each year during the term of this Agreement, if [Plan or PPG] meets or exceeds a [X.X] overall Part C and Part D Star Rating, [Plan or PPG]’s Capitation rate shall be increased by [X.XX] percent and applied retroactively to January 1st of the measurement calendar year. On or about November of each year during the term of this Agreement, if [Plan or PPG] meets or exceeds a [X.X] overall Part C and Part D Star Rating, [Plan or PPG]’s Capitation rate shall be increased by [X.X] percent and applied retroactively to January 1st of the measurement calendar year.

1.1.4 Such decrease or increase shall act as a one-time adjustment, applied to the measurement calendar year. In order to be eligible for any increase as outlined herein, [Plan or PPG] must achieve ≥ [XX] Star Rating in the event Health Net conducts a Mock CAHPS survey and [Plan or PPG] has a minimum of [150 or (XXX for smaller groups)] Member responses.

**II. MEDICARE ADVANTAGE QUALITY ADJUSTMENTS YEAR[S] 2 [THROUGH 4]**

2.1 Quality Adjustments – year[s] two (2) [through (4) (Dates of Service 1/1/XX-12/31/XX)]. The percent of Net Medicare Revenue for the Capitation payment shall be adjusted annually as follows (the “Quality Adjustment”):

2.1.1 After CMS publishes each year’s final Star cut points, Health Net shall determine [Plan or PPG]’s overall Part C and Part D Star Rating.

2.1.2 On or about November of each year during the term of this Agreement, if [Plan or PPG] does not meet or exceed a [X.X] overall Part C and Part D Star Rating, [Plan or PPG]’s Capitation rate shall be decreased by [X.XX] percent and applied retroactively to January 1st of the measurement calendar year.

2.1.3 On or about November of each year during the term of this Agreement, if [Plan or PPG] meets or exceeds a [X.X] overall Part C and Part D Star Rating, [Plan or PPG]’s Capitation rate shall be increased by [X.XX] percent and applied retroactively to January 1st of the measurement calendar year. On or about November of each year during the term of this Agreement, if [Plan or PPG] meets or exceeds a [X.X] overall Part C and Part D Star Rating, [Plan or PPG]’s Capitation rate shall be increased by [X.X] percent and applied retroactively to January 1st of the measurement calendar year.

2.1.4 Such decrease or increase shall act as a one-time adjustment, applied to the measurement calendar year.

2.1.5 In order to be eligible for any increase as outlined herein, [Plan or PPG] must achieve a {XX} Star Rating in the event Health Net conducts a Mock CAHPs survey and [Plan or PPG] has a minimum of [150 or (XXX for smaller groups)] Member responses.

**Table 1 - Sample Calculation**

MACQ Adjustment to Capitation -Illustrative Example  
Measurement Year (MY) 2021

	<u>Amount</u>
2021 PPG Avg Monthly Membership	1,000
2021 Part C PMPM Revenue	\$ 1,000
2021 Part C \$ Revenue	\$ 12,000,000
Contracted % of Revenue	45.0%
<b>2021 PPG Professional Capitation Payment</b>	<b>\$ 5,400,000</b>
MACQ Adjustment % to 2021 Capitation Rate	0.50%
<b>One-Time MACQ Adjustment \$ to 2021 Capitation Rate for MY 2021</b>	<b>\$ 60,000</b>

**III. GENERAL PROVISIONS**

3.1 Health Net reserves the right to modify the methodology defined herein in Exhibit [X], Medicare Advantage Compensation for Quality (MACQ), as determined by CMS changes to program.

## ADDENDUM C

### **MEDI-CAL BENEFIT PROGRAMS**

This Addendum C applies to the Medi-Cal Benefit Program. All Covered Services delivered to Beneficiaries covered by Medi-Cal Benefit Program shall be paid in accordance with this Addendum C regardless of product specific name unless otherwise specifically agreed by the parties and set forth in a separate rate exhibit.

This Addendum includes each of the following with respect to the Medi-Cal Benefit Program: (i) Exhibit C-1, which covers Medi-Cal Benefit Program capitation provisions for Capitated Services rendered under this Addendum; (ii) Exhibit C-2, the Medi-Cal Benefit Program Capitation Rate Exhibit; (iii) Exhibit C-3, outlines the Division of Financial Responsibility (DOFR); (iv) Exhibit C-4, which includes a regulatory required disclosure form for the Medi-Cal Benefit Program; (v) Exhibit C-5, the Medi-Cal FFS Rate Exhibit; and (vi) Exhibit C-6, Participating Physician Group (PPG) Fee for Service Payment Conditions.

The Capitation provisions set forth herein shall be applicable to only those Beneficiaries listed on the applicable Capitation eligibility roster lists provided to PPG under the terms of this Agreement. PPG understands and agrees that the obligations of Health Net set forth in this Addendum and the Exhibits annexed thereto are solely the obligations of Health Net Community Solutions, Inc, and not the obligations of any other Health Net subsidiary or affiliate.

Health Net has entered into one or more Medi-Cal prepaid health plan agreements with the California Department of Health Care Services ("DHCS"). For the purposes of this Addendum, Health Net's Medi-Cal agreements with the DHCS and any subcontracts with Medi-Cal prepaid health plans, are hereinafter collectively referred to as the Medi-Cal Agreement. Health Net has agreed, under the Medi-Cal Agreement, to arrange certain medical services covered under California's Medi-Cal Program, including PPG Capitated Services, to Medi-Cal HMO Beneficiaries enrolled in or otherwise assigned to Health Net, on a prepaid basis. The provisions of the Addendum are required to appear in all subcontracts under the Medi-Cal Agreement by the terms of the Medi-Cal Agreement and by Medi-Cal law and may not be altered. When required under Medi-Cal law, the Agreement shall be effective upon approval by DHCS in writing or operation of law where DHCS has acknowledged receipt of the Agreement and failed to approve or disapprove within sixty (60) calendar days.

**NOTE TO NEGOTIATOR: the following two paragraphs apply only to Providers participating in the CalViva Health program in Fresno, Kings and Madera Counties. The text should be deleted for all other providers.**

PPG understands and agrees that Health Net Community Solutions, Inc. is an affiliate of Health Net and of Health Net of California, Inc. and has entered into an agreement with the Fresno-Kings-Madera Regional Health Authority (CalViva Health) to provide Covered Services to Medi-Cal beneficiaries in Fresno, Kings and Madera Counties who enroll in CalViva Health. PPG understands and agrees that Health Net of California, Inc. is providing Covered Services as a subcontractor to Health Net Community Solutions, Inc. for the CalViva Health Medi-Cal membership. PPG further understands and agrees that it will provide Covered Services to CalViva Health Medi-Cal members pursuant to the Agreement and that all terms and conditions of the Agreement, including reimbursement, shall apply to the provision of Covered services to the CalViva Health Medi-Cal members.

Health Net has or may enter into contracts with certain Payors, including local initiatives such as Cal Viva Health in Fresno, Kings and Madera Counties, to provide or arrange for Covered Services to Medi-Cal beneficiaries enrolled in the Medi-Cal plans of such Payors. PPG understands and agrees that a Payor may have adopted policies and procedures, including, but not limited to, quality assurance and quality improvement programs. PPG further

understands and agrees that PPG and its Participating Providers shall comply with all the policies and procedures adopted by a Payor and shall participate in the Payor's quality assurance and quality improvement programs.

## EXHIBIT C-1

### **MEDI-CAL BENEFIT PROGRAM PROVISIONS**

#### **A. DEFINITIONS**

1. The following definitions for Shared Risk services apply when PPG is paid Capitation for Medi-Cal HMO Beneficiaries assigned to PPG and the acute care hospital(s) associated with PPG is (are) paid by Health Net on a fee-for-service or per diem basis. When the acute care hospital(s) associated with PPG is capitated all shared risk definitions and references to a shared risk contractual relationship shall not apply.

a) Hospital Capitated Services. The Covered Services provided at a medical facility to a Medi-Cal HMO Beneficiary assigned to PPG which are set forth in the attached applicable "Matrix of Health Net, PPG and Shared Risk/Hospital Capitated Services" Addendum hereto.

b) PPG Capitated Services. For purposes of this Addendum C, PPG shall render PPG Capitated Services set forth in Addendum C to Medi-Cal HMO Beneficiaries eligible for coverage and enrolled in Health Net under the Medi-Cal Agreement, who select or are assigned to PPG, as of the end of a particular month.

c) Medi-Cal Primary Hospital. An acute care hospital associated with a PPG with whom Health Net contracts on a capitated compensation basis under the Medi-Cal Risk Program to provide Hospital Capitated Services to the Medi-Cal HMO Beneficiaries assigned to both PPG and Medi-Cal Primary Hospital.

d) Seniors and Persons with Disabilities (SPD) Beneficiaries (SPD Beneficiaries). Seniors and Persons with Disabilities (SPD) means a Medi-Cal HMO Beneficiary who qualifies as Aged/Disabled based upon aid codes as defined by the DHCS ("SPD Beneficiaries"), including those who have been receiving Medi-Cal Services on a Fee for Service basis who are required to enroll in a managed Medi-Cal health plan beginning June 1, 2011.

e) Medicaid Coverage Expansion ("MCE") Beneficiary means a Medi-Cal HMO Beneficiary who is an adult (19-64 years of age) and whose Medi-Cal qualification is determined by the Medicaid expansion under the federal Patient Protection and Affordable Care Act ("ACA"), whose eligibility is based on a Modified Adjusted Gross Income ("MAGI") being at or below 133% of the Federal Poverty Level, and is not covered under any other mandatory Medi-Cal coverage category.

f) Medicaid Coverage Expansion Dual Eligible Beneficiary ("MCE-Dual Eligible") means an MCE beneficiary who is entitled to Medicare Part(s) A and/or B as identified in the eligibility file Health Net receives from the State.

#### **B. DUTIES OF PPG**

1. **Provision of Covered Services**. PPG shall arrange Covered Services for assigned Medi-Cal HMO Beneficiaries, including SPD Beneficiaries. For the purposes of this Addendum, "Covered Services" means those health care services, supplies, and items that are specified as being covered under the Medi-Cal Agreement. PPG and its subcontractors shall arrange Covered Services for Medi-Cal HMO Beneficiaries, in accordance with the following, each of which is hereby incorporated by reference as if set out in full herein:

1.1 The terms and conditions of this Addendum and the Agreement.

1.2 The terms and conditions of the Medi-Cal Agreement and the applicable Evidence of Coverage.

- 1.3 Health Net's Policies, including but not limited to Health Net's Medi-Cal Policies
- 1.4 DHCS Medi-Cal Managed Care Division (MMCD) Policy Letters.
- 1.5 All laws applicable to PPG and Health Net.
- 1.6 Health Net's Utilization Care Management Program and Quality Improvement Program.
- 1.7 Standards requiring services to be provided in the same manner, and with the same availability, as services are rendered to other patients.
- 1.8 No less than the minimum clinical quality of care and performance standards that are professionally recognized and/or adopted, accepted, or established by Health Net.

**2. Preparation and Retention of Records; Access to Records; Audits.** PPG shall prepare and maintain medical and other books and records required by law in a form maintained in accordance with the general standards applicable to such book or record keeping. PPG shall maintain such financial, administrative, and other records as may be necessary for compliance by Health Net with all applicable local, State, and federal laws. PPG shall retain such books and records for a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later; and shall retain all encounter data for a period of at least ten (10) years. PPG shall make PPG's premises, facilities, equipment, books, records, contracts, computer and other electronic systems and encounter data pertaining to the goods and services furnished under the terms of the Agreement available for the purpose of an audit, inspection, evaluation, examination or copying by Health Net, DHCS, the Centers for Medicare & Medicaid Services (CMS), the United States Department of Health and Human Services (DHHS), the California Department of Managed Health Care (DMHC), Inspector General, the Comptroller General, the United States Department of Justice (DOJ), or their designees and any other regulatory agency having jurisdiction over Health Net. The records shall be available at PPG's place of business, or at such other mutually agreeable location in California. When such entities request PPG's records, PPG shall produce copies of the requested records at no charge. PPG shall permit Health Net, and its designated representatives, and designated representatives of local, State, and federal regulatory agencies having jurisdiction over Health Net, to conduct site evaluations and inspections of PPG's offices and service locations. Provider shall comply with all monitoring provisions of the Medi-Cal Agreement and any monitoring requests by DHCS. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the PPG at any time. [22 CCR § 53250(e)(1); W & I § 14452(c); Medi-Cal Agreement] Furthermore, PPG shall timely gather, preserve, and make available to DHCS, CMS, the Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in PPG's possession related to the recovery for litigation, pursuant to the Medi-Cal Agreement.

**3. Federal Disclosure Form.** PPG shall submit to Health Net a completed Disclosure Form, attached to this Addendum, for officers and other persons associated with PPG as required by 42 CFR 455.104, 455.105 and 455.106 and California Welfare and Institutions Code § 14452(a).

**4. Medi-Cal HMO Beneficiary Education.** PPG shall make health education materials and programs available to Medi-Cal HMO Beneficiaries on the same basis that it makes such materials and programs available to the general public and shall use its best efforts to encourage Medi-Cal HMO Beneficiaries to participate in such health education programs. [Medi-Cal Agreement]

**5. Medi-Cal HMO Beneficiaries and State Held Harmless.** PPG agrees that in no event, including, but not limited to, non-payment by Health Net, the insolvency of Health Net, or breach of the Agreement, shall PPG or a subcontractor of Physician bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries, the State of California, or persons other than Health

Net acting on their behalf for services provided pursuant to the Agreement. PPG agrees: (1) this provision shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Medi-Cal HMO Beneficiaries; and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between PPG and Medi-Cal HMO Beneficiaries or persons acting on their behalf. Any modification, addition, or deletion of or to the provisions of this clause shall be effective on a date no earlier than 15 days after DHCS has received written notice of such proposed change and has approved such change. [22 CCR § 53250(e)(6)]

**6. Grievances and Appeals.** PPG agrees to work with Health Net to resolve all grievances and appeals relating to the provision of services to Medi-Cal HMO Beneficiaries in accordance with the Health Net Medi-Cal grievance and appeal procedures. Health Net provided its grievance and appeals policies and procedures to PPG at the time of entering into this Agreement, and PPG shall do the same when entering into a Downstream Subcontractor Agreement. Health Net shall immediately notify PPG of any changes to its grievance and appeals policies and procedures and PPG shall ensure its Network Providers and Downstream Subcontractors are trained on and immediately notified of such changes as well.

**7. Relationship of the Parties.** PPG shall be solely responsible, without interference from Health Net or its agent, for providing PPG Capitated Services to Medi-Cal HMO Beneficiaries, and shall have the right to object to treating any individual who makes onerous the relationship between PPG and Medi-Cal HMO Beneficiary. In the event of a breakdown in such relationship, Health Net shall make reasonable efforts to assign the Medi-Cal HMO Beneficiary to another Participating Provider. If reassignment is unsuccessful, a request may be filed with DHCS to permit termination of services to such Medi-Cal HMO Beneficiary. Approval from DHCS must be obtained before PPG terminates services to such Medi-Cal HMO Beneficiary.

**8. Notice.** PPG shall notify DHCS in the event this Agreement is amended or terminated. Notice to DHCS is considered given when properly addressed and deposited with the United States Postal Service as first class registered mail, postage attached. [Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13, and Title 22, CCR, Sections 53250(e)(4) and 53867.]

**9. Reports.** PPG shall provide Health Net, within the time requested by Health Net, with all such reports and information as Health Net may require to allow it to meet the reporting requirements under the Medi-Cal Agreement or any applicable law or regulatory directive. [Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867]. Furthermore, PPG shall submit to Health Net, complete, accurate, reasonable, and timely provider data requested by Health Net in order for Health Net to meet its provider data reporting requirements to DHCS. [Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.]

**10. Transfer of Care Upon Termination of the Agreement.** PPG shall, pursuant to the requirements of the Medi-Cal Agreement, assist in the orderly transfer of care of all Medi-Cal HMO Beneficiaries under the care of PPG in the event of the termination of the Agreement for any reason.

**11. Cultural and Linguistic Services.** PPG shall, in accordance with the requirements of the Medi-Cal Agreement and Health Net's cultural and linguistic services policies, arrange at its sole cost interpreter services for Beneficiaries either through telephone language services or interpreters. Health Net shall: (1) Provide cultural competency/humility, sensitivity, health equity, and diversity training to Health Net's contracted providers. PPG and its Downstream Subcontractors must ensure that cultural competency/humility, sensitivity, health equity, and diversity training is provided for all of their staff at key points of contact with Beneficiaries per the Medi-Cal Agreement.

**12. No Surcharges and No Copayments.** PPG shall not charge a Member any fee or surcharge, or Copayment except when explicitly allowed by the Benefit Program for covered services rendered pursuant to the Agreement. In addition, PPG shall not collect a sale, use or other applicable tax from Members for the sale or

delivery of medical services. If Health Net receives notice of any such charge, PPG shall fully cooperate with Health Net to investigate such allegations, and PPG shall require its Participating Providers to promptly refund any payment deemed improper by Health Net to the party who made the payment. [Knox-Keene Act and Medi-Cal Agreement]

**13. EPSDT Supplemental Services.** PPG shall arrange for Early and Periodic Screening, Diagnosis and Treatment Supplemental Services for Beneficiaries under the age of 21 in accordance with the requirements of the Medi-Cal Agreement.

**14. CCS (California Children's Services).** PPG is responsible for timely referral of children with potential CCS eligible conditions. Failure to appropriately refer will result in PPG assuming financial responsibility for any related charges. PPG shall not seek reimbursement for such services from Health Net.

**15. CPSP (Comprehensive Perinatal Services Program).** PPG is required to develop formal agreements with DHCS-certified CPSP providers to ensure that all pregnant women have access to care in accordance with DHCS requirements.

**16. Sensitive Services.** PPG understands and agrees that PPG is financially responsible for all Sensitive Services rendered to a Medi-Cal HMO Beneficiary by any health care professional. PPG shall pay the health care professionals either an agreed upon contractual rate or the applicable Medi-Cal Program rate in the absence of a contract.

Sensitive Services are those health care services which are covered by more restrictive confidential treatment rules. In accordance with the Medi-Cal Agreement, Medi-Cal Members may self-refer anywhere to obtain Sensitive Services and no referral or prior authorization shall be required. Access to Sensitive Services shall not be limited in any way geographically or by provider network participation.

The Sensitive Services are as follows:

- abortion (pregnancy termination) services,
- family planning services, inclusive of all methods of birth control covered by the Department of Health Care Services for the Medi-Cal Program.
- sexually transmitted disease testing and treatment, and
- Human Immunodeficiency Virus (HIV) testing and counseling.

**17. Carve-out of California Children's Services (CCS) Program Services.** PPG shall identify and timely refer Beneficiaries with possible CCS-eligible conditions to the appropriate County CCS Program. Upon referral, PPG shall inform the Beneficiary's parent or guardian and shall notify Health Net of any such referral. The parties acknowledge that health care services to treat CCS-eligible conditions are "carved out" of Health Net's coverage obligations under the Medi-Cal Benefit Programs. The CCS Program requires eligible children to be treated at CCS-certified facilities by CCS-paneled providers. The CCS Program may require transfer to CCS-certified facilities with CCS-paneled providers. The CCS Program is financially responsible for payment of health care costs to treat a CCS-eligible condition. The parties understand and agree that Health Net is not financially responsible for payment of services to treat CCS-eligible conditions. In the event Health Net inadvertently pays a claim for such services, Health Net may recover the amount paid through the process provided in either Section 4.3, or 4.8.4 of the Agreement.

**18. Qualified SPD Physician.** PPG shall provide a mechanism for SPD Beneficiaries to select a specialist or clinic as a Primary Care Physician if the specialist or clinic agrees to serve as a primary care provider and is qualified to treat the required range of conditions of the SPD Beneficiary in accordance with Welfare and Institutions Code Section 14182 (b)(11).

**19. Transitioned SPD Beneficiaries.** For SPD Beneficiaries with Health Net who have transitioned from Medi-Cal fee-for-service and who request continued access to an out of network provider, PPG shall provide

continued access for up to 12 months to an out-of-network provider with whom such Beneficiaries have an ongoing relationship (i.e., an existing provider from whom such Beneficiaries are receiving services covered by fee-for-service Medi-Cal) if there are no known quality of care issues with the provider and the provider will accept PPG's Medi-Cal contract rates or Medi-Cal fee for service rates, whichever is higher in accordance with Welfare & Institutions Code 14182(b)(13) and (14). Health Net and PPG shall work together to identify those transitioned SPD Beneficiaries who are entitled to continued access under this Section B-19 using fee-for-service utilization data provided by DHCS.

**20. Immunization Services.** PPG shall ensure that all Participating Providers and/or Professional Providers, who render any Immunization services, of any kind, are registered with, and submit applicable information to a CA immunization registry and shall provide evidence of such, upon request or audit, by Health Net or any designee.

### **C. DUTIES OF HEALTH NET**

**1. Treatment Authorization Request (TAR) for SPD Beneficiaries.** Upon receipt from DHCS, Health Net shall provide PPG with the open treatment authorization request (TAR) forms for its assigned SPD Beneficiaries. PPG shall promptly review the TARs and render all medically appropriate Covered Services.

**2. Notice of Change in Availability or Location of Covered Services.** Health Net is obligated to ensure Medi-Cal HMO Beneficiaries are notified in writing of any changes in the availability or location of Covered Services at least 30 days prior to the effective date of such changes, or within 14 days prior to the change in cases of unforeseeable circumstances. Such notifications must be approved by DHCS prior to the release. In order for Health Net to meet this requirement, PPG is obligated to notify Health Net in writing of any changes in the availability or location of Covered Services at least 40 days prior to the effective date of such changes.

### **D. COMPENSATION PROVISIONS**

**1. Medi-Cal Benefit Programs.** PPG shall arrange and provide Covered Services to Medi-Cal HMO Beneficiaries of Health Net's Benefit Programs covered under this Addendum.

**2. Payment for Capitated Services; Capitation.** Health Net shall compensate PPG for PPG Capitated Services rendered to Medi-Cal HMO Beneficiaries assigned to PPG under a capitation compensation method. Health Net shall pay PPG the applicable Capitation described in this Addendum for each Medi-Cal HMO Beneficiary entitled to receive PPG Capitated Services from PPG during the month to which the Capitation applies, on or before the 15th day following Health Net's receipt of payment for that month from the DHCS. Notwithstanding any provision in this paragraph to the contrary, Health Net shall pay only one Capitation for both mother and newborn child during the child's month of birth and the following month.

**3. Payment for Non-Capitated Covered Services.** PPG and Professional Providers shall render Covered Services for which Capitation is not paid under this Addendum and for which PPG has no financial responsibility under the DOFR. Health Net shall compensate PPG or Professional Provider such services on a FFS basis at the rates set forth in Exhibit C-5, pursuant to the applicable payment conditions set forth in Exhibit C-6. PPG and Professional Providers shall submit claims for such services in accordance with the terms of this Agreement and applicable State and federal law. Such FFS compensation shall be paid within 45 working days of receipt of a complete and accurate claim for Covered Services rendered to a Medi-Cal HMO Beneficiary.

Notwithstanding anything to the contrary contained in this Agreement, if PPG is decertified, suspended and/or terminated by the California Department of Health Care Services ("DHCS"), or other governmental agencies ("DHCS Notice"), PPG acknowledges that it will not be eligible to receive reimbursement for Contracted Services

following the date of the DHCS Notice and Health Net will have no liability to pay PPG under this Agreement upon receipt of the DHCS Notice.

4. **Billing.** Notwithstanding anything to the contrary to the Agreement, if PPG is compensated on a fee-for-service basis, PPG shall submit to Health Net, via Health Net's electronic claims submission program or hardcopy as determined by Health Net, Complete Claims within one hundred eighty (180) days after the month in which the Covered Service is rendered unless PPG demonstrates good cause pursuant to applicable State law. Where Health Net is the secondary payor under Coordination of Benefits, PPG shall submit Complete Claims for Covered Services accompanied by the explanation of benefits (EOB) or explanation of payment (EOP) from the primary payor to Health Net within one hundred eighty (180) days of the date of the EOB/EOP.

If the PPG fails to comply with the timely claims submission/filing requirements set forth above, Health Net shall reimburse the PPG at the following rates: 75% of usual allowance for claims submitted during the seventh through ninth month after the month of service; 50% of usual allowance for claims submitted during the tenth through the twelfth month after the month of service. Health Net shall not be liable for payment to PPG for any Complete Claims received after the twelfth month after the month of service.

**NOTE TO NEGOTIATOR: PLEASE DELETE PARAGRAPH 5 IF NEGOTIATING A DEAL WITH A DUAL RISK PPG, AND RE-NUMBER THE FOLLOWING SECTIONS ACCORDINGLY.**

**NOTE TO NEGOTIATOR: IF THE PPG CURRENTLY HAS SHARED RISK BUDGETS, THE BUDGETS WILL NEED TO BE RE-CALIBRATED.**

5. **Shared Risk Program.** To be eligible for a bonus payment in the Shared Risk Program, PPG must qualify for HEDIS quality performance awards in the most recent measurement year for the applicable Medi-Cal quality incentive programs that it participates in (i.e., Medi-Cal Quality Performance Program, Performance Based Compensation Program, HEDIS Quality Improvement Program, or other applicable program). For each Reconciliation Period, for the purpose of determining whether PPG is entitled to a bonus payment, Health Net will calculate Shared Risk Claims, excluding costs in excess of the Shared Risk threshold of two hundred and fifty thousand dollars (\$250,000) per Beneficiary, and compare them to the corresponding Shared Risk Budget. At least an average of five hundred (500) members must be assigned to PPG during each measurement year in order for PPG to be eligible for a bonus payment or deficit carry over. In the event that Shared Risk Claims are less than the Shared Risk Budget, Health Net shall pay PPG the lesser of a) fifty percent (50%) of the differential between the Shared Risk Budget and the total Shared Risk Claims; or b) ten percent (10%) of the aggregate Capitation. In the event that Shared Risk Claims are more than the Shared Risk Budget, Health Net shall **(alternative language IF withhold is included: "apply any deficit against the Withhold Fund")** apply any deficit against PPG's share of surplus in the following year based on the lesser of a) fifty percent (50%) of the differential between the Shared Risk Budget and the total Shared Risk Claims; or b) five percent (5%) of the aggregate Capitation. Health Net will calculate the shared risk amount payable to PPG ninety (90) days after the exhaustion of each Reconciliation Period. Any amounts payable will be sent to PPG within forty-five (45) days after said ninety (90) day claims run out period. Any Shared Risk Claims not paid during the Reconciliation Period will be applied toward the next reconciliation.

6. **Compensation to Other Providers of PPG Capitated Services.** PPG shall compensate all providers who render PPG Capitated Services to Medi-Cal HMO Beneficiaries assigned to PPG as set forth in this Agreement. In the event that PPG does not process and pay eligible claims submitted to PPG for Capitated Services within the applicable time limits, Health Net may pay such claims at the lesser of Health Net's contract rate with such provider, if any, PPG's subcontract terms, Medi-Cal rates, or provider's Allowable Charges and shall deduct the amounts paid from PPG's Capitation.

7. **Covered Services Reciprocity.** When a Medi-Cal HMO Beneficiary not assigned to PPG under a Capitated Compensation method receives services from PPG, then PPG shall accept compensation based upon the rates set forth in this Addendum.

## **8. Offsetting Against Capitation**

8.1 Health Net shall have the right to offset against Capitation any amounts owed to Health Net by PPG, including but not limited to, amounts owed by PPG under loans guaranteed by Health Net, errors, or Health Net interim payment for Capitated Services, including prior Capitation payments except that Health Net shall not offset against Capitation any deficit in a Shared Risk Program between PPG and Health Net.

8.2 If Health Net is obligated to pay for services which Health Net determines are the financial responsibility of PPG or which Health Net would not otherwise be obligated to pay, Health Net shall have the right to deduct the cost of such services from Capitation due to PPG. Health Net agrees not to deduct any amount as set forth in this Section without first giving PPG fifteen (15) days prior written notice during which time PPG shall have the opportunity to show cause why such amount should not be deducted by Health Net.

For purposes of calculating the amount Health Net shall pay and may deduct from Capitation under this provision, the following shall apply: (i) for PPG and Professional Providers, the FFS rates set forth in the applicable Addendum to this Agreement shall be utilized; (ii) for any other provider who is subcontracted to PPG, such subcontract rates shall be utilized if the subcontract documenting such rates are provided to Health Net by PPG sufficiently in advance of payment to allow Health Net to determine the payment amount under such subcontract; (iii) for a Participating Provider who is contracted with Health Net but who is not subcontracted with PPG or for whom PPG has not timely delivered to Health Net the subcontract documenting PPG's subcontract rate, Health Net's contract rate shall be utilized; or (iv) the actual amount paid by Health Net when none of the above applies.

## **9. Medi-Cal SPD Indemnification Program (OPTIONAL)**

9.1 **Medi-Cal SPD Beneficiaries Indemnification Program.** PPG shall participate in the Medi-Cal SPD Beneficiaries Indemnification Program ("Indemnification Program") for Indemnification Costs incurred by SPD Beneficiaries for PPG Capitated Services.

For purposes of this Section 9, the following terms shall be defined as set forth below:

9.1.1 **Indemnification Budget:** The PMPM amount allocated for each SPD Beneficiary to fund the Indemnification Program.

9.1.2 **Indemnification Reconciliation Period** The applicable 12 month time period used for the purpose of calculating the Indemnification Program's payable amount, if any, which is

- (a) June 1, 202X through May 31 202X for the first reconciliation period and,
- (b) June 1, 202X through May 31, 202X for the second and final reconciliation period.

9.1.3 **Indemnification Costs:** Fee-for-service claims and capitation paid by PPG for SPD Beneficiaries who received PPG Capitated Services during an Indemnification Reconciliation Period. There shall be no allowance for Incurred but Not Reported ("IBNR") claims estimates.

9.2 **Indemnification Budget.** Health Net shall fund the Indemnification Budget at the rate of \$X PMPM (Note to Negotiator: Amount to be negotiated) for SPD Beneficiaries.

9.3 **Eligibility.** PPG's eligibility for payment under this Indemnification Program shall be as follows:

9.3.1 If PPG's Indemnification Costs in an Indemnification Reconciliation Period are less than or equal to ninety-four percent (94%) of the Aged/Disabled Category of Aid capitation amount as set forth in Exhibit C-2 during the applicable Indemnification Reconciliation Period in the aggregate for SPD Beneficiaries, PPG shall not be eligible for payment from the Indemnification Budget for that Indemnification Reconciliation Period.

9.3.2 If PPG's Indemnification Costs in an Indemnification Reconciliation Period are greater than ninety four percent (94%), but less than or equal to one-hundred percent (100%) of the Aged/Disabled Category of Aid capitation amount as set forth in Exhibit C-2 during the applicable Indemnification Reconciliation in the aggregate for SPD Beneficiaries, PPG shall be eligible for an amount equal to fifty percent (50%) of the PPG's Indemnification Budget for that Indemnification Reconciliation Period.

9.3.3 If PPG's Indemnification Costs in an Indemnification Reconciliation Period are greater than one hundred percent (100%) of the Aged/Disabled Category of Aid capitation amount as set forth in Exhibit C-2 during the applicable Indemnification Reconciliation in the aggregate for SPD Beneficiaries, PPG shall be eligible for an amount equal to one hundred percent (100%) of the PPG's Indemnification Budget for that Indemnification Reconciliation Period.

9.4 **Payment.** PPG shall prepare an electronic file in a format specified by Health Net which includes the required data elements that provide Health Net with claims detail for PPG Capitated Services rendered to SPD Beneficiaries in each Indemnification Reconciliation Period and submit this report to Health Net within one hundred and twenty (120) days at the end of each Reconciliation Indemnification Period. Claims costs incurred by SPD Beneficiaries for PPG Capitated Services during the first Indemnification Reconciliation Period that were not submitted by September 30, 202X may be submitted by September 30, 202X and shall be included in the second and final Indemnification Reconciliation Period. September 30, 202X shall be the final date for submission of all Indemnification Costs and no additional submissions shall be allowed after this date.

Health Net shall have forty-five (45) days after receipt of the data to review such data and identify any discrepancies. If Health Net identifies any discrepancies, PPG and Health Net shall meet and confer within thirty (30) days regarding the discrepancies. If PPG and Health Net cannot resolve the discrepancies, either party may elect to resolve the dispute pursuant to Sections 7.5, Provider Dispute Resolution Procedure, and 7.6, Binding Arbitration of the Agreement.

If Health Net determines that PPG is entitled to payment under the Indemnification Program, Health Net shall make such payment to PPG for an Indemnification Reconciliation Period no later than December 1 of the applicable year.

Section 10 only, the following terms and references shall apply as set forth below:

**10. Medi-Cal MCE Beneficiary Indemnification Program (OPTIONAL)**

10.1 **PPG's Medi-Cal MCE Beneficiaries Indemnification Program.** PPG shall participate in the Medi-Cal MCE\_ Beneficiaries Indemnification Program ("Indemnification Program") for Indemnification Costs incurred by MCE Beneficiaries for PPG Capitated Services.

**Definitions**

10.1.1 **Indemnification Budget:** The PMPM amount allocated for each MCE Beneficiary to fund the Indemnification Program.

10.1.2 **Indemnification Reconciliation Period.** The applicable 12-month time period used for the purpose of calculating the Indemnification Program's payable amount, if any, which is

(a) January 1, 202X through December 31 202X

10.1.3 **Indemnification Costs:**

Indemnification costs include fee-for-service claims and capitation paid by PPG for MCE Beneficiaries who received PPG Capitated Services during an Indemnification Reconciliation Period. There shall be no allowance for Incurred but Not Reported ("IBNR") claims estimates during the Indemnification Reconciliation Period. At the end of the Indemnification Reconciliation Period there shall be a one hundred and eighty (180) days claims run-out period for all claims paid for dates of service January 1, 202X through December 31, 202X. All claims paid for services provided to MCE Beneficiaries during the Indemnification Reconciliation Period, shall be counted in determining PPG's eligibility for indemnification as set forth in Section 10.3 below.

10.2 **Indemnification Budget.** Health Net shall fund the Indemnification Budget at the rate of \$X.XX PMPM for MCE Beneficiaries.

10.3 **Eligibility.** PPG's eligibility for payment under this Indemnification Program shall be as follows:

10.3.1 If PPG's Indemnification Costs in the Indemnification Reconciliation Period are less than or equal to ninety-four percent (94%) of the MCE Category of Aid capitation amount as set forth in exhibit C-2 in the aggregate, PPG shall not be eligible for payment from the Indemnification Budget for the Indemnification Reconciliation Period.

10.3.2 If PPG's Indemnification Costs in the Indemnification Reconciliation Period are greater than ninety four percent (94%), but less than or equal to one hundred percent (100%) of the MCE Category of Aid capitation amount as set forth in Exhibit C-2 in the aggregate, PPG shall be eligible for an amount equal to fifty percent (50%) of the PPG's Indemnification Budget for the Indemnification Reconciliation Period.

10.3.3 If PPG's Indemnification Costs in the Indemnification Reconciliation Period are greater than one hundred percent (100%) of the MCE Category of Aid capitation amount as set forth in Exhibit C-2 in the aggregate, PPG shall be eligible for an amount equal to one hundred percent (100%) of the PPG's Indemnification Budget for the Indemnification Reconciliation Period.

10.4 **Payment.** PPG shall prepare an electronic file in a format specified by Health Net which includes the required data elements that provide Health Net with claims, membership, and capitation detail for PPG Capitated Services rendered to MCE Beneficiaries in the Indemnification Reconciliation Period and submit this report to Health Net within one hundred and eighty (180) days at the end of the Indemnification Reconciliation Indemnification Period. Claims costs incurred by MCE Beneficiaries for PPG Capitated Services during the Indemnification Reconciliation Period must submit claims by June 30, 202X, which shall be the final date for submission of all Indemnification Costs and no additional submissions shall be allowed after this date.

Health Net shall have forty-five (45) days after receipt of the data to review such data and identify any discrepancies. If Health Net identifies any discrepancies, PPG and Health Net shall meet and confer within thirty (30) days regarding the discrepancies. If PPG and Health Net cannot resolve the discrepancies, either party may elect to resolve the dispute pursuant to Article 7.5, Provider Dispute Resolution Procedure, and 7.6, Arbitration of Disputes of the Agreement.

If Health Net determines that PPG is entitled to payment under the Indemnification Reconciliation Program, Health Net shall make such payment to PPG for an Indemnification Reconciliation Period no later than September 1, 202X. Failure to make such payment by September 1, will not constitute material breach of the Agreement; however, in the event Health Net fails to make such payment to PPG by September 1, interest shall begin to accrue at fifteen (15%) percent per annum starting September 1st until such time payment is made to PPG.

11. **Copayments, Coinsurance or Deductibles.** PPG understands and agrees that the State of California may impose certain Copayments, Coinsurance or Deductibles as the financial responsibility of Medi-Cal HMO Beneficiaries. If such financial responsibility is imposed by the State of California, PPG agrees that Health Net shall have the right to apply benefit plan factors to the Medi-Cal HMO Beneficiary population based on actuarial assumptions and adjust PPG's Capitation based upon such plan factors. Health Net shall also have the right to adjust PPG's Capitation based on actuarial assumptions in the event benefits are added or deleted which result in changes to the PPG Capitated Services provided to Medi-Cal HMO Beneficiaries. Health Net may adjust the actuarial assumptions, which support the rates in this Capitated Rate Exhibit on a periodic basis and shall advise PPG of any such adjustments in methodology.

12. **Adjustment to Capitation.** PPG further understands and acknowledges that the State of California may reduce Medi-Cal payments to providers or to Health Net on a prospective or retroactive basis. If the State of California notifies Health Net of its intent to reduce Medi-Cal payments to providers or to Health Net and such reduction impacts any service that is or was part of PPG Capitated Services and/or shared risk budget, Health Net shall have the right to adjust PPG's capitation rates and/or shared risk budget, including retroactive adjustments, by an actuarially equivalent amount under this Agreement upon thirty (30) days advance written notice to PPG.

13. **Injectables and Health Net Designated Participating Provider.** This Section shall not apply to those injectables that are determined to be CCS eligible program services.

As to injectables for which Health Net is responsible for reimbursement, Health Net shall compensate PPG at [redacted] % of the State of California Medi-Cal Fee Schedule rates in effect at the time of service. If such medication is not listed on the Medi-Cal Fee Schedule, the value will be determined by the Average Wholesale Price (AWP) as calculated by Health Net in accordance with the Medi-Cal methodology.

Such rates shall be payment-in-full, except for the applicable Coinsurance amount. Health Net shall reimburse PPG at such rates, less the applicable Coinsurance. Health Net shall not be responsible for reimbursing the Beneficiary's Professional Provider for such injectables. PPG shall seek reimbursement from Health Net for such injectables and shall submit claims for such services to Health Net using the CMS 1500 and the appropriate CPT-4, HCPCS and NDC codes.

As to California Health & Safety Code §§ 1375.5 & 1375.8 services, which include chemotherapy drugs, self-injectables, hemophiliac blood factors, adult immunizations, transplant immunosuppressives, and therapeutic injectable and implantable medications (described in regulation as "other") with a cost per value greater than \$250.00 the Parties agree that risk shall be accepted on such injectables, as set forth in the Division of Financial Responsibility Matrix. Such cost value shall be determined by the State of California Medi-Cal Fee Schedule. If such medication is not listed on the Medi-Cal fee schedule, the value will be determined by the Average Wholesale Price (AWP) as calculated by Health Net in accordance with the Medi-Cal methodology.

PPG shall bill the State of California for "California Children's Services" (CCS) carve-out services in accordance with the operations manual. PPG shall not seek reimbursement for such services from Health Net.

14. **Immunizations:** The applicable DOFR sets forth PPG and Health Net's respective financial responsibility for Immunizations. This Section shall not apply to those immunizations that are determined to be CCS eligible program services.

Where Health Net has financial responsibility for a particular immunization, PPG shall seek reimbursement from Health Net for that immunization by submitting claims for such service to Health Net using the CMS 1500, or successor standard form, and the appropriate CPT-4, HCPC, or other applicable procedure code in accordance with Health Net Policies. Health Net shall compensate PPG in accordance with Exhibit C-5, subject to the applicable payment conditions in Addendum E, as payment-in-full, except for applicable Copayments. Health Net shall not be responsible for reimbursing Professional Providers for immunizations

For any new immunizations approved by American Academy of Pediatrics and the Advisory Committee on Immunization Practices (ACIP) of the US Public Health Service after the effective date of this Agreement, Health Net shall reimburse PPG at the lowest of the following: (1) the average wholesale price (AWP) as published in the Drug Topics Red Book, or (2) the lowest acquisition cost through sources made available to PPG by Health Net, unless and until Health Net develops experiential data for that new immunization, and PPG has agreed to accept financial responsibility for that new immunization.

**15. Vaccines for Children Program (VFC).** PPG shall not seek reimbursement from Health Net for immunizations covered by the State of California under the Vaccines for Children Program (VFC), where PPG, or Professional Provider, who is a participant in the VFC program, rendered the immunization.

## **E. GENERAL PROVISIONS**

**1. Subcontracting Under the Agreement.** PPG shall not subcontract for the performance of services under the Agreement without the prior written consent of Health Net. Every such subcontract shall be in writing and provide that it is terminable with respect to Beneficiaries by PPG upon Health Net's request. PPG shall furnish Health Net or DHCS with copies of such subcontracts, and amendments thereto, within ten days of execution or upon request. Each such subcontracting Provider shall meet Health Net's credentialing requirements, prior to the subcontract becoming effective. PPG shall be solely responsible to pay any health care Provider permitted under the subcontract, and shall hold, and ensure that health care Providers hold, Health Net, Beneficiaries and the State harmless from and against any and all claims which may be made by such subcontracting Providers in connection with services rendered to Beneficiaries under the subcontract. PPG shall maintain and make available to Health Net, DHCS, the Centers for Medicare & Medicaid Services (CMS), the United States Department of Health and Human Services (DHHS), the California Department of Managed Health Care (DMHC), Inspector General, the Comptroller General, the United States Department of Justice (DOJ), or their designees and any other regulatory agency having jurisdiction over Health Net, copies of all PPG's subcontracts under the Agreement and to ensure that all such subcontracts are in writing and require that the subcontractor: (1) make premises, facilities, equipment, books, records, contracts, computer and other electronic systems available for the purpose of an audit, inspection, evaluation, examination, or copying by said entities; (2) retain such books and records for a term of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later; (3) maintain such books and records in a form maintained in accordance with the general standards applicable to such book or record keeping. [22 CCR § 53250(e)(3)]

**2. Governing Law.** The Agreement shall be governed by and construed and enforced in accordance with all laws and contractual obligations incumbent upon Health Net. PPG shall comply with all applicable local, State, and federal laws, now or hereafter in effect, to the extent that they directly or indirectly affect PPG or Health Net, and bear upon the subject matter of the Agreement. PPG shall comply with the provisions of the Medi-Cal Agreement, and Chapters 3 and 4 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations. In addition, Health Net is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations. Any provision required to be in the Agreement by either of the above laws shall bind the parties whether or not provided in the Agreement. [22 CCR § 53250(c)(2)]; W & I § 14452(a); Knox-Keene Act]

**3. Confidentiality of Information.** Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 45, Code of Federal Regulations, Section 205.50 and Section 14100.2 of the California Welfare and Institutions Code and the regulations adopted thereunder. For the purposes of this Agreement, all information, records, data, and data elements collected and maintained for or in connection with performance under this Agreement and pertaining to Medi-Cal HMO Beneficiaries shall be protected by PPG from unauthorized disclosure. With respect to any identifiable information concerning a Medi-Cal HMO Beneficiary under this Agreement that is obtained by PPG or its subcontractors, PPG: (1) will not use any such information for any purpose other than carrying out the express terms of this Agreement; (2) will promptly transmit to Health Net all requests for disclosure of such information, (3) will not disclose, except as otherwise specifically permitted by this Agreement, any such information to any party other than Health Net without Health Net's prior written authorization specifying that the information is releasable under applicable law, and (4) will, at the expiration or termination of this Agreement, return all such information to Health Net or maintain such information according to written procedures provided PPG by Health Net for this purpose. PPG shall ensure that its subcontractors comply with the provisions of this paragraph.

**4. Third Party Tort Liability.** PPG shall make no claim for recovery for health care services rendered to a Medi-Cal HMO Beneficiary when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance, including workers' compensation awards and uninsured motorist coverage. Within five days of discovery, PPG shall notify Health Net of cases in which an action by the Medi-Cal HMO Beneficiary involving the tort or workers' compensation liability of a third party could result in a recovery by the Medi-Cal HMO Beneficiary. PPG shall promptly provide: (1) all information requested by Health Net in connection with the provision of health care services to a Medi-Cal HMO Beneficiary who may have an action for recovery from any such third party; (2) copies of all requests by subpoena from attorneys, insurers or Medi-Cal HMO Beneficiaries for copies of bills, invoices or claims for health care services; and (3) copies of all documents released as a result of such requests. PPG shall ensure that its subcontractors comply with the requirements of this provision.

**5. Amendments.** When required under Medi-Cal law, Amendments to the Agreement shall be submitted by Health Net to the DHCS for prior approval at least 30 days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes, which are neither approved nor disapproved by the Department, shall become effective by operation of law 30 days after the DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later. Subcontracts between a prepaid health plan and a subcontractor shall be public records on file with the DHCS. [22 CCR §§ 53250(a), (c)(3), & (e)(4); W & I § 14452(a)]

Notwithstanding the foregoing and any provisions to the contrary in this Agreement, the parties understand and agree that an amendment to the material terms of this Agreement shall be permitted without the consent of PPG if: (i) PPG is a non-institutional provider; (ii) the amendment applies to the Medi-Cal product; (iii) PPG is compensated on a fee-for-service basis; (iv) Health Net gives the PPG a minimum of ninety (90) business days' notice of its intent to amend the Agreement; (v) PPG has the right to exercise its intent to negotiate and agree to the amendment within thirty (30) business days of PPG's receipt of the notice of amendment; and (vi) PPG has the right to terminate the Agreement within ninety (90) business days from the date of receipt of such notice if PPG does not exercise the right to negotiate the amendment and no agreement is reached. In such event, the amendment becomes effective ninety (90) days from the date of the notice set forth in this paragraph if PPG does not exercise its right to negotiate the amendment or to terminate the Agreement as described in this paragraph.

**6. Assignment and Delegation.** Assignment or delegation of an obligation or responsibility under the Agreement shall be void unless prior written approval is obtained from the DHCS in those instances where prior approval by the DHCS is required. In addition, any assignment or delegation of an obligation or responsibility under the Agreement by PPG shall be void unless prior written approval is obtained from Health Net.

7. **Local Health Department Coordination.** As more fully set out in the Medi-Cal Agreement, Health Net or a contracting Medi-Cal plan has (or will) entered into agreements for specified public health services with certain county health departments. The public health agreements specify the scope and responsibilities of the local health departments and Health Net, billing, and reimbursements, reporting responsibilities, and medical record management to ensure coordinated health care services. The public health services specified under the agreements are as follows:

7.1 Family planning services.

7.2 Sexually transmitted disease ("STD") services diagnosis and treatment of disease episode of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale.

7.3 Confidential HIV testing and counseling.

7.4 Immunizations.

7.5 California Children Services.

7.6 Maternal and Child Health.

7.7 Refugee assessments.

7.8 Tuberculosis Direct Observed Therapy.

7.9 Women, Infants, and Children Supplemental Food Program.

7.10 Population based Prevention Programs: collaborate in local health department community-based prevention programs.

PPG shall, in accordance with the terms and conditions of the public health agreements with the local health departments and Health Net's related policies and procedures, be responsible for the coordination and arrangement of the public health services for its assigned Beneficiaries. The services specified in Sections 7.1 through 7.4 above require reimbursement to the applicable local health department. The services specified in Sections 7.5 through 7.10 above do not require reimbursement to the applicable local health department. [Medi-Cal Agreement]

8. **Provider Certification.** PPG is certified to participate in Medicaid/Medi-Cal under Title XIX of the Social Security Act or other applicable State law pertaining to Title XIX of the Social Security Act.

9. **Provider Preventable Conditions.** Health Net and PPG shall comply with the Patient Protection and Affordable Care Act (PPACA), as amended, including any reporting requirements and non-payment for Provider Preventable Conditions. PPG shall comply with Health Net's Policies regarding any reporting requirements and non-payment for Provider Preventable Conditions.

10. **Reviews and/or Investigations.** Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the PPG from participation in the Medi-Cal program; seek recovery of payments made to the PPG; impose other sanctions provided under the State Plan, and direct Health Net to terminate PPG's Agreement due to fraud.

**11. Coordination of Care.** To the extent that PPG is responsible for the coordination of care for Beneficiaries, Health Net shall share with PPG any utilization data that DHCS has provided to Health Net to use for the purpose of Beneficiary care coordination.

**12. Prospective Requirements.** Health Net shall inform PPG of prospective requirements added by DHCS to the agreement between Health Net and DHCS, before the effective date of such requirements. PPG agrees to comply with any changes to such requirements within thirty (30) days of the effect of said requirements from DHCS, unless DHCS instructs otherwise and to the extent possible. PPG shall ensure the same notice is provided to its subcontractors within the same timelines.

**13. PPG Network Requirements.** PPG acknowledges that, in the event PPG does not have, within its network, sufficient coverage, or is unable to meet service requirements of Health Net's Beneficiaries, PPG agrees to authorize, permit and/or refer Beneficiaries to any provider outside PPG's network regardless of affiliation to PPG. PPG shall not use any administrative subcontractors, including, but not limited to, any Administrative Services Organizations, ("ASO") to restrict an assigned Health Net Beneficiary's right to obtain services outside the PPG's network, when PPG's network is inadequate to meet the service requirements of such Health Net Beneficiaries. Furthermore, in the event PPG's network is determined, by Health Net, to be inadequate or that PPG is unable to provide the services that PPG is required to and/or contracted to render to Health Net Beneficiaries, Health Net shall impose any of the following:

- a) require PPG to meet and comply with a Corrective Action Plan, ("CAP").
- b) impose sanctions, including monetary penalties or reductions in payments
- c) as required by DHCS, submit a report of such Provider network inadequacy, to the DHCS.

**14. Emergency Service Providers.** Health Net is responsible for coverage and payment of emergency services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has an agreement with Health Net. Post-stabilization care services following an emergency inpatient admission are covered and paid for in accordance with provisions set forth in 42 CFR 422.113 (c) .

**15. PPG's Performance.** This Agreement is subject to termination, actions, fines, and/or penalties, if DHCS or Health Net determine that PPG has not performed satisfactorily.

**16. Suspected Fraud, Waste, or Abuse.** PPG must notify Health Net, and Health Net Subcontractors or Downstream Subcontractors PPG also contracts with, within ten (10) business days of any suspected Fraud, Waste, or Abuse. Health Net shall share such information with DHCS in accordance with the Medi-Cal Agreement.

**17. Emergency Preparedness.** PPG shall i.) annually submit to Health Net evidence of adherence to CMS Emergency Preparedness Final Rule 81 FR 63859; ii.) advise Health Net as part of PPG's Emergency plan; and iii.) notify Health Net within 24 hours of an Emergency if PPG closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency. Emergency for purposes of this section shall include any natural or manmade disaster or public health crisis.

**18. DHCS Enforcement.** PPG acknowledges and agrees, and shall require its downstream subcontractors to do the same, that DHCS is a direct beneficiary of this Agreement and PPG's downstream subcontractor agreements with respect to all obligations and functions undertaken pursuant to all such agreements, and that DHCS may directly enforce any and all provisions of the agreements.

**19. Quality Improvement and Health Equity.** In the event Health Net desires and PPG accepts delegation of Quality Improvement (QI) and/or Health Equity responsibilities, the parties shall mutually agree on the following in writing:

- 1) QI or Health Equity responsibilities, and specific subcontracted functions and activities of PPG and applicable PPG Downstream Subcontractor;
- 2) The schedule for Health Net's ongoing oversight, monitoring, and evaluation of PPG and applicable PPG Downstream Subcontractor, including quarterly reporting and an annual review of PPG and applicable PPG Downstream Subcontractor's performance;
- 3) PPG and applicable PPG Downstream Subcontractor's reporting requirements and Health Net's approval procedure of PPG and applicable PPG Downstream Subcontractor's reports;
- 4) PPG and applicable PPG Downstream Subcontractor's obligation to report findings and actions of QI or Health Equity activities at least quarterly to Health Net; and
- 5) Health Net's actions and remedies if PPG and applicable PPG Downstream Subcontractor's obligations are not satisfactorily performed.

**EXHIBIT C-2**

**MEDI-CAL BENEFIT PROGRAMS  
CAPITATION RATE EXHIBIT**

**MEDI-CAL BENEFIT PROGRAMS:**

1. **CAPITATION.** PPG shall accept the following Medi-Cal Capitation Payments as payment in full from Health Net for PPG Capitated Services provided to Medi-Cal HMO Beneficiaries including SPD Beneficiaries, assigned to PPG based upon the six Categories of Aid ("COA") listed below (Family/Adult, Aged/Disabled (SPD), Aged-Dual Eligible, Disabled-Dual Eligible/MCE-Dual Eligible, BCCTP, and MCE) and as set forth in the Medi-Cal Agreement.

**NOTE TO NEGOTIATOR: Please work with Finance to determine whether Age/Gender or Flat Rates would be more ideal for your PPG.**

Flat Rates

<u>Category of Aid (COA)</u>	<u>Professional Capitation Rates (PMPM)</u>
Aged- Dual Eligible	\$xx.xx PMPM
Disabled-Dual Eligible/MCE-Dual Eligible	\$xx.xx PMPM
BCCTP	\$xx.xx PMPM
MCE	See age/gender chart below
Family/Adult – Child (0-18)	\$xx.xx PMPM
Family/Adult– Adult (19+)	\$xx.xx PMPM
Aged/Disabled (SPD) – Child (0-18)	\$xx.xx PMPM
Aged/Disabled (SPD) – Adult (19+)	\$xx.xx PMPM

Predominately Age/Gender Rates

<u>Category of Aid (COA)</u>	<u>Professional Capitation Rates (PMPM)</u>
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Aged- Dual Eligible	<b>\$xx.xx PMPM</b>
Disabled-Dual Eligible/MCE-Dual Eligible	<b>\$xx.xx PMPM</b>
BCCTP	<b>\$xx.xx PMPM</b>
MCE	See age/gender chart below
Family/Adult	See age/gender chart below
Aged/Disabled (SPD)	See age/gender chart below

<b>Aid Group - MCE</b>		
<b>Age</b>	<b>Gender</b>	<b>Professional Capitation Rates (PMPM)</b>
19-24	Male	
19-24	Female	
25-34	Male	
25-34	Female	
35-44	Male	
35-44	Female	
45-54	Male	
45-54	Female	
55+*	Male	
55+*	Female	

**\*Members 65 years of age and older will eventually be moved by DHCS to another Category of Aid (e.g. Dual Eligible or Aged/Disabled (SPD))**

<b>Aid Group- Family/Adult Rates</b>		
<b>Age</b>	<b>Gender</b>	<b>Professional Capitation Rates (PMPM)</b>
Under 1	Combined	
1	Combined	
2-4	Combined	
5-14	Combined	
15-18	Male	
15-18	Female	
19-34	Male	
19-34	Female	
35-44	Male	
35-44	Female	
45+	Male	

45+	Female	
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Aid Group-Aged/Disabled (SPD)		
Age	Gender	Professional Capitation Rates (PMPM)
0	Combined	
1-14	Combined	
15-21	Combined	
22-30	Combined	
31-44	Male	
31-44	Female	
45-54	Male	
45-54	Female	
55-64	Male	
55-64	Female	
65+	Combined	

**(Note to Negotiator: Select one of the two Options below)**

**Medi-Cal Primary Hospital: [OPTIONAL]**

**Medi-Cal Shared Risk Budget: [OPTIONAL]**

**Category of Aid (COA)**

**Shared Risk Budget**

Family/Adult	\$.00 Per Medi-Cal HMO Beneficiary Per Month (“PMPM”)
Aged/Disabled	\$.00 Per Medi-Cal HMO Beneficiary Per Month (“PMPM”)
Aged- Dual Eligible	\$.00 Per Medi-Cal HMO Beneficiary Per Month (“PMPM”)
Disabled- Dual Eligible/MCE-Dual Eligible	\$.00 Per Medi-Cal HMO Beneficiary Per Month (“PMPM”)
BCCTP	\$.00 Per Medi-Cal HMO Beneficiary Per Month (“PMPM”)
MCE	\$.00 Per Medi-Cal HMO Beneficiary Per Month (“PMPM”)

**PPG SERVICE AREA: 30 air miles from Medi-Cal HMO Beneficiary’s PCP office.**

## 2. MATERNITY PAYMENT FOR SELECT CATEGORIES OF AID.

**Note to Negotiator: If including Maternity Payments, you must notify Anuj Kalra as soon as possible.**

Health Net will pay PPG Eight hundred dollars (\$800.00) per Maternity event for the professional component of the delivery for [Family/Adult] Medi-Cal Beneficiaries, and One thousand twenty-five dollars (\$1,025.00) for [MCE] Medi-Cal Beneficiaries who are enrolled with PPG on the date of delivery of a child, which includes any retroactive enrollments. PPG shall submit complete Maternity Event encounter information according to Health Net Policies in order to qualify for reimbursement. Incomplete or late PPG submissions that cannot be used to submit to DHCS for reimbursement will not qualify for payment.

### **Definitions:**

a. For purposes related to PPG's Maternity Payment, the Reconciliation Period shall be defined as a calendar month.

b. Maternity Event means a live birth that generates a Vital Record for the State and does not include multiple births and for which Health Net has been paid by the State for such delivery.

### **Administration:**

At the end of each Reconciliation Period, Health Net shall calculate the total amount due PPG for each Maternity Event for applicable Medi-Cal Beneficiaries enrolled with the PPG. Health Net shall pay PPG on a monthly basis as a line-item adjustment on the following month's capitation payment made to PPG.

## 3. MEDICAL LOSS RATIO (MLR) TARGETS

The parties acknowledge that DHCS has implemented or is implementing several changes impacting program funding. Changes include, but are not limited to, adoption of a new encounters-based risk adjustment methodology, incorporating quality measures into the rate setting process, continuing the application of efficiency factors into the rate setting process, and remittance requirements for risk bearing entities whose MLR falls below specific targets. The parties agree to amend terms to incorporate changes once Health Net has finalized the updated contract provisions aligned with changes from DHCS.

**EXHIBIT C-3**

**DIVISION OF FINANCIAL RESPONSIBILITY  
MATRIX OF HEALTH NET, PPG, AND SHARED RISK/HOSPITAL CAPITATED  
SERVICES  
MEDI-CAL BENEFIT PROGRAMS**

The following matrix outlines the Division of Financial Responsibility between Health Net and PPG. The matrix is intended only as a summary guide. The DOFR applies only to Covered Services and does not address any supplement or rider a Beneficiary may have. The applicable Benefit Program shall determine Covered Services. Unless otherwise stated as Out of Area in this matrix, all services are intended as In Area (within the Service Area).

**California Children’s Services (CCS).** CCS covers medically necessary services for specific physically disabling diagnoses for children. Any services outlined in the Division of Financial Responsibility are potentially California Children’s Services (CCS) eligible services depending on a child’s diagnosis. CCS eligible services are excluded from Health Net Risk Services. PPG and Professional Providers are responsible for identifying and timely referring possible CCS eligible conditions to the County CCS Program as further described in Exhibit C-1. The services identified in this Division of Financial Responsibility as being a CCS Carve-out are a guideline only to indicate services commonly covered by CCS. These and all other services may be possible CCS eligible depending on the diagnosis, treatment, or other circumstances as determined by CCS.

<b>CATEGORY OF SERVICE</b>	<b>PPG RISK SERVICES</b>	<b>HEALTH NET RISK SERVICES</b>	<b>HOSPITAL/SHARED RISK SERVICES</b>
<b>ABORTION</b> - Facility Component** - Professional Component**	X		X
<b>ACUPUNCTURE</b>		X	
<b>AIDS</b> - Facility Component** - Professional Component**	X		X
<b>ALLERGY TESTING</b>	X		
<b>ALLERGY TREATMENT AND SERUM</b>	X		
<b>AMBULANCE</b> - In Area (30-mile radius) - Out of Area		X	X
<b>AMNIOCENTESIS TESTING</b> - Facility Component - Professional Component	X		X
<b>ANESTHESIA, Outpatient</b> - Facility Component - Professional Component	X		X
<b>APNEA MONITOR</b>			X
<b>BIOFEEDBACK</b>	X		
<b>BLOOD / BLOOD PRODUCTS</b> - Blood Bank - Hemophilia related Blood Factors - Storage and Collection of Blood - Transfusion Autologous/Homologous			X Medi-Cal Rx Pharmacy Only X X

CATEGORY OF SERVICE	PPG RISK SERVICES	HEALTH NET RISK SERVICES	HOSPITAL/SHARED RISK SERVICES
<b>BURN CARE</b> - Facility Component - Professional Component	X		X
<b>CALIFORNIA CHILDREN'S SERVICES (CCS)</b>	NOT COVERED UNDER THIS AGREEMENT		
<b>CHEMICAL DEPENDENCY – Acute Inpatient Overdose Treatment</b> - Facility Component - Professional Component	X		X
<b>CHEMICAL DEPENDENCY DETOX</b> - Inpatient Detox Facility Component - Inpatient Detox Professional Component	X		X
<b>CHEMICAL DEPENDENCY REHAB</b> - Inpatient Facility Component - Inpatient Professional Component - Outpatient Facility Component - Outpatient Professional Component		X X X X	
<b>CHEMOTHERAPY</b> - Drugs, including Epogen, Neupogen and adjunctive therapies, Outpatient *** - Facility Component, Inpatient including Drugs - Facility Component, Outpatient - Professional Component	X X		X X*
<b>CHIROPRACTIC</b> - Covered in FQHC or RHC setting only	X		
<b>CLINIC VISITS</b> – Non-urgent, Outpatient, Facility & Professional (includes Telehealth)	X		
<b>COLOSTOMY SUPPLIES</b> - Outpatient Dispensing	X		
<b>CONSULTATIONS</b> - Professional Component	X		
<b>CONSULTATIONS, PHARMACIST</b> In Plan & Self-Referral to Out of Plan Provider (Naloxone, Nicotine)	X		
<b>COSMETIC SURGERY – Medically Necessary</b> - Facility Component			X
<b>COSMETIC SURGERY – Medically Necessary</b> - Professional Component	X		
<b>CRITICAL CARE VISITS</b> - Professional Component	X		
<b>DENTAL SERVICES</b> (when a covered benefit) - Facility Component - Professional Component	X		X
<b>DIAGNOSTIC TESTING – Outpatient Facility or Home</b> - Facility Component - Professional Component	X X		
<b>DIAGNOSTIC TESTING, Office</b> - Facility & Professional Component	X		

CATEGORY OF SERVICE	PPG RISK SERVICES	HEALTH NET RISK SERVICES	HOSPITAL/SHARED RISK SERVICES
<b>DIAGNOSTIC ENDOSCOPIC TESTING,</b> Outpatient - Facility Component - Professional Component	X X		
<b>DIALYSIS, Inpatient</b> - Facility Component			X*
<b>DIALYSIS, Outpatient</b> - Facility Component	X*		
<b>DIALYSIS</b> - Professional Component	X*		
<b>DRUGS AND SUPPLIES BILLED BY PHARMACY OR SPECIALTY PHARMACY INCLUDING BUT NOT LIMITED TO:</b> <ul style="list-style-type: none"> <li>• Diabetic supplies, test strips, lancets, syringes</li> <li>• Factor (Hemophilia related)</li> <li>• Blood Glucose Monitors</li> <li>• Oral</li> <li>• Topical</li> </ul>	NOT COVERED BY THIS DOFR. MEDI-CAL RX PHARMACY ONLY		
<b>DURABLE MEDICAL EQUIPMENT (DME)</b> - Outpatient Dispensing			X
<b>ELECTRO CONVULSIVE THERAPY</b> - Facility Component - Professional Component		X X	
<b>EMERGENCY ROOM ADMISSIONS – In Area</b> - Facility Component			X
<b>EMERGENCY ROOM ADMISSIONS – In Area</b> - Professional Component	X		
<b>EMERGENCY ROOM ADMISSIONS - Out of Area</b> - Facility Component		X	
<b>EMERGENCY ROOM ADMISSIONS - Out of Area</b> - Professional Component		X	
<b>EMERGENCY ROOM VISITS - In Area</b> - Facility Component			X
<b>EMERGENCY ROOM VISITS - In Area</b> - Professional Component	X		
<b>EMERGENCY ROOM VISITS - Out of Area</b> - Facility Component		X	
<b>EMERGENCY ROOM VISITS - Out of Area</b> - Professional Component		X	
<b>ENDOSCOPIC SURGICAL / THERAPEUTIC STUDIES, Outpatient</b> - Facility Component - Professional Component	X		X
<b>ENTERAL THERAPY ***</b>			X
<b>EPSDT “BASIC” SERVICES</b>	X		

CATEGORY OF SERVICE	PPG RISK SERVICES	HEALTH NET RISK SERVICES	HOSPITAL/SHARED RISK SERVICES
<b>(e) EPSDT SUPPLEMENTAL SERVICES</b> when medically necessary, Professional Component	X		
<b>(e) EPSDT SUPPLEMENTAL SERVICES</b> (e.g. private duty nursing) when medically necessary, Ancillary Services			X
<b>FAMILY PLANNING - In Plan &amp;- Self-Referral to Out of Plan Provider</b> - Facility Component**			X
<b>FAMILY PLANNING - In Plan &amp;- Self-Referral to Out of Plan Provider</b> - Professional Component**	X		
<b>FAMILY PLANNING, Contraceptives</b> Injectables ***	X		
<b>FAMILY PLANNING, (excludes IUDs) – Contraceptives ***</b> - Outpatient/Office**	X		
<b>GENETIC TESTING</b> - Outpatient	X		
<b>GROWTH HORMONES ***</b>	X		
<b>HEARING AIDS</b>			X
<b>HEARING SCREENING</b>	X		
<b>HIV TESTING &amp; COUNSELING **</b>	X		
<b>HOME HEALTH INFUSION ADMINISTRATION, EXCLUDING DRUGS</b>			X
<b>HOME HEALTH INFUSION DRUGS ***</b>			X
<b>HOME HEALTH SERVICES (not infusion)</b>			X
<b>HOME VISITS</b>	X		
<b>HOSPICE CARE</b> - Facility Component			X
<b>HOSPICE CARE</b> - Professional Component	X		
<b>HOSPITAL BASED PHYSICIANS</b>	X		
<b>HYPERBARIC OXYGEN TREATMENT, Outpatient Facility</b> - Facility Component			X
<b>HYPERBARIC OXYGEN TREATMENT, Outpatient Facility</b> - Professional Component	X		
<b>IMMUNIZATIONS, Adult – COVID-19</b>	X		
<b>IMMUNIZATIONS – Adult ***</b> - In Plan & Self-Referral to Out of Plan Provider	X		
<b>IMMUNIZATIONS, Pediatric – COVID-19</b>	X		
<b>IMMUNIZATIONS –Pediatric***</b> - In Plan & Self-Referral to Out of Plan Provider	X		
<b>IMMUNIZATIONS, Hepatitis B ***</b> - In Plan & Self-Referral to Out of Plan Provider	X		
<b>IMPLANTS, SURGICAL</b>			X
<b>INDIAN HEALTH CLINIC SERVICES</b> -Self-Referral to Out of Plan Provider	X		

CATEGORY OF SERVICE	PPG RISK SERVICES	HEALTH NET RISK SERVICES	HOSPITAL/SHARED RISK SERVICES
<b>INFUSION THERAPY ADMINISTRATION,</b> Outpatient Facility , excluding drugs			X
<b>INHALATION DRUGS,</b> Office, or Clinic***	X		
<b>INJECTABLES, SELF ***</b>	X		
<b>LABORATORY TESTS,</b> Inpatient – Professional Component	X		
<b>LITHOTRIPSY</b> - Facility Component - Professional Component	X*		X*
<b>LOCAL EDUCATION AGENCY (LEA) ASSESSMENT SERVICES</b>	X		
<b>LOCAL EDUCATION AGENCY (LEA)</b> pursuant to Individualized Education Plan/Individualized Family Service Plan	X		
<b>MATERNITY/OBSTETRICAL SERVICES,</b> Deliveries & Non-Deliveries – Inpatient - Facility Component			X
<b>MATERNITY/OBSTETRICAL SERVICES -</b> Non-Deliveries – Outpatient, includes Fetal Non- Stress testing - Facility Component	X		
<b>MATERNITY/OBSTETRICAL SERVICES –</b> Deliveries & Non-Deliveries - Professional Component	X		
<b>MEDICAL ADMISSIONS -</b> In Area and Non- Emergency Out of Area - Facility Component - Professional Component	X		X
<b>MENTAL HEALTH –</b> Inpatient - Facility Component - Professional Component		X X	
<b>MENTAL HEALTH –</b> Outpatient - Facility Component - Professional Component		X X	
<b>NURSE MIDWIVES-</b> In or Out of Plan	X		
<b>NUTRITION/DIET COUNSELING</b>	X		
<b>OBSERVATION CARE, DIRECT ADMISSION –</b> Outpatient Facility (1) - Facility Component - Professional Component	X		X
<b>OFFICE VISITS</b> (includes Telehealth)	X		
<b>OUTPATIENT FACILITY SERVICES / TECHNICAL COMPONENT</b> Not listed elsewhere on DOFR			X
<b>PAIN MANAGEMENT</b> - Outpatient	X		
<b>PATHOLOGY –</b> Inpatient, Ambulatory Surgery or Emergency Room - Professional Component - Technical Component	X		X

CATEGORY OF SERVICE	PPG RISK SERVICES	HEALTH NET RISK SERVICES	HOSPITAL/SHARED RISK SERVICES
<b>PATHOLOGY &amp; LABORATORY SERVICES</b> – Mobile (including in the home) - Professional Component - Technical Component	X X		
<b>PATHOLOGY &amp; LABORATORY SERVICES</b> –Office	X		
<b>PATHOLOGY &amp; LABORATORY SERVICES</b> - Outpatient (Includes Pre-Admission Tests within 72 hrs. of related admission) - Professional Component - Technical Component	X X		
<b>PATHOLOGY &amp; LABORATORY SERVICES</b> , Outpatient, Office, Mobile, Home (COVID-19 testing, including specimen collection) ** - Professional Component - Technical Component	X X		
<b>PERIODIC EXAMS</b>	X		
<b>PHYSICIAN VISITS</b> – Inpatient, Outpatient, SNF, Office, Patient’s home	X		
<b>PODIATRY SERVICES</b>	X		
<b>PROFESSIONAL SERVICE / TECHNICAL &amp; PROFESSIONAL COMPONENT</b> Not listed elsewhere on DOFR	X		
<b>PROSTHETICS/ORTHOTICS DEVICES</b> - Inpatient - Surgically Implanted			X X
<b>PROSTHETICS/ORTHOTICS</b> - Outpatient Dispensing	X		
<b>RADIATION THERAPY</b> - Facility Component			X
<b>RADIATION THERAPY</b> - Professional Component	X		
<b>RADIOLOGY</b> – Inpatient, Ambulatory Surgery or Emergency Room - Professional Component - Technical Component	X		X
<b>RADIOLOGY</b> – Office	X		
<b>RADIOLOGY</b> – Outpatient (Includes Pre-Admission Tests within 72 hrs. of related admission) - Professional Component - Technical Component	X X		
<b>RADIOLOGY</b> -Mobile (including in the home) <sup>2</sup> - Professional Component - Technical Component	X X		
<b>RECONSTRUCTIVE SURGERY</b> - Facility Component - Professional Component	X		X

CATEGORY OF SERVICE	PPG RISK SERVICES	HEALTH NET RISK SERVICES	HOSPITAL/SHARED RISK SERVICES
<b>SEXUALLY TRANSMITTED DISEASE ORAL DRUG TREATMENT** ***</b>	X		
<b>SKILLED NURSING FACILITY</b> – includes Ancillary Services while Hospitalized - Facility Component			X
<b>SKILLED NURSING FACILITY</b> - Professional Component	X		
<b>SPEECH AND HEARING EXAMS, includes</b> Speech Pathology Services	X		
<b>SUPPLIES-INCONTINENCE MEDICAL</b> (e.g.: ointments, creams, garments, briefs, or diapers)	X		
<b>SUPPLIES- Medical, Surgical</b> - Related to a Hospital Stay - Related to Outpatient, Office & Home	X		X
<b>SUPPLIES, DIABETIC</b> - Chem. Strips, Lancet, Needles, Syringes - Blood Glucose Monitor	NOT COVERED BY THIS DOFR. MEDI-CAL RX PHARMACY ONLY		
<b>SURGERY</b> - Office	X		
<b>SURGERY</b> - Professional Component	X		
<b>SURGERY, Inpatient</b> - Facility Component			X
<b>SURGERY</b> – Outpatient Ambulatory Surgery Center or Hospital - Outpatient Facility Component (includes supplies)			X
<b>THERAPEUTIC INJECTABLE AND IMPLANTABLE MEDICATION ***</b> - Equal or less than \$250.00 cost per dose - More than \$250.00 cost per dose	X X		
<b>THERAPY/REHABILITATION:</b> includes Physical, Occupational, Respiratory, Speech, and Cardiac Rehab) - Inpatient - Outpatient/Office	X		X
<b>TRANSGENDER, INJECTABLE, AND IMPLANTABLE MEDICATION ***</b> - Hormones (Pre & Post Op)		X	
<b>TRANSGENDER SERVICES</b> - Non-Medical Cosmetic Procedures - Pre-Op MD Consults - Psychiatric Pre-Op Evaluation - Voice Therapy, Professional		X X X X	
<b>TRANSGENDER SURGERY</b> – Complete and Partial InterSex Reassignment Procedures - Facility Component Inpatient & Outpatient (includes preadmission testing at the same facility within 72 hours of admission) - Professional Component		X  X	

CATEGORY OF SERVICE	PPG RISK SERVICES	HEALTH NET RISK SERVICES	HOSPITAL/SHARED RISK SERVICES
<b>TRANSPLANTS (Non-experimental)</b> - Drugs (Immunosuppressive, stem cell mobilizers, G-CSF) *** - Facility Component - Organ Procurement - Professional Component		X  X X X	
<b>TRANSPLANT EVALUATIONS</b> - Facility Component - Professional Component		X X	
<b>TRANSPORTATION – MEDICAL NON-EMERGENCY</b> (Transportation via Gurney or Litter Van and/or Wheelchair van)		X	
<b>TRANSPORTATION – NON-MEDICAL</b> (Transportation to medical services by car, taxi, or other forms of public/private conveyances)		X	
<b>URGENT CARE SERVICES – In Area</b> - Facility and Professional	X		
<b>URGENT CARE SERVICES – Out of Area</b> - Facility and Professional		X	
<b>VISION CARE – Eye Exams for Non-Refractive Diagnoses</b>	X		
<b>VISION CARE – Eye Exams for Refractive Diagnoses</b>	X		
<b>VISION CARE: Implanted Intraocular Lenses</b>			X
<b>WELL BABY EXAMS</b>	X		
(e) EPSDT Supplemental Services related to Alcohol and Drug Treatment, Mental Health, and Dental Services are not covered under this Agreement.			

**\*CCS (California Children's Services).** PPG is responsible for timely referral of children with potential CCS eligible conditions. Failure to appropriately refer will result in PPG assuming financial responsibility for any related charges. PPG shall not seek reimbursement for such services from Health Net.

\*\*Sensitive Service – Please refer to Exhibit C-1. Section B, Duties of PPG, 16 Sensitive Services.

\*\*\* Excludes drugs or medical supplies that are billed on pharmacy claims, i.e. all self-administered drugs (oral, injectable, topical), physician administered, or medical supplies billed by a pharmacy. These excluded drugs or medical supplies should be billed to the Medi-Cal Rx Pharmacy Benefit Manager (PBM), Magellan or its successor. Drugs or medical supplies billed by a provider on a medical claim are processed according to the DOFR category.

**Footnote: NOTE TO NEGOTIATOR - RADIOLOGY AND PATHOLOGY SHOULD HAVE THE SAME RISK**

**Long Term Care (LTC)**

CATEGORY OF SERVICE	PPG RISK SERVICES	HEALTH NET RISK SERVICES	HOSPITAL/ SHARED RISK SERVICES
<b>LONG TERM CARE<sup>¶</sup>- SUB ACUTE</b> - Facility Component (Medi-Cal) - Professional Component (Medi-Cal)	X	X	
<b>LONG TERM CARE<sup>¶</sup> SKILLED NURSING Includes Bed Hold and LOA<sup>3</sup></b> - Facility Component (Medi-Cal Level B) -Professional Component (Medi-Cal Level B)	X	X	
<b>LONG TERM CARE<sup>¶</sup>NON-SKILLED NURSING Includes Bed Hold and LOA<sup>3</sup></b> -Facility Component (Medi-Cal Level A) -Professional Component (Medi-Cal Level A)	X	X	

<sup>¶</sup>Long Term Care Facility-based Medi-Cal covered services are Health Net financial responsibility.

Footnote (3): Incontinence supplies and Enteral nutrition products provided to patients in a Nursing Facility Level A (NF-A), Nursing Facility Level B (NF-B) are reimbursed as part of the facility's daily rate

**Hospice Long Term Care (LTC) Room and Board**

CATEGORY OF SERVICE	PPG RISK SERVICES	HEALTH NET RISK SERVICES	HOSPITAL/ SHARED RISK SERVICES
<b>HOSPICE LTC – Facility Component (Medi-Cal Level A &amp; B)</b>		X	

**In-Home Supportive Services (IHSS)**

CATEGORY OF SERVICE	PPG RISK SERVICES	HEALTH NET RISK SERVICES	HOSPITAL/ SHARED RISK SERVICES
<b>In-Home Supportive Services (IHSS)</b>		X	

**Community Based Adult Services (CBAS)**

CATEGORY OF SERVICE	PPG RISK SERVICES	HEALTH NET RISK SERVICES	HOSPITAL/ SHARED RISK SERVICES
<b>Community Based Adult Services (CBAS)</b>		X	

**Multi-Purpose Senior Services Program (MSSP):**

CATEGORY OF SERVICE	PPG RISK SERVICES	HEALTH NET RISK SERVICES	HOSPITAL/ SHARED RISK SERVICES
<b>Multi-Purpose Senior Services Program (MSSP)</b>		X	

(1). Observation Care shall be consistent with CMS guidelines related to payment for hospital Outpatient Prospective Payment for Direct to Observation admissions and InterQual criteria. Observation Care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be

discharged from the hospital. Observation Services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. When direct admission to Observation is ordered for patients who do not present through the emergency department the same purpose is applied that the member require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. The Observation Services of short-term treatment, assessment and reassessment in an outpatient facility unit must be reasonable and necessary and meet the minimum severity and purpose described under CMS guidelines to be covered. All direct to observation admissions must have PPG authorization and on-going care management. Any service such as laboratory, radiology or diagnostic testing that can safely be performed in an outpatient facility or office, in absence of the observation component, are excluded from the observation category under this Agreement. Any direct to observation admissions that do not meet CMS guidelines will be classified under the DOFR as the applicable DOFR category within the PPG's PPA, e.g. diagnostic testing, lab or radiology and have the corresponding financial risk owner. The decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient should usually be made in less than 24 hours. For any direct to observation admission greater than 24 hours, PPG must notify Health Net consistent with the notification requirements for an inpatient admission. For the purposes of the DOFR, Observation Care, Direct Admission, OP Facility does not include the care performed within an emergency area or emergency related holding unit or post-operative care and should not be used for services that should be performed in an inpatient setting.

**EXHIBIT C-4**

**MEDI-CAL BENEFIT PROGRAMS  
DISCLOSURE FORM**

(Required by California Welfare and Institutions Code Section 14452)

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency.

- 1) the identity of all owners with a control interest of five (5) percent or greater,
- 2) certain business transactions as described in 42 CFR 455.105, and
- 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity.

If there are any changes to the information disclosed in this form, an updated form should be completed and submitted to Health Net Community Solutions, Inc. within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you:		
<input type="checkbox"/> Individual		
<input type="checkbox"/> Group Practice		
<input type="checkbox"/> Disclosing Entity		
Name of Individual, Group Practice, or Disclosing Entity		
DBA Name		
Federal Tax Identification Number	NPI	CAQH Number

Section I

Please list the name, title address, date of birth, and Social Security Number for each individual having an ownership or control interest in this provider of five (5) percent or greater.			
Please list the name, Tax Identification Number, business address or each organization, corporation, or entity having an ownership or control interest of five (5) percent or greater. (42 CFR 455.104) Please attach a separate sheet if necessary.			
Name of individual or entity	DOB	Address	SSN (for individual) or TIN (for entity)

Section II

Are any of the individuals listed in Section one related to each other?

Yes  
 No

If yes, list the individual's name above who are related to each other (spouse, sibling, parent, child). 42 CFR 455.104

Name	Relationship

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of five (5) percent or more?

Yes  
 No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of five (5) percent or more. 42 CFR 455.104

Name of individual or entity	DOB	Address	SSN (for individual) or TIN (for entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program?

Yes  
 No

If yes, list those persons below. 42 CFR 455.106

Name and Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than \$25,000 or any significant business transactions with any subcontractors?

Yes  
 No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than \$25,000 during the previous twelve (12) month period; and any significant business transactions between this

provider and any wholly owned supplier, or between the provider and any subcontractor, during the past five (5) year period. 42 CFR 455.105		
Name of Supplier or Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information) as a Disclosing Entity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date or birth, Address, Social, Security Number, and percent of interest.				
Name and Title	DOB	Address	SSN	% of Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

\_\_\_\_\_

Signature Title (indicate if authorized Agent)

\_\_\_\_\_

Name (please print) Date

**EXHIBIT C-5**

**MEDI-CAL BENEFIT PROGRAMS  
PPG FEE-FOR-SERVICE RATE EXHIBIT**

Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Exhibit C-6, Health Net shall pay, and PPG shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered pursuant to this Addendum, the lesser of: (i) the rates listed below, or (ii) 80% - 100% of PPG's Allowable Charges.

<b>Category of Service</b>	<b>Compensation</b>
Covered Services delivered or arranged by PPG	100% of the State of California Medi-Cal Fee Schedule rates  <b>Maximum rate is 100%; rates greater than 100% of State Medi-Cal fee schedule or any rates based on other reimbursement methodology require approval from State Health Programs Director</b>
Pharmaceuticals Without an established Medi-Cal Value	Average Wholesale Price (AWP) – 18%
Immunizations Without an established Medi-Cal Value	Average Wholesale Price (AWP) – 18%
Durable Medical Equipment/Medical Supplies without an established Medi-Cal Value	15% of covered Allowable Charges, not to exceed \$500 per item.
By Report (BR) Procedures and Procedures not Listed -Procedures with Medi-Cal Units not Established but with a Medicare Value  -Procedures without Medi-Cal Units or a Medicare Established Value	80% of the Current Medicare Allowable  15% of PPG's Allowable Charges

## EXHIBIT C-6

### **PARTICIPATING PHYSICIAN GROUP (PPG) FEE-FOR-SERVICE PAYMENT CONDITIONS**

The Payment Conditions set forth in this Addendum supplement Health Net Policies and are applicable to Medi-Cal Benefit Programs.

1. The codes listed in the applicable Rate Exhibit shall be used by the parties for the purpose of defining the services for which payment will be made under this Agreement. PPG shall utilize the specified codes listed in the applicable Rate Exhibit when submitting Complete Claims for Covered Services under this Agreement.

2. The parties acknowledge that applicable coding agencies periodically issue coding modifications. Such modifications may be implemented by Health Net within sixty (60) days of the date Health Net receives the modification from the applicable coding agency or notification from PPG. The parties agree that in the event such coding modifications have the effect of changing a payment amount in this Agreement, the resulting payment amount change shall be effective on a prospective basis. The parties further agree to reasonably and in good faith discuss any contract rate amendment that may be appropriate based on comprehensive and substantive coding changes by the applicable coding agency within ninety (90) days of written notification by either party. Any and all rate modifications that may result from such contract amendment shall be effective on a prospective basis.

3. PPG shall utilize valid CPT/HCPCS/NDC/ICD diagnosis codes, or successor codes, when submitting Complete Claims for Covered Services under this Agreement. The parties acknowledge that applicable coding agencies periodically issue coding modifications. Such modifications may be implemented by Health Net within sixty (60) days of the date Health Net receives the modification from the applicable coding agency. The parties agree that in the event such coding modifications have the effect of changing a payment amount in this Agreement, the resulting payment amount change shall be effective on a prospective basis. The parties further agree to reasonably and in good faith discuss any contract rate amendment that may be appropriate based on comprehensive and substantive coding changes by the applicable coding agency within ninety (90) days of written notification by either party. Any and all rate modifications that may result from such contract amendment shall be effective on a prospective basis.

4. Pharmaceuticals shall include inhaled/infused/injected medications provided by and delivered in PPG/Professional Provider office. Support drugs and injection supplies for patient self-administered injections shall be supplied only through a Health Net preferred specialty pharmacy provider. AWP pricing shall be determined by Health Net utilizing a nationally recognized source for pharmaceutical pricing to be updated at least quarterly. PPG shall bill administered dosage in accordance with applicable HCPCS codes. Multi-dose vials shall be reimbursed on a per dose basis.

5. Immunizations shall include procedure codes for immune globulins, vaccines and toxoids that identify the product only. The administration for immune globulins, vaccines and toxoids are separate from the product itself and are not considered immunizations. Average Wholesale Price (AWP) is determined by Health Net utilizing a nationally recognized database updated monthly. Multi-dose vials shall be reimbursed on a per dose basis.

6. The rates set forth in this Agreement apply to all current and future locations billed under this and future Tax Identification Numbers indicated by PPG through a signed W-9 form and subject to terms of this Agreement.

## ADDENDUM D

### SALUD CON HEALTH NET HMO BENEFIT PROGRAMS

#### A. APPLICABILITY AND COMPENSATION PROVISIONS.

1. PPG understands and agrees that the obligations of Health Net set forth in this Addendum are only the obligations of Health Net of California, (hereafter “Health Net”) and not the obligations of Health Net or any other Affiliate of Health Net. PPG shall be compensated according to this Addendum and this Addendum shall be applicable to only those Salud Con Health Net HMO Beneficiaries listed on the applicable Capitation eligibility roster lists.

2. **Benefit Programs.** This Addendum is applicable to the following Benefit Programs:

- Salud Con Health Net HMO

3. **Compensation for PPG Capitated Services.** As compensation for rendering PPG Capitated Services, Health Net shall pay PPG Capitation as set forth in this Addendum for each Salud Con Health Net Beneficiary eligible to receive services from PPG during any particular month. Capitation shall be payable on a per Member per month (PMPM) basis. Capitation shall be computed on the basis of the most current information available and shall be paid by Health Net by wire transfer on or before the fifteenth (15th) day of each month or the first business day following the fifteenth if the fifteenth is a holiday or on a weekend. Each Capitation payment shall be accompanied by a remittance summary. The remittance summary identifies the total Capitation payable and those Salud Con Health Net Beneficiaries for whom Capitation is being paid. In the event of a Capitation error, resulting in an overpayment or underpayment to PPG, Health Net shall adjust subsequent Capitation to offset such error.

4. **Compensation to Other Providers of PPG Capitated Services.** PPG shall compensate all providers who render PPG Capitated Services to Salud Con Health Net Beneficiaries assigned to PPG. In the event that PPG does not process and pay eligible claims submitted to PPG for Capitated Services within applicable time limits, Health Net may pay such claims at the lesser of Health Net’s contract rate with such provider, if any, PPG’s subcontract terms, or provider’s Allowable Charges/ Health Net shall deduct any such claim amounts paid from PPG’s Capitation, as set forth in the Operations Manual.

5. **Payment for Non-Capitated, Covered Services** PPG and Professional Providers shall render Covered Services for which Capitation is not paid under this Addendum and for which PPG has no financial responsibility under the DOFR. Health Net shall compensate such services on a FFS basis at the rates set forth in Exhibit D-2, pursuant to the applicable payment conditions set forth in Addendum E. PPG and Professional Providers shall submit claims for such services in accordance with the terms of this Agreement and applicable State and federal law.

#### B. SALUD CON HEALTH NET HMO CAPITATION PROVISIONS.

**NOTE TO NEGOTIATOR: RATE OPTIONS MUST BE DISCUSSED WITH FINANCIAL ANALYST FROM CONTRACTS ANALYSIS DEPARTMENT BEFORE OFFERING A PARTICULAR RATE TO THE PROVIDER.**

1. **[OPTION 1: Use for Providers that will have a cap floor. Be sure to use one option and strike the other depending upon the business strategy.] Professional Capitation Rate.** For Salud Con Health Net HMO line of business, Health Net shall provide for a floor guarantee as set forth below per member per month. The floor guarantee calculation shall be based on the gross capitation paid per member per month to PPG for Salud

Con Health Net lines of business. Gross capitation shall be defined as the normalized rate per member per month as set forth below and adjusted by age, sex, and benefit plan factors, and prior to any deductions. By the first of February each year, Health Net shall notify PPG of the prior calendar year's gross capitation amount reimbursed to PPG for the Salud Con Health Net HMO line of business. If the gross capitation amount reimbursed to PPG is higher than the floor guarantee, no additional reimbursement shall be made by Health Net. If the gross capitation amount reimbursed to PPG is lower than the floor guarantee, then Health Net shall reimburse PPG the additional per member per month amount to equal the floor guarantee for the Salud Con Health Net line of business within sixty (60) days from the date of determination.

Period	Normalized Rate	Floor Guarantee
Effective:	\$ PMPM	\$ PMPM
Effective:	\$ PMPM	\$ PMPM

1. **[OPTION 2: Use for Providers that will be paid only a flat cap amount. Be sure to use one option and strike the other depending upon the business strategy.] Professional Capitation Rate.** For Salud Con Health Net HMO line of business, Health Net shall pay PPG the following flat per Member per month ("PMPM") capitation amount:

Period	Flat Rate
Effective:	\$ PMPM
Effective:	\$ PMPM

2. **Shared Risk Program:** Health Net shall be solely responsible for all Shared Risk Services and for pharmacy benefit costs of Salud Con Health Net Beneficiaries.

**C. PROFESSIONAL STOP LOSS PROGRAM**

<b>SELECT OPTION ONE OR OPTION TWO</b>
<p><b>OPTION ONE:</b> PPG elects not to participate in the Professional Stop Loss Program. PPG shall provide Health Net with proof of Professional Stop Loss coverage.</p> <p><b>OPTION TWO:</b> PPG's Professional Stop Loss threshold shall be \$ [redacted] per Beneficiary during the calendar year. The cost to PPG for the Professional Stop Loss Program shall be \$ [redacted] PMPM, which, shall be deducted from Capitation. PPG shall report potential stop loss claims and receive payment for such claims in accordance with procedures set forth in the operations manual.</p>

**D. BENEFIT PROGRAM REQUIREMENTS**

PPG agrees:

1. That all Participating Providers will comply with the terms and conditions of this Addendum, the terms of the applicable Benefit Programs, and with Health Net Policies.

2. To comply with Health Net efforts to provide Case Management. PPG agrees to provide PPG's written treatment plan within five (5) working days of receipt of request from Health Net. A treatment plan includes a statement of diagnosis, current patient condition, current or proposed treatment, and anticipated outcomes.

3. That if PPG admits or arranges for an inpatient admission of a Beneficiary to a non-Participating Provider or facility for an elective procedure, PPG shall document that PPG has given such Beneficiary prior notice of the following:

- a) Provider or facility is non-participating;
- b) The non-Participating Provider or facility will not be restricted to seeking payment only from Health Net; and
- c) The non-Participating Provider or facility may bill the Beneficiary for amounts other than deductibles, Copayments, and medical services not covered under the Beneficiary's Coverage Certificate.

4. That PPG may appeal a Utilization/Care Management decision as set forth in Health Net Policies

5. Health Net agrees that any determination under the Utilization/Care Management Program that a Beneficiary's services rendered by PPG were not Medically Necessary shall not retroactively affect PPG's right to payment hereunder if such services were authorized by Health Net prior to admission and the information provided by PPG to Health Net regarding the Beneficiary's medical condition was substantially true and accurate.

#### E. GENERAL PROVISIONS

1. Non-Provider Capitated Services. With the exception of medically necessary emergency services, PPG agrees to refer Salud Con Health Net HMO Beneficiaries only to the participating Salud Con Health Net facilities.

**NOTE TO NEGOTIATOR – CONFIGURATION HAS REQUESTED THAT PHARMACEUTICALS, INJECTABLES AND IMMUNIZATIONS ALL HAVE THE SAME REIMBURSEMENT RATES. PHARMACEUTICAL RATES ARE LISTED IN THE RATE EXHIBIT. PHARMACEUTICALS/INJECTIONS AND IMMUNIZATIONS SHARE THE SAME J-CODES. HAVING THE SAME RATES ENSURES AUTOMATION.**

#### F. INJECTABLES

Injectables. As to injectables for which Health Net is responsible for reimbursement, PPG shall obtain such injectables from Health Net designated Participating Providers as described in Health Net Policies. If PPG does not utilize a Health Net designated Participating Provider, Health Net shall not be responsible for such injectables unless such injectables are not available from the Health Net designated Participating Provider. PPG shall be compensated at the Health Net Fee Schedule for such pharmaceuticals which shall be comprised of the lesser of 100% of provider's Allowable charges or XXX% of Medicare allowable for drugs with an established Medicare value. For drugs with no established Medicare value, the payment shall be the lesser of 100% of provider's Allowable charges or X% of AWP. AWP pricing shall be determined by Health Net utilizing a nationally

recognized source for pharmaceutical pricing to be updated at least quarterly. PPG shall bill administered dosage in accordance with applicable HCPCS codes. Multi-dose vials shall be reimbursed on a per dose basis.

Such rates shall be payment-in-full, except for the applicable Coinsurance amount. Health Net shall reimburse PPG at such rates, less the applicable Coinsurance. Health Net shall not be responsible for reimbursing the Beneficiary's Professional Provider for such injectables. PPG shall seek reimbursement from Health Net for such injectables and shall submit claims for such services to Health Net using the CMS 1500 Form and the appropriate CPT-4, HCPCS and NDC codes.

As to California Health & Safety Code §§ 1375.5 & 1375.8 services, which include chemotherapy drugs, self-injectables, hemophiliac blood factors, adult immunizations, transplant immunosuppressives, and therapeutic injectable and implantable medications (described in regulation as "other") with a cost per value greater than \$250.00 the Parties agree that risk shall be accepted on such Injectables, as set forth in the Division of Financial Responsibility Matrix. Such cost value shall be determined by the Medicare allowable fee schedule. If such medication is not listed on the Medicare allowable fee schedule, the value will be determined by the Average Wholesale Price (AWP) as calculated by Health Net in accordance with the CMS methodology.

## **G. IMMUNIZATIONS**

**Immunizations:** The applicable DOFR sets forth PPG and Health Net's respective financial responsibility for Immunizations.

Where Health Net has financial responsibility for a particular immunization, PPG shall seek reimbursement from Health Net for that immunization by submitting claims for such service to Health Net using the CMS 1500, or successor standard form, and the appropriate CPT-4, HCPC, or other applicable procedure code in accordance with Health Net Policies. Health Net shall compensate PPG in accordance with Exhibit E-2, subject to the applicable payment conditions in Addendum E, as payment-in-full, except for applicable Copayments. Health Net shall not be responsible for reimbursing Professional Providers for immunizations

For any new immunizations approved by American Academy of Pediatrics and the Advisory Committee on Immunization Practices (ACIP) of the US Public Health Service after the effective date of this Agreement, Health Net shall reimburse PPG at the lowest of the following: (1) the average wholesale price (AWP) as published in the Drug Topics Red Book, or (2) the lowest acquisition cost through sources made available to PPG by Health Net, unless and until Health Net develops experiential data for that new immunization, and PPG has agreed to accept financial responsibility for that new immunization.

**EXHIBIT D-1**

**DIVISION OF FINANCIAL RESPONSIBILITY  
MATRIX OF HEALTH NET, PPG, AND SHARED RISK/HOSPITAL CAPITATED  
SERVICES**

**SALUD CON HEALTH NET HMO BENEFIT PROGRAMS**

The following matrix outlines the Division of Financial Responsibility between Health Net and PPG. The matrix is intended only as a summary guide. The DOFR applies only to Covered Services and does not address any supplement or rider a Beneficiary may have. The applicable Benefit Program shall determine Covered Services. Unless otherwise stated as Out of Area in this matrix, all services are intended as In Area (within the Service Area).

**NOTE TO NEGOTIATOR: THE AIDS CATEGORIES OF SERVICE HAVE BEEN REMOVED FROM THE DOFR. IF YOUR CONTRACT STILL HAS AIDS REINSURANCE, IT MUST BE REMOVED AS WELL.**

CATEGORY OF SERVICE	PPG CAPITATED SERVICES	HEALTH NET RISK SERVICES	IHA AMP HMO/ SHARED RISK/HOSPITAL CAPITATED SERVICES
<b>ALLERGY IMMUNOTHERAPY</b>	X		
<b>ALLERGY TESTING</b>	X		
<b>ALPHA-FETOPROTEIN</b>	X		
<b>AMBULANCE</b> - In Area (30 Mile Radius) - Out of Area			X X
<b>ANESTHESIOLOGY</b>	X		
<b>BIOFEEDBACK</b>	X		
<b>BLOOD / BLOOD PRODUCTS</b> - Blood Bank - Hemophilia related Blood Factors - Storage and Collection of Blood - Transfusion Autologous/Homologous			X X X X
<b>CHEMICAL DEPENDENCY DETOX</b> - Inpatient Detox Facility Component - Inpatient Detox Professional Component	X		<u>X</u>
<b>CHEMICAL DEPENDENCY REHAB</b> - Inpatient Facility Component - Inpatient Professional Component - Outpatient Facility Component - Outpatient Professional Component		X X X X	
<b>CHEMOTHERAPY</b> - Drugs, including Epogen, Neupogen and adjunctive therapies - Outpatient - Facility Component - Inpatient including Drugs - Facility Component - Outpatient - Professional Component	X  X		X X

<b>CATEGORY OF SERVICE</b>	<b>PPG CAPITATED SERVICES</b>	<b>HEALTH NET RISK SERVICES</b>	<b>IHA AMP HMO/ SHARED RISK/HOSPITAL CAPITATED SERVICES</b>
<b>CHIROPRACTIC</b>	X		
<b>CLINIC VISITS</b> – Non-urgent, Outpatient, Facility & Professional (includes Telehealth)	X		
<b>COLOSTOMY SUPPLIES</b>			X
<b>CONSULTATIONS</b>	X		
<b>COSMETIC SURGERY (Medically Necessary)</b> - Facility Component - Professional Component	X		X
<b>CRITICAL CARE VISITS</b>	X		
<b>DENTAL SERVICES</b> - Facility Component - Professional Component	X		X
<b>DIAGNOSTIC TESTING</b> – Outpatient Facility or Home - Facility Component - Professional Component	X X		
<b>DURABLE MEDICAL EQUIPMENT</b> - Outpatient (includes home) - Surgically Implanted			X X
<b>EMERGENCY ROOM ADMISSIONS</b> – In-Area - Facility Component - Professional Component	X		X
<b>EMERGENCY ROOM ADMISSIONS</b> – Out of Area - Facility Component - Professional Component			X X
<b>EMERGENCY ROOM VISITS</b> – In Area - Facility Component - Professional Component	X		X
<b>EMERGENCY ROOM VISITS</b> – Out-of-Area - Facility Component - Professional Component			X X
<b>EXTENDED CARE/SKILLED NURSING FACILITY</b> - Facility Component - Professional Component	X		X
<b>GROWTH HORMONES</b>			X
<b>HEARING AIDS</b>	X		
<b>HEMODIALYSIS</b> - Facility Component includes ESRD related drugs, supplies, and laboratory - Professional Component			X X

CATEGORY OF SERVICE	PPG CAPITATED SERVICES	HEALTH NET RISK SERVICES	IHA AMP HMO/ SHARED RISK/HOSPITAL CAPITATED SERVICES
<b>HOME HEALTH</b>			X
<b>HOME VISITS</b>	X		
<b>HOSPICE</b> - Facility Component - Professional Component	X		X
<b>HOSPITAL BASED PHYSICIANS</b> - Inpatient, Ambulatory Surgery or Emergency Room Admissions - Professional Component - Technical Component	X		X
<b>HYPERBARIC OXYGEN THERAPY, OUTPATIENT</b> - Facility Component			X
<b>HYPERBARIC OXYGEN THERAPY, OUTPATIENT</b> - Professional Component	X		
<b>IMMUNIZATIONS</b> , Pediatric – COVID-19	X		
<b>IMMUNIZATIONS</b> , Pediatric not subject to H&S Code 1367.36 (1)	X		
<b>IMMUNIZATIONS</b> , Pediatric subject to H&S Code 1367.36 unless PPG has accepted risk as shown below		X	
<b>IMMUNIZATIONS</b> , Pediatric - Meningococcal vaccine - 1 <sup>st</sup> and 2 <sup>nd</sup> Doses (e.g. Menactra®, Menveo®, Bexsero®)	X		
<b>IMMUNIZATIONS</b> , Pediatric – Tdap (e.g. Boostrix® Adacel®)	X		
<b>IMMUNIZATIONS</b> , Pediatric - Rotavirus vaccine (e.g. Rota Teq® and Rotarix®)		X	
<b>IMMUNIZATIONS</b> , Pediatric - Human Papilloma Virus Vaccine (e.g. Gardasil®, Cervarix®)		X	
<b>IMMUNIZATIONS</b> , Pediatric - Varicella Virus -1st & 2nd Doses (e.g. Varivax ®)	X		
<b>IMMUNIZATIONS</b> , Pediatric – Influenza Vaccines Ages 5 – 17	X		
<b>IMMUNIZATIONS</b> , Adult	X		
<b>IMMUNIZATIONS</b> , Adult – COVID-19	X		
<b>IMMUNIZATIONS</b> , Adult – Human Papilloma Virus Vaccine (e.g. Gardasil®, Cervarix®)	X		
<b>INFANT APNEA MONITOR</b>			X

<b>CATEGORY OF SERVICE</b>	<b>PPG CAPITATED SERVICES</b>	<b>HEALTH NET RISK SERVICES</b>	<b>IHA AMP HMO/ SHARED RISK/HOSPITAL CAPITATED SERVICES</b>
<b>INFERTILITY TREATMENTS IVF, GIFT, ZIFT &amp; AI</b> - Facility Component - Professional Component	X		X
<b>INFUSION THERAPY ADMINISTRATION,</b> Outpatient Facility, excluding drugs			X
<b>INHALATION DRUGS,</b> Office or Clinic)	X		
<b>INJECTABLES, SELF ADMINISTERED</b>	X		
<b>INPATIENT VISITS, Professional</b>	X		
<b>LITHOTRIPSY</b> - Facility Component - Professional Component	X		X
<b>MATERNITY – Deliveries and Non-Deliveries</b> - Facility Component - Professional Component	X		X
<b>MEDICAL ADMISSIONS</b> In Area and Non-Emergency Out of Area - Facility Component - Professional Component	X		X
<b>MENTAL HEALTH – Inpatient</b> - Facility Component - Professional Component		X X	
<b>MENTAL HEALTH – Outpatient</b> - Facility Component - Professional Component		X X	
<b>OBSERVATION CARE, DIRECT ADMISSION – Outpatient Facility</b> - Facility Component - Professional Component	X		X
<b>OFFICE VISITS</b> (includes Telehealth)	X		
<b>OUTPATIENT FACILITY SERVICES / TECHNICAL COMPONENT</b> Not listed elsewhere on DOFR			X
<b>PATHOLOGY – Inpatient, Ambulatory Surgery or Emergency Room</b> - Professional Component - Technical Component	X		X
<b>PATHOLOGY &amp; LABORATORY SERVICES</b> - Mobile (including in the home)	X		
<b>PATHOLOGY &amp; LABORATORY SERVICES</b> - Office	X		

<b>CATEGORY OF SERVICE</b>	<b>PPG CAPITATED SERVICES</b>	<b>HEALTH NET RISK SERVICES</b>	<b>IHA AMP HMO/ SHARED RISK/HOSPITAL CAPITATED SERVICES</b>
<b>PATHOLOGY &amp; LABORATORY SERVICES,</b> Outpatient (Includes Pre-Admission Tests within 72 hrs. of related admission) - Professional Component - Technical Component	X X		
<b>PATHOLOGY &amp; LABORATORY SERVICES,</b> Outpatient, Office, Mobile, Home (COVID-19 testing, including specimen collection) ** - Professional Component - Technical Component	X X		
<b>PATIENT EDUCATION</b>	X		
<b>PERIODIC EXAMS</b>	X		
<b>PROFESSIONAL SERVICE / TECHNICAL &amp; PROFESSIONAL COMPONENT</b> Not listed elsewhere on DOFR	X		
<b>PROSTHETICS/ORTHOTICS DEVICES</b> - Outpatient Dispensed (including Home) - Surgically Implanted			X X
<b>RADIATION THERAPY -OUTPATIENT/ OFFICE</b> - Technical Component	X		
<b>RADIATION THERAPY</b> - Professional Component	X		
<b>RADIOLOGY – Inpatient, Ambulatory Surgery or Emergency Room</b> - Professional Component - Technical Component	X		X
<b>RADIOLOGY-Mobile (including in the home)</b>	X		
<b>RADIOLOGY – Office</b>	X		
<b>RADIOLOGY – Outpatient (Includes Pre-Admission Tests within 72 hrs. of related admission)</b> - Professional Component - Technical Component	X X		
<b>SPEECH AND HEARING EXAMS</b>	X		
<b>SUPPLIES- Medical, Surgical</b> - Related to a Hospital Stay - Related to Outpatient, Office & Home	X		X
<b>SUPPLIES, DIABETIC</b> - Chem. Strips, Lancet, Needles, Syringes - Glucometer			X X
<b>SURGERY – Inpatient</b> - Facility Component - Professional Component	X		X

<b>CATEGORY OF SERVICE</b>	<b>PPG CAPITATED SERVICES</b>	<b>HEALTH NET RISK SERVICES</b>	<b>IHA AMP HMO/ SHARED RISK/HOSPITAL CAPITATED SERVICES</b>
<b>SURGERY – Office</b>	X		
<b>SURGERY – Outpatient</b> - Facility Component - Professional Component	X		X
<b>THERAPEUTIC INJECTABLE AND IMPLANTABLE MEDICATION</b> - Equal or less than \$250.00 cost per dose - More than \$250.00 cost per dose	X X		
<b>THERAPY/REHABILITATION:</b> includes Physical, Occupational, Respiratory, Speech, and Cardiac Rehab) - Inpatient - Outpatient/Office	X		X
<b>TRANSGENDER, INJECTABLE, AND IMPLANTABLE MEDICATION</b> - Hormones (Pre & Post Op)		X	
<b>TRANSGENDER SERVICES</b> - Non-Medical Cosmetic Procedures - Pre-Op MD Consults - Psychiatric Pre-Op Evaluation - Voice Therapy, Professional		X X X X	
<b>TRANSGENDER SURGERY – Complete and Partial InterSex Reassignment Procedures</b> - Facility Component Inpatient & Outpatient (includes preadmission testing at the same facility within 72 hours of admission) - Professional Component		X X	
<b>TRANSPLANTS (Non-experimental)</b> - Drugs (Immunosuppressive, stem cell mobilizers, G-CSF) - Facility Component - Organ Procurement - Professional Component		X X X X	
<b>TRANSPLANT EVALUATIONS</b> - Facility Component - Professional Component		X X	
<b>URGENT CARE VISITS – In-Area</b>	X		
<b>URGENT CARE VISITS – Out-of-Area</b>			X
<b>VISION CARE</b> - Exams and Medically Necessary Care - Implanted Intraocular Lenses - Lenses and Frames (Non-Cataract)	X	X	X

(1) Except where a pediatric immunization which is not subject to H & S 1367.36 is otherwise specifically described elsewhere in the DOFR.

(2) Observation Care shall be consistent with CMS guidelines related to payment for hospital Outpatient Prospective Payment for Direct to Observation admissions and InterQual criteria. Observation Care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation Services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. When direct admission to Observation is ordered for patients who do not present through the emergency department the same purpose is applied that the member require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. The Observation Services of short-term treatment, assessment and reassessment in an outpatient facility unit must be reasonable and necessary and meet the minimum severity and purpose described under CMS guidelines to be covered. All direct to observation admissions must have PPG authorization and on-going care management. Any service such as laboratory, radiology or diagnostic testing that can safely be performed in an outpatient facility or office, in absence of the observation component, are excluded from the observation category under this Agreement. Any direct to observation admissions that do not meet CMS guidelines will be classified under the DOFR as the applicable DOFR category within the PPG's PPA, e.g. diagnostic testing, lab or radiology and have the corresponding financial risk owner. The decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient should usually be made in less than 24 hours. For any direct to observation admission greater than 24 hours, PPG must notify Health Net consistent with the notification requirements for an inpatient admission. For the purposes of the DOFR, Observation Care, Direct Admission, Outpatient Facility does not include the care performed within an emergency area or emergency related holding unit or post-operative care and should not be used for services that should be performed in an inpatient setting.

**NOTE TO NEGOTIATOR – PLEASE ENSURE THAT RADIOLOGY AND PATHOLOGY HAVE THE SAME RISK.**

**\*\* NOTE TO NEGOTIATOR – FOR PATHOLOGY/LABORATORY SERVICES COVID-19, DO NOT AGREE TO FURTHER DEFINE COVID TESTING TO PCR/DIAGNOSTIC VS ANTIBODY, IT SHOULD BE ALL COVID-19 TESTING.**

**\*\* NOTE TO NEGOTIATOR – FOR PATHOLOGY/LABORATORY SERVICES COVID-19, RISK SHOULD NOT SHIFT TO HN, X's WILL REMAIN IN THE PPG COLUMN.**

**EXHIBIT D-2**

**SALUD CON HEALTH NET HMO BENEFIT PROGRAMS  
PPG FEE-FOR-SERVICE RATE EXHIBIT**

Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Addendum E, Health Net or Payor shall pay and PPG or Professional Provider shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered under commercial Benefit Programs pursuant to this Addendum, the lesser of: (i) the rates listed below, or (ii) 65% - 100% of PPG's Allowable Charges.

<b>Category of Service</b>	<b>Compensation</b>
Covered Services delivered or arranged by PPG, excluding Laboratory services	___% of CMS Allowable
Anesthesia Services when provided by an Anesthesiologist or Certified Registered Nurse Anesthetist (American Society of Anesthesiology (ASA) unit scale)	\$ / ASA unit
Medical/Surgical Services by an Anesthesiologist or Certified Registered Nurse Anesthetist	___% of CMS Allowable
Laboratory Services performed in PPG or Professional Provider office	___% of CMS Allowable
Pharmaceuticals	
- With an established Medicare Value	the lesser of 100% of provider's Allowable Charges or XXX% of Medicare allowable
- Without an established Medicare Value	the lesser of 100% of PPG's Allowable Charges or X% of AWP
OB Services	NTN: Choose One Option
	___% of CMS Allowable
	or
- CPT 59400: Global Obstetric care with vaginal delivery	\$0000.00/
- CPT 59510: Global Obstetric care with cesarean delivery	\$0000.00/
- CPT 59610: Vaginal Delivery after previous cesarean delivery	\$0000.00/
- CPT 59618: Attempted vaginal delivery, resulting in cesarean	\$0000.00/
Immunizations	
- With an established Medicare Value	the lesser of 100% of PPG's Allowable Charges or XXX% of Medicare allowable

- Without an established Medicare Value	the lesser of 100% of PPG's Allowable Charges or X% of AWP
By Report (BR) Covered Services, Covered Services not listed and Covered Services with relativities not established.	65-100 % of Allowable Charges for Covered Services

## ADDENDUM E

### **PARTICIPATING PHYSICIAN GROUP (PPG) FEE-FOR-SERVICE PAYMENT CONDITIONS**

The Payment Conditions set forth in this Addendum supplement Health Net Policies, and are applicable to Commercial Benefit Programs; Medicare Benefit Programs; and Salud Con Health Net HMO Benefit Programs.

1. PPG shall utilize valid CPT/HCPCS/ICD diagnosis codes, or successor codes, when submitting Complete Claims for Covered Services under this Agreement. The parties acknowledge that applicable coding agencies periodically issue coding modifications. Such modifications may be implemented by Health Net within sixty (60) days of the date Health Net receives the modification from the applicable coding agency. The parties agree that in the event such coding modifications have the effect of changing a payment amount in this Agreement, the resulting payment amount change shall be effective on a prospective basis. The parties further agree to reasonably and in good faith discuss any contract rate amendment that may be appropriate based on comprehensive and substantive coding changes by the applicable coding agency within ninety (90) days of written notification by either party. Any and all rate modifications that may result from such contract amendment shall be effective on a prospective basis.

2. Pharmaceuticals shall include inhaled/infused/injected medications provided by and delivered in PPG/Professional Provider office. Support drugs and injection supplies for patient self-administered injections shall be supplied only through a Health Net preferred specialty pharmacy provider. AWP pricing shall be determined by Health Net utilizing a nationally recognized source for pharmaceutical pricing to be updated at least quarterly. PPG shall bill administered dosage in accordance with applicable HCPCS codes. Multi-dose vials shall be reimbursed on a per dose basis.

3. Immunizations shall include procedure codes for immune globulins, vaccines and toxoids that identify the product only. The administration for immune globulins, vaccines and toxoids are separate from the product itself and are not considered immunizations. Average Wholesale Price (AWP) is determined by Health Net, in accordance with CMS methodology, utilizing a nationally recognized database updated monthly. Multi-dose vials shall be reimbursed on a per dose basis.

4. The rates set forth in this Agreement apply to all current and future locations billed under this and future Tax Identification Numbers indicated by PPG through a signed W-9 form and subject to terms of this Agreement.

5. Obstetric case rates include professional services for antepartum care, delivery, and postpartum care. Facility services are not included in case rate and shall be billed separately by Facility.

## ADDENDUM F

### **FINANCIAL SOLVENCY ADDENDUM**

#### **[Applicable only to Delegated PPGs]**

This Addendum is required to comply with the financial standards and reporting requirements sections 1300.75.4 through 1300.75.4.8 of Title 28 of the California Code of Regulations.

#### **I. DEFINITIONS**

- 1.1 **“Cash-to-Claims Ratio”** is PPG’s cash, readily available marketable securities, and receivables, excluding all risk pool, risk-sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected within sixty (60) days divided by PPG’s unpaid claims liability. Unpaid claims liability is claims payable plus incurred but not reported claims (“IBNR”).
- 1.2 **“Contracted Plans”** means all full-service health care service plans, as defined in section 1345(f) of the California Health & Safety Code, with which PPG has contracts involving a Risk Arrangement.
- 1.3 **“Corrective Action Plan”** (“CAP”) means a plan reflected in a document containing requirements for correcting and monitoring PPG's efforts to correct any financial solvency deficiencies in the Grading Criteria, or other financial deficiencies or claims payment deficiencies, determined through the Department’s review or audit process, indicating that PPG may lack the capacity to meet its contractual obligations consistent with the requirements of section 1300.70(b)(2)(H)(1) of Title 28 of the California Code of Regulations.
- 1.4 **“Department”** means the California Department of Managed Health Care. Whenever the Solvency Regulations reference the Department, that reference includes the Department or its External Party.
- 1.5 **“External Party”** means the Department or its designated agent, which may be contracted or appointed to fulfill the Department’s functions stated in the Solvency Regulations.
- 1.6 **“Grading Criteria”** means the four grading/reviewing criteria specified in Health and Safety Code sections 1375.4(b)(1)(A)(i), (ii), (iii), and (iv) and the Cash-to-Claims Ratio as defined above.
- 1.7 **“Risk Arrangement”** means both "risk-sharing arrangement" and "risk-shifting arrangement," which are defined as follows:
- (a) Risk-Sharing Arrangement means any compensation arrangement between PPG and Health Net under which PPG shares the risk of financial gain or loss with Health Net.
  - (b) Risk-Shifting Arrangement means a contractual arrangement between PPG and Health Net under which Health Net pays PPG on a fixed, periodic, or capitated basis, and the financial risk for the cost of services provided pursuant to the contractual arrangement is assumed by PPG.
- 1.8 **“Solvency Regulations”** means sections 1300.75.4 through 1300.75.4.8 of Title 28 of the California Code of Regulations.

#### **II. OBLIGATIONS OF HEALTH NET**

- 2.1 Monthly Membership Reports. Notwithstanding any different provisions of the Agreement, Health Net will provide the following information to PPG on a monthly basis for Beneficiaries assigned to PPG, within ten (10) calendar days following the start of each month:
- (a) Membership information containing at least the following elements for each Beneficiary: i) identification number; ii) name; iii) birth date; iv) gender; v) address (including zip code); vi) benefit plan selected; vii) employer group identification (name and number); viii) identity of other third party coverage (if known); ix) dates of enrollment/disenrollment; x) PPG number; xi) primary care physician selected; xii) primary care physician effective date; xiii) type of change to coverage; xiv) co-payment amounts; xv) deductible (if applicable); xvi) amount of monthly capitation payment.
  - (b) The following additional information: i) Beneficiary additions and terminations for the month (including at least: Beneficiary name, Beneficiary identification number); ii) number of additional Beneficiaries under each benefit plan; iii) number of terminated Beneficiaries under each benefit plan.
  - (c) Health Net shall submit the information from Section 2.1(a) and 2.1(b) to PPG electronically, unless both Health Net and PPG agree in writing that hard copy reports will be submitted instead.
  - (d) If the information from Section 2.1(a) and 2.1(b) above is provided to PPG in more than one report, all reports shall be processed by Health Net on the same date.
  - (e) Within forty-five (45) calendar days of the close of each calendar quarter, Health Net shall disclose to PPG a reconciliation of any variances between the reports for information listed in sections 2.1(a) and 2.1(b) above through electronic transmission (or in hard copy if mutually agreed upon by PPG and Health Net).
- 2.2 Quarterly Risk-Sharing Reports. Health Net shall provide to PPG on a quarterly basis, within forty-five (45) calendar days following the close of each calendar quarter, a quarterly risk-sharing report. The quarterly risk-sharing report shall contain a detailed description of each and every amount (including expenses and income) that is sufficient to allow verification of amounts allocated to PPG and to Health Net under each and every risk-sharing arrangement.
- (a) Where applicable, the following information at a minimum, shall be provided in the quarterly risk-sharing report: i) total number of Beneficiary months; ii) total budget allocation for the Beneficiary months; iii) total expenses paid during the period; iv) a description of the incurred but not reported (IBNR) claims methodology used for incurred expenses during the period; and v) a description of each and every amount of expense allocated to the Risk Arrangement by Beneficiary identification number, date of service, description of service by claim codes, net payment, and date of payment.
  - (b) Health Net shall submit the quarterly risk-sharing report to PPG electronically, unless Health Net and PPG mutually agree in writing that hard copy reports will be submitted instead.
- 2.3 Annual Statement of Risk-Sharing Accounts & Payment. For all Risk-Sharing Arrangements, Health Net shall provide PPG with a preliminary payment report, consistent with the requirements of Section 2.2 of this Addendum, no later than one hundred fifty (150) calendar days, and payments, if any, no later than one hundred eighty (180) calendar days after the close of the contract year or the Agreement's termination date, whichever occurs first.
- 2.4 Annual Financial Risk Disclosure. On the Agreement anniversary date each year, Health Net shall disclose to PPG the following information for each and every type of Risk Sharing Arrangement (including, but not

limited to, Medicare Advantage, Medi-Cal, commercial, point of service, small group, and individual plans) covered under the Agreement:

- (a) A matrix of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to PPG, a hospital(s), or Health Net under the Risk Arrangement.
- (b) Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of benefit plan type and Risk Arrangement.
- (c) All factors used to adjust payments or risk-sharing targets, including, but not limited to, the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.
- (d) The amount of payment for each and every service to be provided under the Agreement, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the fee schedule shall be incorporated into the Agreement by reference and shall specify Medicare RBRVS year if RBRVS is the methodology for the fee schedule development. For any proprietary fee schedule, the Agreement shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

2.5 Annual Disclosure of Capitation Payments. On the Agreement anniversary date each year, Health Net shall disclose to PPG the amount of capitation payments to be paid per member per month.

2.6 Capitation Deduction Detail. Health Net shall provide to PPG sufficient details to allow PPG to verify the accuracy and appropriateness of any deductions from capitation payments made by Health Net including, but not limited to, Beneficiary name, Beneficiary number, Beneficiary date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

### **III. OBLIGATIONS OF PPG**

#### **III. OBLIGATIONS OF PPG**

3.1 Cash-to-Claims Ratio. PPG shall maintain at least the following Cash-to-Claims Ratio: 0.75

3.2 Quarterly Financial Survey. No later than forty-five (45) calendar days following the close of each quarter of its fiscal year, PPG agrees to submit a quarterly financial survey report in an electronic format to the Department as required by section 1300.41.8 of Title 28 of the Solvency Regulations as set forth below:

(a) The quarterly financial survey report shall include the following under all Risk Arrangements as of December 31 of the preceding calendar year:

- (i) A Financial survey report, (including a balance sheet, an income statement, and a statement of cash flows), or comparable financial statements if PPG is a nonprofit entity, and supporting schedule information (including, but not limited to, aging of receivable information), reflecting the results of operations for the immediately preceding quarter, prepared in accordance with Generally Accepted Accounting Principles ("GAAP"). Financial survey reports must be on a combining basis with an affiliate, if PPG or such PPG affiliate is legally or financially responsible for payment of PPG's claims. Any affiliated entity included in this financial survey report must be separately identified in a combining schedule format. For the purposes of this section, PPG's use: (1) of a "sponsoring

organization” arrangement to reduce its liabilities for the purposes of calculating tangible net equity and working capital or (2) an affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial obligation to pay PPG’s claims liability.

(ii) A claims report, which includes the percentage of claims that have been timely reimbursed, contested or denied during the quarter by PPG in accordance with the requirements of sections 1371 and 1371.35 of the California Health & Safety Code, section 1300.71 of Title 28 of the California Code of Regulations, and any other applicable state and federal laws and regulations. If less than ninety-five percent (95%) of all complete claims have been reimbursed, contested, or denied on a timely basis, the claims report must also describe the reasons why PPG’s claims adjudication process is not meeting the requirements of applicable law, any actions taken to correct the deficiency, and any results of the actions. This claims report is for the purpose of monitoring the financial solvency of PPG and is not intended to change or alter existing state and federal laws and regulations relating to claims payment settlement practices and timeliness.

(iii) A statement as to whether or not PPG has estimated and documented, on a monthly basis, its liability for (“IBNR”) claims in accordance with section 1300.77.2 of Title 28 of the California Code of Regulations (“IBNR Statement”) and that these estimates are the basis for the quarterly financial survey report submitted to the Department. If the estimated and documented liability is not in compliance with section 1300.77.2 of Title 28 of the California Code of Regulations in any way, the IBNR Statement shall describe in detail for each deficiency the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. PPG’s failure to: (1) estimate and document, on a monthly basis, its liability for IBNR claims or (2) maintain its books and records on an accrual accounting basis shall be deemed PPG’s failure to maintain, at all times, positive tangible net equity (“TNE”) and positive working capital as set forth in section 3.2(a)(iv) below.

(iv) A statement as to whether or not PPG has maintained at all times throughout the quarter (1) a positive TNE as defined in section 1300.76(e) of Title 28 of the California Code of Regulations and (2) a positive level of working capital, calculated according to GAAP (“TNE/Working Capital Statement”). If either the required TNE or the required working capital has not been maintained at all times, a statement must be included in the quarterly financial survey report that describes in detail the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. PPG may reduce its liabilities or increase its cash for purposes of calculating its TNE, working capital and Cash-to-Claim Ratio in a manner allowed by Health and Safety Code Section 1375.4(b)(1)(B) so long as the sponsoring organization has filed with the Department: (1) its audited annual financial statements within one hundred-twenty (120) calendar days of the end of the sponsoring organization’s fiscal year and (2) a copy of the written guarantee meeting the requirements of Health and Safety Code section 1375.4(b)(1)(B). For purposes of the Health and Safety Code section 1375.4(b)(1)(B), a sponsoring organization shall have a TNE of at least twice the total of all amounts that it has guaranteed to all persons and entities, or TNE in a lesser amount approved by the Department. If PPG has a sponsoring organization, PPG shall provide a statement demonstrating the capacity of the sponsoring organization to guarantee PPG’s debts as well as the nature and scope of the guarantee provided consistent with Health and Safety Code Section 1375.4(b)(1)(B).

(v) For each calendar year quarter a statement as to whether or not PPG has, at all times during the quarter, maintained a Cash-to-Claims Ratio as required in section 3.1 above, calculated in a manner consistent with GAAP. If the required Cash-to-Claims Ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey

report that describes in detail the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

3.3 Annual Financial Survey. PPG agrees to submit to the Department on a yearly basis, not more than one hundred-fifty (150) calendar days after the close of PPG's fiscal year, annual financial survey reports, in an electronic format determined by the Department as required by section 1300.41.8 of Title 28 of the California Code of Regulations, based upon PPG's annual audited financial statement prepared in accordance with generally accepted auditing standards and containing all of the following:

- (a) An annual financial survey report, based upon PPG's annual audited financial statements, (including at least a balance sheet, an income statement, a statement of cash flows, and footnote disclosures) or comparable financial statements if PPG is a nonprofit entity, and supporting schedule information, (including, but not limited to, aging of receivable information and debt maturity information) for the immediately preceding fiscal year, prepared by an independent certified public accountant in accordance with GAAP. For the purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (Division 1, Sections 1 through 99.2, Title 16 of the California Code of Regulations) shall apply.
- (b) The financial survey reports of PPG shall be on a combining basis with an affiliate if PPG or such affiliate is legally or financially responsible for the payment of PPG's claims. Any affiliated entity included in the report shall be separately identified. For the purpose of this Section, PPG's use of: (1) a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating TNE and working capital or (2) an affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial obligation to pay PPG's claims liability. When combined financial statements are required, the independent accountant's report or opinion must address all the entities included in the combined financial statements. If the accountant's report or opinion makes reference to the fact that another auditor performed a part of the examination, PPG shall also file the report or opinion issued by the other auditor.
- (c) Opinion of an independent certified public accountant indicating whether PPG's annual audited statements present fairly, in all material respects, the financial position of PPG and whether the financial statements were prepared in accordance with GAAP. If the opinion is qualified in any way, the survey report shall include an explanation regarding the nature of the qualification.
- (d) An IBNR Statement consistent with the requirements outlined in section 3.2(a)(iii) of this Addendum. If the estimated and documented liability is not in compliance with Section 1300.77.2 of Title 28 of the California Code of Regulations in any way, the IBNR Statement shall describe in detail for each deficiency the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. PPG's failure to: (1) estimate and document, on a monthly basis, its liability for IBNR claims or (2) maintain its books and records on an accrual accounting basis shall be deemed PPG's failure to maintain, at all times, positive tangible net equity ("TNE") and positive working capital as set forth in section 3.3(e) below.
- (e) A TNE/Working Capital Statement consistent with the TNE reporting requirements as outlined in Section 3.2(a)(iv) of this Addendum. If either the required TNE or the required working capital has not been maintained at all times, the TNE/Working Capital Statement shall describe in detail the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. PPG may reduce its liabilities for purposes of calculating its TNE and working capital in a manner as required by section 1300.41.8 of Title 28 of the California Code of Regulations and as outlined in section 3.2(a)(iv) of this Addendum.
- (f) For each fiscal year a statement as to whether or not PPG has at all times during the year maintained a Cash-to Claims Ratio as required in section 3.1 above, calculated in a manner consistent with GAAP. If the required Cash-to-Claims Ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the nature of the

deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

- (g) A statement as to whether PPG maintains professional stop-loss coverage.
- (h) A copy of PPG's complete annual audited financial statement, including footnotes and the certificate or opinion of the independent certified public accountant.

3.4 Annual Statement of Organization Survey. PPG shall submit to the Department a "Statement of Organization," in an electronic format determined by the Department to be filed with PPG's annual financial survey report. Such Statement of Organization shall include the following information as of December 31 of each calendar year prior to the filing:

- (a) Name and address of PPG;
- (b) Financial and public contact person, with title, address, telephone, fax and e-mail address;
- (c) A list of all health plans with which PPG has Risk Arrangements;
- (d) Type of PPG: Independent Practice Association (IPA), PPG, Foundation or other entity, or some combination. If PPG is a foundation, identify each and every PPG within the foundation and whether any of those PPGs independently qualifies as a risk-bearing organization as defined in Health and Safety Code Section 1375.4(g).
- (e) Corporate status: professional corporation, partnership, not-for-profit corporation, sole proprietor, or other form of business;
- (f) The name, address, and principal officer of each of PPG's affiliates as defined in section 1300.45(c)(1) and (2) of Title 28 of the California Code of Regulations;
- (g) Whether PPG is partially or wholly owned by a hospital or hospital system;
- (h) A matrix listing all major categories of medical care offered by PPG, including but not limited to anesthesiology, cardiology, orthopedics, ophthalmology, oncology, obstetrics/gynecology, and radiology, and next to each listed category in the matrix a disclosure of the compensation model (salary, fee-for-service, capitation, other) used by PPG to compensate the majority of providers of that category of care;
- (i) An approximation of the number of enrollees served by PPG through Risk Arrangements, pursuant to a list of ranges developed by the Department;
- (j) The name of any Management Services Organization ("MSO") that PPG contracts with for administrative services;
- (k) Total number of contracted physicians in employment and/or contractual arrangements with PPG;
- (l) Disclosure by California county or counties of PPG's primary service area (excluding out-of-area tertiary facilities and providers);
- (m) PPG's address, telephone number and website link, if available, where providers may access written information and instructions for filing of provider disputes with PPG's dispute resolution mechanism consistent with requirements of section 1300.71.38 of Title 28 of the California Code of Regulations
- (n) Any other information which the Department deems reasonable and necessary, as permitted by law to understand the operational structure and finances of PPG.

3.5 Attestation. PPG shall submit a written verification for each report made under Sections 3.2, 3.3, and 3.4 of this Addendum stating that the report is true and correct to the best knowledge and belief of a principal officer of PPG, and signed by a principal officer, as defined by section 1300.45(o) of Title 28 of the California Code of Regulations.

3.6 Notification to Department & Health Net. PPG agrees to notify the Department and Health Net no later than five (5) business days from discovering that PPG has experienced any event that materially alters its financial situation or threatens its solvency.

3.7 Department Evaluation of PPG. PPG shall:

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- (a) Permit the Department to make any examination that it deems reasonable and necessary to implement section 1375.4 of the Health and Safety Code, and provide to the Department for inspection and copying, upon request, any books, or records that the Department deems relevant or useful in such examination, as permitted by law.
- (b) Comply with the Department’s review and audit process that is used to determine PPG’s compliance with the Grading Criteria.
- (c) Permit the Department to obtain and evaluate supplemental financial information pertaining to PPG when:
  - (i) PPG fails to satisfactorily demonstrate its compliance with the Grading Criteria;
  - (ii) PPG experiences an event that materially alters its ability to remain compliant with the Grading Criteria;
  - (iii) The External Party’s review or audit process indicates that PPG may have insufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of sections 1300.70(b)(2)(H)(1) of Title 28 of the California Code of Regulations; or
  - (iv) The Department receives information from complaints submitted to the HMO Help Center, Health Net reporting, medical audits and surveys or any other source that indicates PPG may be delaying referrals or authorizations or failing to meet access standards for basic health care services based on financial considerations.

**IV. OBLIGATIONS OF PPG & HEALTH NET**

4.1 Corrective Action Plans. PPG and Health Net shall comply with the Department’s Corrective Action Plan (“CAP”) process as set forth in Section 1300.75.4.8 of the Solvency Regulations.

**V. MISCELLANEOUS PROVISIONS**

5.1 Material Breach. PPG’s failure to substantially comply with the provisions of this Addendum shall constitute a material breach of the Agreement. In such cases, the parties shall abide by the material breach provisions set forth in the Agreement. Health Net may not request or accept a waiver of any of the provisions of this Addendum.

5.2 Agreement Remains in Full Force and Effect. Except as specifically amended by this Addendum, all other conditions contained in the Agreement shall continue in full force and effect.

**ADDENDUM G**

**BUSINESS ASSOCIATE ADDENDUM**

A. This Addendum contemplates that PPG (hereinafter in this Addendum, “Business Associate”) will provide a service to, or perform a function on behalf of Health Net, as more fully set forth in the Agreement, and in

connection therewith, which is limited to claims processing, and/or Utilization Management, and/or credentialing, as more specifically set forth in the Agreement and/or delegation agreement, as applicable, Business Associate may use or disclose Protected Health Information including Electronic Protected Health Information (“ePHI”) (collectively “PHI”), that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and certain privacy and security regulations found at 45 CFR Parts 160 through 164 (“HIPAA Regulations”), as they may be amended from time to time; the Health Information Technology for Economic and Clinical Health Act (“HITECH Act”); and the Final Omnibus HIPAA/HITECH Rules (78 Fed. Reg. 5566 (Jan. 25, 2013)) (the “Final Regulations”). HIPAA, the HIPAA Regulations, the HITECH Act, and the Final Regulations are collectively referred to in this Addendum as the “HIPAA Requirements.”

- B. Protected Health Information (“PHI”) and Electronic Protected Health Information (“ePHI”) shall have the meaning given to such terms at 45 C.F.R. § 160.103.
- C. Any entity which creates, uses, maintains, discloses or receives PHI from or *on behalf of Health Net* is a business associate, as defined in the HIPAA Requirements at 45 C.F.R. § 160.103; in addition, any entity (including an agent) that creates, receives, maintains, or transmits PHI *on behalf of a business associate* is now also considered a business associate under 45 C.F.R. § 160.103 (and all such entities shall be referred to in this Addendum as “Subcontractors”).
- D. Pursuant to the HIPAA Requirements, all business associates of Health Net (and all Subcontractors of business associates) must agree in writing to certain mandatory provisions regarding the safeguarding, use and disclosure of PHI; and
- E. The purpose of this Addendum is to satisfy the requirements of the HIPAA Requirements, including, but not limited to, business associate contract requirements set forth at 45 C.F.R. § 164.308(b)(1) and § 164.314(a) and § 164.504(e), as they may be amended from time to time.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

- 1. Definitions. Unless otherwise provided in this Business Associate Addendum, other capitalized terms have the same meaning as set forth in the HIPAA Requirements.
- 2. Scope of Safeguards, Use and Disclosure of Protected Health Information. Except as otherwise limited in this Business Associate Addendum, Business Associate shall safeguard, use, and disclose PHI solely to provide the services, or perform the functions, described in the Agreement, provided that such use or disclosure would not violate the HIPAA Requirements if so used or disclosed by Health Net. Business Associate, to the full extent applicable, shall ensure that its directors, officers, and employees shall:
  - (a) Not use or further disclose PHI other than as permitted or required by this Business Associate Addendum or as Required By Law;
  - (b) Implement appropriate administrative, physical, and technical safeguards to protect the confidentiality and integrity of the PHI that Business Associate creates, receives, maintains, or transmits on behalf of Health Net and to prevent use or disclosure of PHI other than as provided by this Business Associate Addendum;
  - (c) Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a safeguard, use or disclosure of PHI by Business Associate in violation of the requirements of this Business Associate Addendum;

- (d) Report promptly to Health Net's designated Privacy Officer at [privacy@healthnet.com](mailto:privacy@healthnet.com) any use or disclosure of PHI not provided for by this Business Associate Addendum of which Business Associate becomes aware;
- (e) Require Subcontractors to whom Business Associate provides PHI received from, or created or received by Business Associate on behalf of, Health Net, to agree in writing to the same safeguards, restrictions and conditions that apply to Business Associate with respect to such PHI under this Business Associate Addendum and notify Subcontractors that they will incur liability under their agreement and under the HIPAA Requirements for non-compliance;
- (f) Provide to Health Net in the form and format specified by Health Net (or, as directed by Health Net, to an Individual), and in the time and manner reasonably designated by Health Net, but in any event no later than 10 calendar days after written request by Health Net, any information necessary to allow Health Net to respond timely to a request by an Individual for a copy of the Individual's PHI pursuant to 45 C.F.R. § 164.524;
- (g) Maintain for a period of six (6) years all Designated Record Sets relating to PHI received from, or created or received by Business Associate on behalf of, Health Net;
- (h) Maintain for a period of six (6) years records of all disclosures of PHI, other than for the purpose(s) set forth in this Business Associate Addendum, including the date, name of recipient, description of PHI disclosed and purpose of disclosure;
- (i) Provide to Health Net or, as directed by Health Net, to an Individual, in the time and manner reasonably designated by Health Net, but in any event no later than 10 calendar days after written request by Health Net, any necessary information collected in accordance with Section 2(H) of this Business Associate Addendum in order to allow Health Net to respond timely to a request by an Individual for an accounting of the disclosures of the Individual's PHI pursuant to 45 C.F.R. § 164.528;
- (j) Make any amendments to PHI that Health Net directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of Health Net or an Individual in the time and manner designated by Health Net;
- (k) Make reasonable efforts to implement any restriction of the use or disclosure of PHI that Health Net has agreed to as described under Section 4(c) of this Business Associate Addendum;
- (l) Business Associate shall use appropriate administrative, physical, and technical safeguards to prevent improper use or disclosure of PHI in any form or media. As required by 45 C.F.R. Part 164, Subpart C with respect to ePHI, develop, implement, maintain, use and comply with administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that Business Associate creates, receives, maintains, or transmits on behalf of Health Net as required by 45 CFR Part 164, Subpart C;
- (m) Additionally, as required by 45 CFR Part 164, Subpart C, with respect to ePHI, ensure that any Subcontractor, to whom Business Associate provides PHI, agrees, in writing, to develop, implement maintain, use, and comply with reasonable and appropriate safeguards to protect the ePHI. Business Associate shall implement and comply with (and ensure that its Subcontractors implement and comply with) the administrative safeguards set forth at 45 C.F.R. 164.308, the physical safeguards set forth at 45 C.F.R. 310, the technical safeguards set forth at 45 C.F.R. 164.312, and the policies and procedures set forth at 45 C.F.R. 164.316 to reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI and ePHI that it accesses, uses, creates, maintain, transmits and/or discloses on behalf of Health Net. Business Associate acknowledges the foregoing safeguards, policies and procedures requirements shall

apply to Business Associate and Business Associate's Subcontractors in the same manner that such requirements apply to Health Net;

- (n) To disclose to its Subcontractors or other authorized third parties, only (i) the information contained in a "limited data set," as such term is defined at 45 C.F.R. 164.514(e)(2), or, (ii) if needed by Business Associate or its Subcontractors or other authorized third parties, the minimum necessary data to accomplish the intended purpose of such requests or disclosures. In all cases, Business Associate shall request and disclose PHI only in a manner that is consistent with guidance issued by the Secretary from time to time;
- (o) Additionally, as required by 45 CFR Part 164, Subpart C, with respect to ePHI, report to Health Net any Security Incident (whether at Business Associate or at a Subcontractor) of which Business Associate becomes aware;
- (p) Make Business Associate's internal practices, books, and records relating to the safeguards, use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Health Net available to Health Net or, at the request of Health Net, to the Department of Health and Human Services ("DHHS"), in a time and manner designated by Health Net or DHHS, for purposes of determining Health Net's compliance with the HIPAA Requirements; provided that, in all events, Business Associate shall immediately notify Health Net upon receipt by Business Associate of any request received from DHHS relating to Health Net's compliance with the HIPAA Requirements and shall provide Health Net with copies of any materials provided to DHHS;
- (q) Business Associate agrees that with respect to any and all PHI received from Health Net or created or received by Business Associate on behalf of Health Net that Business Associate maintains, or which is maintained by any Subcontractor of Business Associate, in any form (collectively for this Section referred to as "Health Net PHI") and no longer needed to perform services under the Agreement, or, at any time upon Health Net's written request, Business Associate will return or destroy all Health Net PHI, and shall retain no copies of such Health Net PHI; provided that if such return or destruction is not feasible or contrary to the record retention requirements of the Agreement or applicable law, Business Associate shall extend the protections of the Agreement to the Health Net PHI and limit further uses and disclosures to those purposes that make the return or destruction of the Health Net PHI infeasible or that require Business Associate to retain PHI. A senior officer of Business Associate shall certify in writing to Health Net that all PHI has been returned or destroyed as provided above and that Business Associate retains no copies of PHI in any form;
- (r) Allow Health Net, upon reasonable notice, to inspect Business Associate's policies, procedures, and practices with respect to compliance with the terms of this Business Associate Addendum; provided, however, that Health Net has no duty to inspect and its decision not to inspect does not relieve Business Associate of its compliance responsibility;
- (s) To the extent that Business Associate carries out one or more of Health Net's obligations under the HIPAA Requirements, Business Associate must comply with all requirements of the HIPAA Requirements that would be applicable to Health Net;
- (t) Business Associate must honor all restrictions consistent with 45 C.F.R. §164.522 that Health Net or the Individual makes the Business Associate aware of, including the Individual's right to restrict certain disclosures of protected health information to a health plan where the individual pays out of pocket in full for the healthcare item or service, in accordance with the HIPAA Requirements; and

- (u) Except as provided for in this Business Associate Addendum, in the event Business Associate receives an access, amendment, accounting of disclosure, or other similar request directly from an Individual, Business Associate shall provide Health Net with written notice of such request within five (5) business days of such request. If applicable, within five (5) business days of notice to Business Associate by Health Net of a request for an accounting of disclosures, access or amendment request, Business Associate shall make available the PHI to Health Net as required for Health Net to comply with 45 C.F.R. §164.528; provide Access consistent with the requirements of 45 C.F.R. §164.524; and/or, provide an accounting consistent with the requirements of 45 C.F.R. §164.528. If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable Health Net to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. §17935(e).

### 3. Reporting of Breaches.

- (a) In addition to the obligations set forth elsewhere in this Business Associate Addendum, Business Associate agrees that, except as specifically provided in subsection (c), Business Associate agrees to report to Health Net's Privacy Officer at [privacy@healthnet.com](mailto:privacy@healthnet.com) any Breach of Unsecured PHI, including any Breach of Unsecured PHI involving Business Associate's Subcontractors, the same business day after Discovery of a Breach. More specifically, as provided for in 45 C.F.R. § 164.102, Business Associate recognizes and agrees that any acquisition, access, use or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule (Subpart E of 45 C.F.R. Part 164) is presumed to be a Breach. As such, Business Associate shall (i) notify Health Net of any non-permitted acquisition, access, use or disclosure of PHI, and (ii) assist Health Net in performing (or at Health Net's direction, perform) a risk assessment to determine if there is a low probability that the PHI has been compromised. Such notice shall include the identification of each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate, to have been, accessed, acquired, or disclosed in connection with such Breach. Notifications should be sent to [privacy@healthnet.com](mailto:privacy@healthnet.com). In addition, Business Associate shall provide any additional information reasonably requested by Health Net for purposes of investigating and responding to the Breach.
- (b) In the case of a Breach of Unsecured PHI (whether by Business Associate or Business Associate's Subcontractor), Business Associate agrees to provide Health Net with information to enable it to assess whether there is a low probability that the data involving protected health information has been compromised and to cooperate with Health Net in meeting any other obligations under the HIPAA Requirements and other applicable security breach notification laws. The information must include information regarding the following factors: the nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification; the unauthorized person(s) who used the protected health information or to whom the disclosure was made; whether the protected health information was actually acquired or viewed; and, the extent to which the risk to the protected health information has been mitigated.
- (c) **Additional Responsibilities in the Event of Breach.** Business Associate shall take prompt steps to limit or avoid the recurrence of any Breach and take any other action pertaining to such unauthorized access or disclosure required by applicable federal and state laws and regulations. Business Associate shall comply with this provision regardless of any actions taken by Health Net. Business Associate further agrees to mitigate, to the extent practicable, any harmful effect that becomes known to Business Associate of a Breach or a use or disclosure of PHI by Business Associate in violation of the requirements of this Business Associate Addendum.

4. Obligations of Health Net To assist Business Associate in the proper use and disclosure of PHI, Health Net shall:
  - (a) Provide Business Associate with the notice of privacy practices that Health Net produces in accordance with 45 C.F.R. § 164.520, as well as any changes to such notice;
  - (b) Provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures;
  - (c) Notify Business Associate of any restriction on the use or disclosure of PHI that Health Net has agreed to in accordance with 45 C.F.R. § 164.522; and
  - (d) Not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Requirements if the PHI were to be so used or disclosed by Health Net.
  
5. Standard Transactions. . To the extent Business Associate conducts Standard Transaction(s) on behalf of Health Net, Business Associate shall, without limitation, comply with the HIPAA Regulations, "Administrative Requirements for Transactions," 45 C.F.R. § 162.100 et seq., and shall not: (a) Change the definition, data condition or use of a data element or segment in a standard; (b) Add any data elements or segments to the maximum defined data set; (c) Use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) Change the meaning or intent of the standard's implementation specifications.
  
6. Termination for Breach.
  - (a) Health Net and Business Associate each shall have the right to terminate the Agreement upon written notice to the other if either Party determines that the other Party has breached a material term of the provisions of this Business Associate Addendum; provided that Health Net's remedies under this Business Associate Addendum and the section(s) of the Agreement related to termination, if any, shall be cumulative.
  - (b) As an alternative to the preceding paragraph, either Party may choose to provide the other Party with ten (10) days written notice of the existence of an alleged material breach and afford the Party in breach the opportunity to cure such alleged material breach. The Party receiving such breach notice must cure such breach to the satisfaction of the non-breaching Party or the non-breaching Party may declare a material breach in accordance with Section 6(a) above. If termination of this Business Associate Addendum or the Agreement is not feasible, Health Net shall report the problem to the Secretary of U.S. Health and Human Services.
  
7. Future Confidentiality of PHI. Upon the expiration or earlier termination of the Agreement, for any reason and only upon written request by Health Net, Business Associate shall return or destroy all PHI received from Health Net, or created or received by Business Associate on behalf of Health Net that Business Associate still maintains and retain no copies of such PHI; provided that if such return or destruction of PHI is infeasible, Business Associate shall provide to Health Net notification of the conditions that make return or destruction infeasible and shall extend the protections of this Business Associate Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. Business Associate agrees that if applicable state law requires the retention of Health Net PHI for a specified time period, Business Associate shall postpone destruction of such Health Net PHI in compliance with applicable state law.

8. Survival of Terms. The obligations of Business Associate under Sections 2(f), 2(g), 2(h), 2(i), 2(p), 2(q) and 3 of this Business Associate Addendum shall survive the termination or expiration of the Agreement.
9. Injunctive Relief. Business Associate agrees that the remedies at law for any breach by it of the terms of this Business Associate Addendum shall be inadequate and that monetary damages resulting from such breach are not readily measured. Accordingly, in the event of a breach or threatened breach by Business Associate of the terms of this Business Associate Addendum, Health Net shall be entitled to immediate injunctive relief. Nothing herein shall prohibit Health Net from pursuing any other remedies available to it for such breach, and Health Net's rights under this Business Associate Addendum and the sections of the Agreement related to injunctive relief, if any, shall be cumulative.
10. Amendment of Addendum. In the event of a material change in the HIPAA Requirements or state law affecting safeguards or the use or disclosure of PHI, or amendments for new or changed Standard Transactions or Identifiers, Health Net may amend this Business Associate Addendum and the Agreement as necessary to comply with the change in the law or regulation and such amendment shall become effective sixty (60) days after receipt by Business Associate. Health Net's rights and remedies under this Business Associate Addendum and the section(s) of the Agreement related to amendments, if any, shall be cumulative.
11. Notice of Investigation or Lawsuit and Indemnification. Business Associate shall notify Health Net immediately upon receipt of notice of an investigation or of a lawsuit filed against Business Associate related to or arising from the use or disclosure of PHI by Business Associate or a Business Associate Subcontractor pursuant to this Business Associate Addendum. Any indemnification provision in the Agreement shall apply to Business Associate's and Health Net's use and disclosure of PHI pursuant to this Business Associate Addendum; provided, however, that the limits of liability and limits on consequential type damages, if any, provided in the Agreement shall not apply in the event of a breach of this Business Associate Addendum or with respect to Business Associate's obligations for indemnification.
12. Confidentiality. Notwithstanding the foregoing, PHI shall not be included within the definition of "confidential information" in the section(s) of the current Agreement related to protection of confidential information, if any, as Business Associate's obligations with respect to PHI are set forth in this Business Associate Addendum.
13. State Law Requirements. To the extent that State law is more stringent than the HIPAA Requirements, any safeguard, use or disclosure of PHI by Business Associate shall be made in accordance with State law.
14. Interpretation. Any ambiguity in this Business Associate Addendum shall be resolved in favor of a meaning that permits Health Net to comply with the HIPAA Requirements.
15. Effective Date. This Business Associate Addendum shall be effective on the effective date of the Agreement.

**CALIFORNIA  
PROVIDER PARTICIPATION AGREEMENT  
FEE-FOR-SERVICE DIRECT NETWORK TEMPLATE**

This Provider Participation Agreement (“Agreement”) is made and entered into by and between the Provider identified on the signature page of this Agreement (“Provider”), and Health Net of California, Inc. on behalf of itself and its subsidiaries and affiliates (collectively, “Health Net”). This Agreement is effective as of the effective date shown on the signature page of this Agreement, subject to the completion of any applicable credentialing requirements.

**RECITALS**

A. Provider has the legal authority to enter into this Agreement, and to deliver or arrange for the delivery of Contracted Services.

B. Health Net has the legal authority to enter into this Agreement, and to perform the obligations of Health Net hereunder with respect to the Benefit Programs.

C. The parties desire to enter into this Agreement to arrange for Provider to participate in one or more of Health Net’s networks of Participating Providers that render Contracted Services to Beneficiaries of various Benefit Programs.

D. Provider’s primary consideration shall be the quality of the health care services rendered to Beneficiaries, pursuant to Title 10 CCR 2240.4.

**AGREEMENT**

NOW, THEREFORE, in consideration of the above recitals and the covenants contained herein, the parties hereby agree as follows:

**I. DEFINITIONS**

Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Article I.

**1.1 Allowable Charges.** Allowable Charges is defined as Provider’s billed charges for Contracted Services.

**1.2 Beneficiary.** A person who is properly enrolled in and eligible to receive Covered Services under a Benefit Program at the time Covered Services are rendered. The parties acknowledge that the term ‘member’ may be used by Health Net in certain related materials, such as Benefit Program documents covering various products, marketing materials, and Health Net Policies. For reference purposes, the term Beneficiary includes the term ‘member’ wherever used.

**1.3 Benefit Program.** The group agreement, evidence of coverage, certificate of insurance, summary plan description or similar documents in effect at the time Covered Services are rendered for lines of business offered through Health Net. The Benefit Programs in which Provider participates and terms and conditions such as payment rates relating to such Benefit Programs, are set forth in the Addenda to this Agreement.

**1.4 Coinsurance.** That portion of the cost of Covered Services that a Beneficiary is obligated to pay under a particular Benefit Program which is calculated as a percentage of the contracted reimbursement rate for such services. Coinsurance does not include Copayments or Deductibles.

**1.5 Complete Claim.** A Complete Claim means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides reasonably relevant information as defined by applicable State or federal statutes and regulations, and which is submitted to Health Net or a Payor by Provider for payment of Contracted Services that may be processed by Health Net or a Payor without obtaining additional information from Provider or from a third party.

**1.6 Contracted Services.** Covered Services that are (i) those services which Provider is licensed to provide and which Provider customarily provides to its patients, and (ii) to be provided to a Beneficiary under the terms of the applicable Benefit Program in effect at the time such services are rendered or as required by State or federal law, and (iii) compensated in accordance with this Agreement except as otherwise may be required by State or federal law.

**1.7 Coordination of Benefits.** The allocation of financial responsibility between two or more payors of health care services, each with a legal duty to pay for or provide Covered Services to a Beneficiary at the same time.

**1.8 Copayment.** That portion of the cost of Covered Services that a Beneficiary is obligated to pay under a particular Benefit Program, which generally is a fixed dollar amount and is paid at the time Covered Services are rendered. Copayments do not include Coinsurance or Deductibles.

**1.9 Covered Services.** The health care services, equipment and supplies that are covered as determined by the Benefit Program and by applicable State and federal law and regulations, including without limitation decisions issued as a result of independent medical review conducted under applicable State or federal law.

**1.10 Deductible.** The amount of money that a Beneficiary must pay before the Benefit Program pays certain benefits for Covered Services. Deductibles do not include Coinsurance or Copayments.

**1.11 Dispute.** The term “Dispute”, as used in this Agreement, including Sections 7.5 and 7.6, shall mean any controversy or disagreement that may arise out of or relate to this Agreement, or the breach thereof, whether involving a claim in tort, contract or other applicable area of law.

**1.12 Emergency.** The term “Emergency” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient’s health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Active labor is considered an Emergency. “Active labor” means labor at the time that either of the following could reasonably occur: (1) There is inadequate time to effect safe transfer to another Hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the Enrollee or unborn child.

Certain Benefit Plans require adherence to the federal and government program standard for defining and Emergency, which defines an Emergency as : a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the patient’s health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

**1.13 Excluded Services.** Those health care services, equipment and supplies that are determined by Health Net or a Payor to be non-Covered Services under the applicable Benefit Program in effect at the time such services are rendered and for which Provider may bill the Beneficiary.

**1.14 Facility(ies).** All service locations owned, operated, leased, or subcontracted by Provider at which Contracted Services are provided under this Agreement. Provider's service locations as of the date this Agreement is executed by the parties are listed on an exhibit to this Agreement.

**1.15 Health Net.** A network of managed health care delivery or indemnity companies, owned, controlled, controlling, under common control with, managed or administered in whole or in part now or hereafter, by Health Net, LLC, its successors and assigns.

**1.16 Health Net Policies.** The policies, procedures and programs established by Health Net and applicable to Participating Providers in effect at the time Covered Services are rendered, including without limitation Health Net's grievance and appeal procedures, provider dispute and/or appeal process, drug formulary or preferred drug list, fraud detection, recovery procedures, eligibility verification, billing and coding guidelines, payment and review policies, anti-discrimination requirements, medical management programs, continuity of care policies, provider manuals and/or operations manuals. The medical management program includes policies regarding topics such as credentialing, utilization management, quality improvement, catastrophic care management, peer review, medical and other record reviews, outcome rate reviews, Prior Authorization, and Referral.

**1.17 Medically Necessary.** A Medically Necessary service or supply is one that meets the following criteria: it is an otherwise covered category of service, not specifically excluded and is recommended by the treating physician and determined by Health Net's Medical Director or physician designee to be: (i) for the purpose of treating a medical condition; (ii) the most appropriate supply or level of service, considering potential benefits and harm to the Beneficiary; not furnished primarily for the convenience of the Beneficiary or Provider; not required solely for custodial, comfort or maintenance reasons; consistent with Health Net Policies and furnished in the most appropriate place of service consistent with nationally recognized review criteria and/or guidelines, such as, for example, Milliman or Interqual criteria; and (iii) known to be effective and safe in improving health outcomes. For new treatments, services or supplies, effectiveness is determined by scientific evidence. For existing treatments, services or supplies, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. The fact that a physician or other provider may prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary or make it a Covered Service.

**1.18 Participating Provider.** A facility, physician, physician organization, physician group, independent practice association, health care provider, supplier, or other organization which has met applicable credentialing requirements, if any, and has, or is governed by, an effective written agreement directly with Health Net or indirectly through another entity, such as a Provider, to provide Covered Services.

**1.19 Pavor.** Any public or private entity contracted with Health Net which provides, administers, funds, insures or is responsible for paying Participating Providers for Covered Services rendered to Beneficiaries under a Benefit Program, including self-funded health plans.

**1.20 PPG.** A participating physician group that has entered into an agreement with Health Net to deliver or arrange for the delivery of certain Covered Services to Beneficiaries.

**1.21 Primary Care Physician (PCP).** A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who: (i) is duly licensed and qualified under the laws of the relevant jurisdiction to render certain Covered Services; (ii) is a Participating Provider; and (iii) meets the credentialing standards of Health Net for designation as a PCP; and (iv) is responsible for coordinating the provisions of health care services and providing for continuity of care and twenty-four (24) hours a day, seven (7) days a week availability to Beneficiaries.

**1.22 Prior Authorization.** The written or electronically issued prior approval by Health Net or its designee for the provision of Covered Services which may be required under a Benefit Program or a Health Net Policy.

**1.23 Professional Provider.** The physicians, allied health professionals and other health care providers who contract with Provider, or are employed by Provider, and who have been accepted by Health Net to provide

Contracted Services to Beneficiaries under the terms and conditions of this Agreement, and billed through Provider's federal tax identification number and/or national provider identifier. Professional Providers covered by this Agreement as of the date this Agreement is executed by the parties are listed on an exhibit to this Agreement.

**1.24 Records.** Books, documents, contracts, subcontracts, and records prepared and/or maintained by a party that relate to this Agreement whether in written or electronic format, including without limitation medical records, Beneficiary billing and payment records, financial records, policies and procedures, and other books and records that may be required by applicable federal and State law.

**1.25 Referral.** The written or electronically issued referral of a Beneficiary by a Participating Provider to another health care provider that may be required under a Benefit Program or a Health Net Policy prior to the rendition of Covered Services, usually for a specified number of visits or type or duration of treatment.

**1.26 State.** The State of California.

**1.27 Surcharge.** An additional fee which is charged to a Beneficiary for a Covered Service, but which is not approved by the applicable State and federal regulatory authority, and is neither disclosed nor provided for in a Benefit Program.

## **II. DUTIES OF PROVIDER**

**2.1 General Obligations.** Provider agrees on behalf of itself, and each of its Facilities and Professional Providers, as applicable, that during the term of this Agreement and any renewal terms, each of them is:

- 2.1.1 licensed without restriction or limitation by the State to provide Contracted Services to the extent required by the State;
- 2.1.2 operating and providing Contracted Services in compliance with applicable local, State, and federal laws, rules, regulations and legal standards of care;
- 2.1.3 delivering Contracted Services to Beneficiaries in the same manner and with the same availability, as services are delivered to other patients;
- 2.1.4 maintaining such physical plant, equipment, patient service personnel and allied health personnel as may be necessary to provide Contracted Services;
- 2.1.5 available to Beneficiaries twenty-four (24) hours per day, seven (7) days per week on an Emergency basis.
- 2.1.6 Provider shall notify Health Net in writing, thirty (30) days in advance, of any changes, including but not limited to, federal tax identification numbers, practice or billing addresses, office email address, phone numbers, office hours, non-English languages spoken by Provider or medical office staff, hospital affiliation and admitting privileges, and/or national provider identifier numbers. In addition, Provider shall acknowledge and respond in a timely manner to all Health Net requests for practice information updates. Provider shall inform Health Net within five (5) business days when either of the following occurs:
  - A) Provider is not accepting new patients, or
  - B) Provider had previously not accepted new patients, but is currently accepting new patients.
- 2.1.7 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Provider agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii)

maintain the confidentiality of Member information and records pursuant to this Agreement; and  
iii) allow Health Net to use Provider's performance data.

- 2.1.8 Provider agrees to cooperate and implement the California Health and Human Services Data Exchange Framework data sharing that requires the real time exchange of health information for members as outlined in California Assembly Bill 133 and Health Net Policies.

**2.2 Provision of Services.** Provider agrees to render Contracted Services to Beneficiaries of Benefit Programs under the terms and conditions of this Agreement. Notwithstanding the foregoing, Provider understands and agrees that Health Net or a Payor does not have an obligation under this Agreement to assign or refer to Provider any minimum amount of Beneficiaries. Health Net has not represented or guaranteed to Provider that any Beneficiaries shall receive Covered Services from Provider or that Provider shall participate in all networks of Participating Providers offered by or through Health Net.

Provider acknowledges that Health Net or a Payor shall not be liable for, nor will exercise control or direction over, the manner or method by which Provider, Facilities, and/or Professional Providers render any Covered Services to Beneficiaries under this Agreement.

**2.3 Verification of Eligibility.** Except in an Emergency, Provider shall verify the eligibility of Beneficiaries using Health Net's telephonically or electronically available system before providing Contracted Services, in compliance with the timeframes and procedures set forth in Health Net Policies.

**2.4 Non-Discrimination.** Provider shall not discriminate against any Beneficiary in the provision of Contracted Services hereunder, whether on the basis of the Beneficiary's coverage under a Benefit Program, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, source of payment, utilization of medical or mental health or substance use disorder services or supplies, equipment, pharmaceuticals or supplies, health status (including without limitation, Beneficiaries who are, were, or may be victims of domestic violence, or have or may have conditions that are caused by domestic violence ), genetic information, or other unlawful basis including, without limitation, the filing by such Beneficiary of any complaint, grievance or legal action against Provider, Health Net or Payor. Provider agrees to make reasonable accommodations for Beneficiaries with disabilities or handicaps, including but not limited to, providing such auxiliary aides and services to Beneficiaries as are reasonable, necessary and appropriate for the proper rendering of Contracted Services at the Provider's expense.

**2.5 Professional Providers and Facilities.** The following provisions apply when Provider utilizes Professional Providers or Facilities to deliver Contracted Services to Beneficiaries:

- 2.5.1 Provider binds its Facilities and Professional Providers, if any, covered by this Agreement, to the terms and conditions of this Agreement, to the extent Contracted Services and/or contractual provisions are performed by, or apply to, such Facilities and Professional Providers;
- 2.5.2 No new or satellite facility shall be added to this Agreement, or be allowed to deliver Covered Services under this Agreement until Health Net has approved such Facility. Health Net reserves the right to deny participation under this Agreement to any new or satellite facility without any obligation to provide a right to appeal except as may be required by applicable State and federal law.
- 2.5.3 In the event Provider desires to add a new Participating Provider, Provider shall notify Health Net in writing as soon as possible but no later than sixty (60) days before such proposed addition is to become effective with Health Net. Provider agrees that no new Professional Provider shall be added to this Agreement, or be allowed to render Covered Services under this Agreement, unless and until Health Net has approved the addition of such Professional Provider. Health Net reserves the right to deny participation under this Agreement to any proposed new Participating Provider without any obligation to provide a right to appeal except as may be required under State or federal law.

Provider additionally shall comply with the terms of Section 2.6 hereof with respect to its Facilities and Professional Providers, to the extent Facilities are not owned, and/or Professional Providers are not employed, by Provider.

**2.6 Subcontracting.** The following requirements shall survive termination of this Agreement with respect to Contracted Services rendered during the term of the Agreement and apply when Contracted Services are provided by a subcontractor, such as a reference laboratory:

- 2.6.1 Provider shall furnish Health Net with copies of its subcontracts within ten (10) days of Health Net's written request.
- 2.6.2 Every subcontract shall comply with all applicable local, State and federal laws, including privacy/confidentiality and medical record accuracy laws, be consistent with the terms and conditions of this Agreement, and shall not be used by Provider with respect to Beneficiaries, Benefit Programs and/or Contracted Services upon the reasonable request of Health Net.
- 2.6.3 Provider shall not subcontract either directly or indirectly, with any provider that has been excluded from participation in the Medicare Advantage Program under Section 1128 or 1128A [42 U.S.C. 1320a-7] of the Social Security Act or in the State Medi-Cal program.
- 2.6.4 Each such subcontractor shall meet applicable Health Net credentialing requirements, if any, prior to the subcontract becoming effective with respect to Contracted Services.
- 2.6.5 (i) Provider shall be solely responsible to pay the subcontractor and (ii) Provider shall hold Health Net, Payors and Beneficiaries harmless from and against any and all claims which may be made by subcontractors in connection with Covered Services provided to Beneficiaries by the subcontractor; and (iii) Provider shall require that the subcontractor hold Health Net, Payors, and Beneficiaries harmless from and against any and all claims for payment for such services and shall not attempt to collect any sums owed by Provider from Health Net or a Beneficiary.
- 2.6.6 Subcontracts shall not restrict the rights and obligations of a healthcare provider to communicate freely with Beneficiaries regarding their medical condition and treatment alternatives including medication treatment options, regardless of benefit coverage limitations.
- 2.6.7 In the event that any of Provider's subcontracts fail to comply with the requirements set forth herein, Health Net or Payor shall not be required to recognize the existence or validity of the subcontract with respect to Beneficiaries, Benefit Programs and/or Covered Services. Health Net or a Payor shall further have the right, but not the obligation, to directly pay subcontractors submitting claims for Contracted Services, and to recoup any compensation otherwise due by Health Net or a Payor to Provider pursuant to the terms and conditions of this Agreement. Provider shall indemnify and hold harmless Health Net or a Payor for all such payments and related costs.

**2.7 Participating Providers.** Except in an Emergency, as otherwise permitted in the applicable Benefit Program Requirements, or as otherwise required by applicable federal or State law, if Provider refers a Beneficiary for Covered Services, Provider shall refer Beneficiary only to Participating Providers and Provider shall coordinate such referrals with Health Net or its designee to facilitate the utilization of the most appropriate Participating Provider based upon the Medical Necessary level of care required for the Beneficiary.

Prior to rendering any non-emergency episode of care, Provider shall determine and disclose to EPO and PPO Beneficiaries the out-of-network providers who are likely to be involved in providing care and the estimated cost of that non-participating provider's care (e.g. for a surgery, Provider shall disclose to the Beneficiary prior to the surgery, all non-participating providers, such as anesthesiologists, radiologists, and pathologists, who are anticipated to be involved in the Beneficiary's care, and the estimated cost of such out-of-network services).

Provider's disclosure shall be made sufficiently in advance of the scheduled episode of care to afford the Beneficiary a reasonable opportunity to explore alternate arrangements.

**2.8 Health Net Policies.** Provider shall participate in and comply with all Health Net Policies in effect on the effective date of this Agreement, and as modified periodically by Health Net in accordance with Section 3.2 of this Agreement. Provider hereby acknowledges that it has had the opportunity to review Health Net Policies regarding quality improvement and utilization management that pertain to Health Net and Provider's rights and obligations under this Agreement at least fifteen (15) business days prior to the date Provider has executed this Agreement.

**2.9 Prior Authorization and Referrals.** When either Prior Authorization and/or a Referral is required for the rendition of a health care service, the receipt of the required Prior Authorization and/or the required Referral, each being separate and distinct requirements, is a prerequisite to payment of Complete Claims for Covered Services in addition to confirming eligibility prior to delivering service as required by this Agreement and Health Net Policies. Health Net (or its designee as applicable) may rescind or modify its Prior Authorization, in a manner consistent with Health Net Policies, based on variety of factors, including but not limited to the eligibility of the Beneficiary and whether the rendered service is a Covered Service. However, when Health Net or its designee issues a Prior Authorization for a specific service under a Benefit Program regulated by the California Department of Managed Health Care or the California Department of Insurance, Health Net (or its designee as applicable) shall not rescind or modify its Prior Authorization after Provider has rendered the specified and authorized service in good faith and pursuant to the terms of the Prior Authorization for any reason, including, but not limited to, Health Net's subsequent rescission, cancellation, or modification of the Beneficiary's contract or Health Net's subsequent determination that it did not make an accurate determination of the Beneficiary's eligibility; provided, however that this section shall not be construed to expand or alter benefits available to a Beneficiary under such Benefit Program.

**2.10 Notification.** Provider shall notify Health Net or a Payor and the appropriate PCP or PPG as applicable, as soon as possible, but no later than 24 hours or by the next business day after a Beneficiary is admitted to a Facility.

**2.11 Credentialing Program.** Provider shall submit to Health Net or its designee any applicable Credentials Application, which meets minimum requirements of Health Net. Provider or any Professional Provider or subcontractor shall not begin performing Provider's obligations under this Agreement, until Provider and/or Professional Provider and/or Facility has satisfied applicable credentialing or re-credentialing requirements, if any.

**2.12 Insurance.** Provider shall maintain insurance in amounts and types as required by Health Net Policies. Provider agrees to provide Health Net with a Certificate of Insurance from Provider's insurance carrier or other mutually agreeable written evidence of such insurance coverage within three (3) days of such request by Health Net. Provider also agrees to notify Health Net in writing at least thirty (30) days prior to any termination, cancellation or material modification of any policy for all or any portion of the coverage required herein.

**2.13 Trade names, Trademarks, Directories.** Provider shall not use or display the trade names, trademarks, or other identifying information of Health Net without Health Net's prior written approval of both form and content, which approval shall not be unreasonably withheld. However, this provision shall not prohibit Provider from posting a reasonable notice on its website or in its Facilities listing by name those insurance carriers that are accepted by Provider so long as the notice lists each name in substantially similar format. Provider shall supply all printed materials and other information requested by Health Net in connection with the production of provider directories within seven (7) days of Health Net's request. Provider agrees that Health Net may list the name, address, telephone number and other factual information of Provider, each Facility and Professional Provider, and of Provider's subcontractors and their facilities in its provider directories, marketing and informational materials, and electronic media.

**2.14 Non-Solicitation.** Neither Provider nor any employee, agent or subcontractor of Provider shall solicit or attempt to convince or otherwise persuade any Beneficiary to discontinue participation in any Benefit Program or in any other manner interfere with Health Net's contract and/or property rights; provided, however, that this provision does not prohibit Provider from posting a reasonable notice on its website or in its Facilities listing by name those insurance carriers that are accepted by Provider so long as the notice lists each name in substantially similar format. Notwithstanding the foregoing, Health Net in no way restricts Provider from discussing medical treatment options with Beneficiaries regardless of Benefit Program coverage options.

**2.15 Language Assistance Program.** Provider shall comply with Health Net’s ongoing language assistance program to ensure Limited English Proficient (“LEP”) Beneficiaries have appropriate access to language assistance while accessing Provider services, pursuant to Health and Safety Code §§ 1367(e)(3), 1367.04 and 1367.07 and Insurance Code §§ 10133.8 and 10133.9 and corresponding provisions of the California Code of Regulations.

**2.16 Additional Rights and Obligations.** Any additional rights or obligations of Provider or Health Net shall be set forth in the Addenda to this Agreement.

**2.17 Federal Lobbying Restriction.** Health Net is obligated under 31 U.S.C. § 1352 to obtain certain information from subcontractors engaged to fulfill part or all of Health Net’s obligations under its health maintenance contracts with state and local governments, the proceeds of which are funded by federal grants or federal appropriations. To that end, Provider certifies and agrees as follows:

Certification: Provider certifies that it has not and will not use any funds received from Health Net under this Agreement to lobby Congress or any employee or member of Congress, or any federal agency or federal government employee or official (hereinafter “the federal government”) for the award of any federal contract, grant, appropriation or loan (or the continuation, extension, renewal, amendment, or modification of the same) or for the ability to participate in any federal cooperative agreement.

Required Disclosures: Provider also agrees that if it engages any person to lobby the federal government for the award to Health Net of a federal contract, grant, appropriation, or loan (or the continuation, extension, renewal, amendment, or modification of the same) or for the ability to participate in any federal cooperative agreement involving Health Net, the undersigned will fully and truthfully execute Standard Form LLL as set forth in Health Net Policies, and will provide such executed form to Health Net. Provider understands that Health Net is legally obligated to provide such information to certain federal grant and contract recipients with which it contracts, and further understands that all executed Standard Form LLLs will be supplied to the federal government. Provider agrees to supplement its disclosure under this paragraph promptly if there is a change in any of the information therein.

Subcontracting Obligation: If Provider engages any subcontractor to perform all or part of its obligations under this Agreement, it will require the subcontractor (1) to sign a certification stating that it will not use funds earned under the subcontract to lobby for the award of a federal contract, grant, appropriation or loan (or the continuation, extension, renewal, amendment, or modification of the same) or for the ability to participate in any federal cooperative agreement, and (2) to execute Standard Form LLL, in the event that it engages any person to lobby the federal government for such purposes. Provider will promptly provide to Health Net any Standard Form LLLs executed by its subcontractor(s).

**2.18 Benefit Programs Funded with Federal Funds.** Provider shall, for Benefit Programs funded in whole or in part with federal funds, ensure compliance with all State and/or federal laws, rules, regulations, and other mandates governing payment to providers whose names appear on one or more excluded provider lists maintained by State and/or federal agencies. Such agencies include, but are not limited to, the U.S. Office of the Inspector General (OIG), the CA Department of Healthcare Services (DHCS), and the General Services Administration (GSA). Where any such law, rule, regulation, and/or mandate impose a compliance obligation on a party, and where such compliance depends upon the other party's cooperation, the other party shall not unreasonably withhold such cooperation, sought on reasonable notice.

### III. DUTIES OF HEALTH NET

**3.1 Payment.** Health Net shall, or Health Net shall require Payor to, make payment to Provider for Contracted Services in accordance with Article IV and the applicable addenda, schedules and exhibits of this Agreement.

**3.2 Health Net Policies.** Health Net Policies are set forth in references and forms available to Provider through the Provider Section of Health Net’s website at “<https://providerlibrary.healthnetcalifornia.com>” or by other means which Health Net will communicate to Provider periodically. Health Net Policies in existence as of the effective date of this Agreement are hereby incorporated into this Agreement by reference. Notwithstanding the foregoing and/or any other provision of this Agreement, the parties agree that a formal amendment to this Agreement shall not be required to effectuate modifications to Health Net Policies. Modifications to Health Net Policies may be made periodically as determined by Health Net in accordance with the procedures set forth in applicable State law (including without limitation the California Health Care Providers’ Bill of Rights). Such modifications shall be deemed incorporated in this Agreement as of the effective date of such modification unless otherwise mutually agreed by the parties in writing at the time of the modification in accordance with applicable State law (including without limitation the California Health Care Providers’ Bill of Rights).

**3.3 Insurance.** Health Net shall maintain appropriate insurance programs or policies including bodily injury and personal injury coverage, which includes persons serving on Health Net committees as insured by definition. In the event that a policy or program is terminated or the coverage of committee persons is materially changed, Health Net shall so notify Provider.

**3.4 Reporting to Regulators.** Health Net and/or Payor shall accept sole responsibility for filing reports, obtaining approvals and complying with applicable laws and regulations of State, federal and other regulatory agencies having jurisdiction over Health Net and/or Payor; provided, however, that Provider agrees to cooperate in providing Health Net and/or Payor with any information and assistance reasonably required in connection therewith, including without limitation, permitting the regulatory agencies to conduct periodic site evaluations of Provider, Facilities, Professional Providers and any of their equipment, operations, and billing and medical records of Beneficiaries. Such records shall be located in the State.

**3.5 Access To This Agreement.**

3.5.1 Access by Health Net. As of the effective date of this Agreement, the following Health Net subsidiaries and affiliates may at their option access this Agreement: Health Net of California, Inc., Health Net Life Insurance Company, Health Net Community Solutions, Inc., Wellcare of California, Inc., Arizona Complete Plan, Health Net Health Plan of Oregon, Inc., Health Net Insurance Services, Inc., Health Net Federal Services, LLC., and Network Providers LLC. Notwithstanding the foregoing, Provider agrees that any other subsidiary or affiliate of Health Net not listed above may access the rates and terms set forth in this Agreement. This would include members of non-California based health plan affiliates who may be treated by Provider. To the extent Health Net allows a Health Net subsidiary or affiliate to access this Agreement, Health Net binds such subsidiaries and/or affiliates to the terms and conditions of this Agreement.

3.5.2 Access by Payors. To the extent Health Net allows a self-funded Payor to access this Agreement, Health Net has obligated such self-funded Payor to fund a claims payment account in a sufficient and timely manner to pay claims for services provided by health care providers like Provider. In the event a self-funded Payor accessing this Agreement fails to sufficiently and timely fund a claims payment account to the material detriment of Provider, Provider may terminate this Agreement as to such self-funded Payor in accordance with Section 5.3 hereof, and, notwithstanding the provisions of Section 4.6 of this Agreement, take legal action against the self-funded Payor and/or Beneficiary as may be permitted by law. Additional information regarding Payors and conditions for accessing this Agreement is set forth in Addendum A of this Agreement.

**3.6 Notification to Beneficiaries; Termination of a Professional Provider.** Health Net shall notify Beneficiaries who are affected by the termination of a specialist Professional Provider in writing, immediately upon notification of such termination but no later than thirty (30) calendar days prior to the effective date of such specialist’s termination. Applicable to Commercial HMO Benefit Programs only: For Beneficiaries covered by an

HMO Benefit Program, Health Net shall be required to issue a notice regarding the termination of a specialist's contract that contains the following language in not less than eight-point type: "If you have been receiving care from a health care Provider, you may have a right to keep your Provider for a designated time period. Please contact Health Net's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO customers, by telephone at its toll-free number, 1-888-466-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.dmhc.ca.gov."

**IV. FINANCIAL OBLIGATIONS.** The terms of this Article IV shall survive termination of this Agreement with respect to Covered Services rendered during the term of this Agreement:

**4.1 Payment Rates.** Health Net shall pay (or shall require Payor to pay), and Provider shall accept as payment in full for Contracted Services, the rates payable by Health Net or Payor under the terms and conditions of this Agreement (including the payment conditions, chargemaster and other provisions set forth in the applicable addenda, schedules and exhibits to this Agreement), less Copayments, Coinsurance and Deductibles payable by Beneficiaries in accordance with the applicable Benefit Program or as otherwise permitted by the section of this Agreement covering Third Party Lien Recoveries. Any overpayment, inaccurate payment or other payment error made by Health Net or Payor shall not be deemed or construed or otherwise operate to change the payment terms or rates provided for under this Agreement.

**4.2 Billing and Payment.**

4.2.1 **Billing.** Provider shall submit to Health Net/Payor, via Health Net's/Payor's electronic claims submission program or hardcopy as determined by Health Net/Payor, Complete Claims within one hundred twenty (120) days after Provider renders Contracted Services unless Provider demonstrates good cause pursuant to applicable State law. Where Health Net and/or Payor is the secondary payor under Coordination of Benefits, Provider shall submit Complete Claims for Covered Services accompanied by the explanation of benefits (EOB) or explanation of payment (EOP) from the primary payor to Health Net or a Payor within one hundred twenty (120) days of the date of the EOB/EOP. If Provider fails to comply with the timely claims submission/filing requirements set forth herein, Health Net shall have no obligation to pay for such claims, and Provider shall be prohibited from billing the Beneficiary as set forth in Section 4.6 hereof.

Provider agrees that Health Net or a Payor shall have the right to determine the accuracy of all Complete Claims submitted to it prior to payment, including verification of diagnostic codes, DRG assignment, and whether Provider has delivered the Covered Service in good faith and pursuant to the terms of an applicable Prior Authorization.

4.2.2 **Payment.** Health Net or Payor, as applicable, shall make payment on each of Provider's timely-submitted Complete Claims in accordance with this Agreement and pursuant to the timeframes, procedures and other requirements of applicable State and federal law, including without limitation the calculation and payment of interest on overdue payments. Payment of interest plus the amount of any Complete Claim payment deficiency shall be Provider's sole measure of damages (i.e., claims for consequential or incidental damages do not apply) for failure of Health Net or Payor to make timely and accurate payments. In no event shall Health Net be under any obligation to pay Provider for any claim or expense, which is the responsibility of a self-funded Payor.

4.2.3 **Appeals.** In addition to the dispute resolution and arbitration rights described in Section 7.5 and Section 7.6 herein, Provider may dispute any Health Net action that adjusts, denies, or contests a claim, billing practice, or other contractual provision so long as Provider submits a written dispute to the Health Net Provider Appeals Unit. Unless Provider demonstrates good cause pursuant to applicable State or federal law, Health Net or Payor shall not grant Provider reconsideration or appeal of a claims payment for Covered Services that exceed three hundred sixty five (365) days of

Health Net's action or in the case of inaction, within three hundred sixty five (365) days after the time for contesting or denying claims (as defined in applicable State or federal law) has expired. Appeals shall be submitted by Provider in accordance with the procedures, and to the address for Health Net's Provider Appeals Unit, listed in Health Net Policies. If Provider fails to comply with the timely appeals submission/filing requirements set forth herein, Health Net shall have no obligation to pay for such claims except as otherwise required by applicable State and federal law, and Provider shall be prohibited from billing the Beneficiary as set forth in Section 4.6 hereof. Provider and Health Net agree to comply with all timeliness and procedural requirements for submitting and responding to disputes submitted to Health Net's Provider Appeals Unit as set forth in Health Net Policies.

#### **4.3 Recoupment of Overpayments; Right of Offset.**

- 4.3.1 Provider shall inform Health Net of any overpayment made to Provider, and shall return any such overpayment to Health Net within thirty (30) business days from the date Provider first becomes aware of any such overpayment.
- 4.3.2 In the event Health Net determines that it has overpaid a claim, either in connection with an audit or otherwise, Health Net shall notify Provider in writing through a separate overpayment notice clearly identifying the claim, the name of the Beneficiary, the date of service and explanation of the basis upon which Health Net or Payor believes the amount paid on the claim was in excess of the amount due, including any interest and penalties that may be due on the claim. Such overpayment notice shall be issued within (i) three hundred sixty-five (365) days of the date of payment on the overpaid amount for claims arising from Benefit Programs regulated by the California Department of Managed Health Care or the California Department of Insurance, or within (ii) three (3) years from the date of payment on the overpaid amount for claims arising from other types of Benefit Programs that are not regulated by the California Department of Managed Health Care or the California Department of Insurance, or (iii) at any time, in the event of fraud and/or misrepresentation. Such notice shall be sent to Provider's address of record with Health Net for the receipt of claim related correspondence and payments unless Provider informs Health Net in writing of an alternative address to which such notices are to be sent at least thirty (30) days in advance of the address change.
- 4.3.3 If Provider does not contest Health Net's overpayment notice, Provider shall reimburse Health Net or Payor within thirty (30) business days from the date Provider receives the overpayment notice. If Provider fails to reimburse Health Net or Payor within those thirty (30) business days, then, beginning on the first calendar day after the expiration of this thirty (30) business day time period, Health Net shall commence offsetting, as set forth herein and interest shall accrue on any and all unpaid amounts at the rate of ten percent (10%) per annum.
- 4.3.4 In the event, Provider wishes to contest the overpayment notice, it must do so within thirty (30) business days from the date Provider receives the overpayment notice, by sending to Health Net's Provider Appeals Unit (at the address listed in Health Net Policies) a written appeal clearly stating the basis upon which Provider believes that the claim was not overpaid. Health Net shall review and make a decision with respect to Provider's appeal, and shall notify Provider of its decision in writing within forty-five (45) business days from the date Health Net receives Provider's written appeal. In the event Health Net denies Provider's appeal and upholds Health Net's determination that an overpayment has been made, Provider shall reimburse Health Net or Payor for the overpayment within thirty (30) business days from the date it receives the written notice of Health Net's denial of Provider's written appeal. If Provider fails to reimburse Health Net or Payor within those thirty (30) business days, then beginning on the first calendar day after the expiration of this thirty (30) business day time period, Health Net may commence offsetting as set forth herein, and interest shall accrue on any and all unpaid amounts at the rate of ten percent (10%) per annum.

4.3.5 If Health Net or Payor exercises offset rights hereunder against Provider's current claims payments, Health Net or Payor shall give Provider a detailed written explanation identifying the specific overpayments that have been offset against the specific current claims payments.

4.3.6 If Provider desires to continue to contest the overpayment, it shall do so by following the dispute resolution process set forth in Sections 7.5 and 7.6 of this Agreement.

**4.4 Eligibility.** The parties acknowledge that verification of eligibility by Health Net is based on information available to Health Net from its customers on the date Provider seeks verification. Health Net shall use reasonable efforts to discourage its customers from retroactively canceling or adding Beneficiaries to a Benefit Program and encourage its customers to timely and accurately provide eligibility information. In the event Contracted Services are provided to an individual who is not a Beneficiary, based on an erroneous or delayed enrollment/eligibility list the following shall apply: (i) when the individual is enrolled in a substitute or replacement health care service or insurance plan which is obligated under applicable law to make payment to Provider for services delivered to the individual, Provider shall seek payment from the substitute or replacement carrier; and (ii) when the individual does not have substitute or replacement coverage, Health Net shall pay Provider for Contracted Services delivered to the individual by Provider prior to the time Provider received notice of that individual's ineligibility pursuant to the terms and conditions of this Agreement, provided, however, for those Benefit Programs that are not regulated by the California Department of Managed Health Care or the California Department of Insurance, as an additional prerequisite for payment pursuant to this Section 4.4(ii), Provider shall submit to Health Net evidence that Provider has unsuccessfully sought payment through two billing cycles for all or a portion of such charges from the patient or the person having legal responsibility for the patient, or from the entity having financial responsibility for such payment. In the event Health Net pays Provider pursuant to this Section 4.4, Provider shall have no further right and shall not attempt to collect any additional payment from the individual for said services (except for applicable Copayments, Coinsurance and Deductibles) and Provider hereby assigns and transfers all legal rights of collection and Coordination of Benefits for services to Health Net.

**4.5 Collection of Copayments, Coinsurance and Deductibles.** Provider shall collect all Copayments, Coinsurance and Deductibles due from Beneficiaries, and shall not waive or fail to pursue such collection except when otherwise permitted through Provider's established patient financial assistance program. Provider shall not charge Beneficiary any fees or Surcharges for Contracted Services rendered pursuant to this Agreement (except for Copayments, Coinsurance and Deductibles). In addition, Provider shall not collect a sales, use or other applicable tax from Beneficiaries for the sale or delivery of Contracted Services unless required by applicable State or federal law. If Health Net or any Payor receives notice of any attempt to collect or the receipt of any inappropriate additional charges, including without limitation Surcharges, Health Net or Payor shall take appropriate action. Provider shall cooperate with Health Net or such Payor to investigate such allegations, and shall promptly refund to the party who made the payment, any payment reasonably determined to be improper by Health Net or a Payor.

**4.6 Beneficiary Held Harmless.** Provider agrees that in no event, including, but not limited to, non-payment by Health Net or a Payor, insolvency of Health Net or a Payor, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries or persons acting on their behalf other than Health Net or a Payor for Contracted Services provided pursuant to this Agreement except for Copayments, Coinsurance, Deductibles, Excluded Services or permitted third party liens under this Agreement and as permitted under Section 3.5.2 hereof. This provision shall not prohibit collection of Copayments, Coinsurance or Deductibles or Excluded Services or permitted third party liens under this Agreement made in accordance with applicable Benefit Program Requirements. Provider agrees that: (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Beneficiaries; and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Beneficiaries or persons acting on their behalf. Provider agrees to (iii) address any and all concerns it has with claims payment through Health Net's provider appeal process pursuant to Health Net Policies and (iv) give the Beneficiary and Health Net confirmation that Provider has rescinded the collection notice and taken any other actions necessary to clear the Beneficiary's credit record of the collection matter.

**4.7 Conditions for Compensation for Excluded Services.** Provider may bill a Beneficiary for Excluded Services rendered by Provider to such Beneficiary only if the Beneficiary is notified in advance that the services to be provided are not Covered Services under the Beneficiary's Benefit Program, and the Beneficiary requests in writing that Provider render the Excluded Services, prior to Provider's rendition of such services.

**4.8 Coordination of Benefits.** Provider agrees to conduct Coordination of Benefits in accordance with federal and State laws and regulations and Health Net Policies (“Coordination of Benefit Rules”), including but not limited to, the prompt notification to Health Net or a Payor of any third party entity who may be responsible for payment and collection of Copayments. Provider shall not bill Beneficiaries for any portion of Contracted Services not paid by the primary carrier when Health Net or a Payor is the secondary carrier, but shall seek payment from Health Net/Payor. When Health Net or a Payor is secondary under the Coordination of Benefits Rules, Health Net or a Payor shall pay Provider an amount up to Beneficiary’s primary plan’s copayment, coinsurance or deductibles as applicable, where that payment does not exceed Health Net’s contracted rate under this Agreement. In the event that Medicare is the primary carrier and Health Net Commercial Benefit Program is secondary, Health Net shall pay Provider only up to Medicare's allowable amount and/or the Beneficiary's Copayment, Coinsurance or Deductibles as applicable. When Health Net Medi-Cal is the secondary Payor, Health Net will not pay more than the Provider would receive if DHCS were paying secondary in accordance with Medi-Cal Coordination of Benefits. Such recoveries shall be performed in accordance with the applicable Benefit Program Requirements and Health Net Policies.

**4.9 Third Party Recoveries; Workers Compensation.** In the event Provider provides Covered Services to Health Net Beneficiaries for injuries resulting from the acts of third parties, or resulting from work related injuries, Provider shall have the right to recover from any settlement, award, or recovery from any responsible third-party the reasonable and necessary charges for such Covered Services to the extent permitted by applicable law. Provider shall notify Health Net of any such recovery and shall provide Health Net with an accounting of all such sums recovered. In the event Provider has recovered sums from a third party, Provider agrees to pay such recovered sums to Health Net up to the fee-for-service amounts that Health Net paid to Provider, to the extent that Health Net has not recovered such amounts from its own third party recovery efforts. Provider shall pay these amounts to Health Net within sixty (60) days of Health Net informing Provider of the amounts Health Net recovered from its own third party recovery efforts, if any. This section does not obligate, nor does it prohibit, either Health Net or Provider to undertake such third party recovery efforts.

**4.10 Reciprocity.** Provider agrees that Health Net may allow the payment rates set forth in this Agreement to be used by Participating Providers and PPGs who may periodically be responsible for compensating Provider for Covered Services rendered by Provider to a Beneficiary.

**4.11 Telehealth.** Health Net shall reimburse Provider for the diagnosis, consultation, or treatment of a commercial Beneficiary appropriately delivered through Telehealth services, on the same basis and to the same extent as the reimbursement for the same service through in-person diagnosis, consultation, or treatment. Telehealth shall be defined as applicable in California law and regulations, California Health and Safety Code Sections 1374.14 and 1374.141, California Insurance Code Sections 10123.855 and 10123.856, and California Business and Professions Code Section 2290.5.

## **V. TERM AND TERMINATION**

**5.1 Term.** The term of this Agreement shall commence on the Effective Date and shall continue for a period of one (1) year thereafter (the “Initial Term”). Either party may terminate this Agreement effective as of the end of the Initial Term by providing at least one hundred twenty (120) days prior written notice to the other party. This Agreement shall automatically renew for successive one (1) year periods (the “Renewal Terms”).

**5.2 Immediate Termination.** Either party may terminate this Agreement immediately upon notice to the other party, in the event of: (i) a party’s violation of material law, rule or regulation; (ii) a party’s failure to maintain the insurance coverage specified hereunder; or (iii) a felony conviction or a plea of guilty, nolo contendere or no

contest related to the medical and/or financial practices of a party. Health Net may terminate this Agreement immediately upon notice to Provider in the event of (iv) action taken by a State or federal regulator that results in a material restriction upon Provider's ability to perform Covered Services, including if applicable, operate a Facility or reportable discipline against Provider's license, accreditation, or certification; (v) Health Net's determination that the health, safety or welfare of any Beneficiary may be in jeopardy if this Agreement is not terminated; (vi) any material adverse finding as a result of a lawsuit or claim, related to the medical and/or financial practices of Provider.

**5.3 Termination Due to Material Breach.** In the event either party believes the other party has committed a material breach of this Agreement, the non-breaching party shall send the other party a written Notice Of Breach and Demand to Cure ("Notice"). Without limiting either party's other termination rights under this Article V, in the event that either party fails to cure a material breach of this Agreement within thirty (30) days of receipt of the Notice from the other party (the "Cure Period"), the non-defaulting party may terminate this Agreement by providing the defaulting party thirty (30) days prior written notice of termination. The non-defaulting party may exercise this termination option, if at all; within thirty (30) days of the date the Cure Period expires. If the breach is cured within the Cure Period, or if the breach is one, which cannot reasonably be corrected within the Cure Period, and the defaulting party is making substantial and diligent progress toward correction during the Cure Period to the reasonable satisfaction of the non-defaulting party, this Agreement shall remain in full force and effect. The provisions of this Section 5.3 shall not apply to Health Net claims payment timeliness issues which are governed by Article IV of this Agreement, unless and until the parties have completed the dispute resolution process set forth in Sections 7.5 and 7.6 of this Agreement, and the dispute relates to habitual, chronic and material claims payment timeliness issues. In the event a Payor fails in its obligations under the terms of this Agreement to make Complete Claim payments to Provider when due, Provider may terminate the specific delinquent Payor without terminating this Agreement in its entirety, but only after all of the following conditions have been met: (i) Payor has failed to make a payment to Provider within the applicable time frame set forth in this Agreement; (ii) Provider provides written notice to Payor that such payment has not been made; (iii) Payor fails to remit payment to Provider within ten (10) days following Payor's receipt of Provider's written notice; (iv) Provider has made a good-faith attempt to meet with Health Net and Payor to resolve the payment issue(s).

**5.4 Termination Upon Notice.** Either party may terminate this Agreement during a Renewal Term for any reason or no reason upon one hundred twenty (120) days prior written notice to the other party. In the event that either party provides the other party with such notice, and following Health Net's completion of any applicable regulatory filing requirements, Health Net may, at its option, begin to transition Beneficiaries under this Agreement to another Participating Provider.

**5.5 Information to Beneficiaries.** The parties each agree not to disparage the other in any information supplied by either party to Beneficiaries or other third parties in connection with any expiration, termination or non-renewal of this Agreement. Health Net shall assume sole responsibility for notifying Beneficiaries, and Health Net may commence transferring Beneficiaries to alternate providers, prior to the effective date of any expiration, termination or non-renewal of this Agreement in accordance with State and federal law. If Beneficiaries seek services or Participating Providers order tests or seek services from Provider after the effective date of any expiration, termination or non-renewal, Provider shall inform such Beneficiaries and Participating Providers only that Provider no longer has an agreement with Health Net to render Covered Services and shall direct them to Health Net's customer service department. Provider shall not otherwise initiate communications with Beneficiaries or other third parties, verbally or in writing, concerning the expiration, termination or non-renewal of this Agreement and Provider's participation in Health Net's Participating Provider network, unless the parties have agreed in writing to the content of such communications in the context of a mutually agreed communication plan. Nothing in this provision is intended nor shall it be construed to prohibit or restrict Provider, Professional Provider, or other Participating Providers from (i) disclosing to any Beneficiary information regarding treatment options available, the risks, benefits and alternatives thereto, or (ii) disclosing to any Beneficiary the decision or process of Health Net or a Payor to Prior Authorize or deny benefits under a Benefit Program, or (iii) posting a reasonable notice on Provider's website or in Provider's Facilities listing by name those insurance carriers that are accepted by Provider, provided that the notice lists each name in substantially similar format. The terms of this Section 5.5 shall survive termination of this Agreement.

**5.6 Effect of Termination.** In the event that a Beneficiary is receiving Contracted Services on the date this Agreement expires, non-renews, and/or terminates, upon the request of Beneficiary and Health Net, Provider shall continue to provide Contracted Services to the Beneficiary until the later of: (i) treatment is completed; (ii) the Beneficiary is discharged if Provider is an inpatient facility; (iii) the Beneficiary is assigned to another Participating Provider; or (iv) the anniversary date of the Beneficiary's Benefit Program. Provider's compensation for such Contracted Services shall be at the rates contained in the applicable Addendum hereto. If Provider's services are continued beyond the expiration, non-renewal, and/or termination of this Agreement, Provider shall be subject to the same contractual terms and conditions that were imposed on Provider prior to the expiration/non-renewal/termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.

## **VI. RECORDS, AUDITS AND REGULATORY REQUIREMENTS**

**6.1 Medical and Other Records.** Provider shall prepare and maintain Records in accordance with the general standards applicable to such Record-keeping and in compliance with all applicable federal and State confidentiality and privacy laws. Provider shall maintain such Records for at least ten (10) years after the rendition of Contracted Services, and Records of a minor child shall be kept for at least three (3) years after the minor has reached the age of eighteen (18), but in no event less than ten (10) years after the rendition of Contracted Services. Additionally, Provider shall maintain such Records as may be necessary and reasonably requested by Health Net to comply with applicable federal and State law, and accrediting agency reporting requirements, rules and regulations. Provider shall comply with and require Professional Providers to comply with all confidentiality and Beneficiary records accuracy requirements. Provider's Records shall be and remain the property of Provider.

**6.2 Access to Records and Audits by Regulatory Agencies.** Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit designated representatives of local, State, and federal regulatory agencies having jurisdiction over Health Net or Payor and designated representatives of public and private exchange-based purchasers and accreditation agencies having jurisdiction over Health Net or Payor (collectively referred to as "Regulatory Agencies"), access to Provider's Records, at Provider's place of business in this State during normal business hours, in order to audit, inspect and review and make copies of such Records. Such Regulatory Agencies shall include, but not be limited to, the State Department of Health Care Services, the State Department of Insurance, the State Department of Managed Healthcare, the United States Justice Department, CMS, the United States Department of Health and Human Services, Covered California, the National Committee for Quality Assurance, and any of their representatives. When requested by Regulatory Agencies, Provider shall produce copies of any such Records at no charge. Additionally, Provider agrees to permit Regulatory Agencies or their representatives, to conduct site evaluations, inspections and audits of Provider's Records, offices and service locations at no cost to Health Net, Payor, and/or Regulatory Agencies, and within a reasonable time period, but not more than five (5) days after the request is submitted to Provider.

**6.3 Access to Records and Audits by Health Net.** Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit Health Net or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, in order to audit, inspect, review, perform chart reviews, and duplicate such Records unless Provider agrees to a remote audit of such records. If performed on site, access to Records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least thirty (30) business days prior written notice by Health Net or its designated representative, but not more than sixty (60) days following such written notice. Provider shall attend an exit interview upon completion of the audit for the purpose of obtaining a mutually agreed upon reconciliation of the initial audit findings. Such exit interview shall be conducted at a mutually agreeable time at Provider's place of business in this State during normal business hours upon at least ten (10) days prior written notice by Health Net or its designated representative, but not more than thirty (30) days following such written notice. In the event Provider fails to attend the scheduled exit interview, Provider shall be deemed to have accepted the audit findings. If the audit was performed remotely, such exit interview shall consist of Health Net or its designated representative sharing its audit findings with Provider via written or electronic communications as determined by Health Net. Provider shall be allowed ten (10) days to contest

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the audit results. If not contested within ten (10) days then Provider shall be deemed to have accepted the audit findings. Provider may be reimbursed reasonable fees associated with the retrieval of Provider's Records and or duplication and preparation of requested Provider Records pursuant to applicable State law, including California Health and Safety code Section 123110. Audit findings relating to any audit of claims shall include adjustment for late charges, overcharges and undercharges. Any such adjustments shall be the net amounts as reflected in the audit findings. Any payments owed by one party to the other as the result of an audit shall be paid within thirty (30) days of the exit interview for such audit.

**6.4 Continuing Obligation.** The obligations of Provider under this Article VI shall not be terminated upon termination of this Agreement, whether by rescission, non-renewal or otherwise. After such termination of this Agreement, Health Net, Payors and Regulatory Agencies shall continue to have access to Provider's Records as necessary to fulfill the requirements of this Agreement and to comply with all applicable laws, rules and regulations.

**6.5 Regulatory Compliance.** Each party agrees to comply with all applicable local, State, and federal laws, rules and regulations, now or hereafter in effect, regarding the performance of the party's obligations hereunder, including without limitation, laws or regulations governing Beneficiary confidentiality, privacy, appeal and dispute resolution procedures to the extent that they directly or indirectly affect Provider, a Beneficiary, Health Net, or Payor, and bear upon the subject matter of this Agreement. If Health Net is sanctioned by any Regulatory Agency for non-compliance that is caused by Provider, Provider shall compensate Health Net for amounts tied to this sanction incurred by Health Net including Health Net's costs of defense and fees.

## VII. GENERAL PROVISIONS

**7.1 Amendments.** This Agreement may be amended by mutual written agreement of the parties. Notwithstanding the foregoing, amendments required to comply with State or federal laws or regulations, requirements of Regulatory Agencies, or requirements of Accreditation Agencies, shall not require the consent of Provider or Health Net and shall be effective immediately on the effective date of the requirement. The parties acknowledge that changes to Health Net Policies that may affect a party's rights or obligations under this Agreement are addressed in Section 3.2 hereof.

**7.2 Separate Obligations.** The rights and obligations of Health Net under this Agreement shall apply to each Health Net subsidiary or affiliate and/or Payor accessing this Agreement only to the extent such Health Net subsidiary or affiliate and/or Payor has accessed this Agreement with respect to the Benefit Programs of such Health Net subsidiary or affiliate or Payor. A Health Net subsidiary or affiliate or Payor shall not be responsible for the obligations of any other Health Net subsidiary or affiliate or Payor under this Agreement with respect to the other's Benefit Programs. The terms of this Section 7.2 shall survive termination of this Agreement.

**7.3 Assignment.** Provider shall not assign this Agreement in whole or in part without Health Net's prior written consent, which consent shall not be unreasonably withheld, conditioned or delayed. Any change in control of Provider resulting from a merger, consolidation, stock transfer or asset sale shall be deemed an assignment or transfer for purposes of this Agreement that requires Health Net's prior written consent. Health Net expressly reserves the right to assign, delegate or transfer any or all of its rights, obligations or privileges under this Agreement to an entity controlling, controlled by, or under common control with Health Net, LLC.

**7.4 Confidentiality.** The Parties each agree that, unless disclosure is required by state or federal law, they shall hold Beneficiary health information and all confidential or proprietary information or trade secrets of each other, in trust and confidence. The Parties each agree that, unless disclosure is required by state or federal law, they shall keep strictly confidential all customized, non-template terms and rates set forth in this Agreement (including without limitation all addenda, exhibits, and any past or future amendments to this Agreement). The Parties further agree that in the event a disclosure is required by state or federal law, they shall disclose only the specific information mandated by such law in order to comply with the applicable legal requirements. Notwithstanding the foregoing, the Parties acknowledge and agree that this provision does not preclude disclosure by Health Net to Beneficiaries,

customers, Regulatory Agencies and exchanges of certain financial terms of this Agreement, including without limitation detailed information contained in the Explanation of Benefits, Records under the conditions set forth in Article VI of this Agreement, and/or information regarding the method of compensation used by Health Net with respect to Health Net's Participating Provider networks, e.g., fee-for-service, capitation, shared risk pool, DRG or per diem. Health Net, Payors and Provider agree that such information shall be used only for the purposes contemplated herein, and not for any other purpose. Health Net, Payors and Provider agree that nothing in this Agreement shall be construed as a limitation of (i) Provider's rights or obligations to discuss with the Beneficiaries matters pertaining to the Beneficiaries' health regardless of Benefit Program coverage options or (ii) Health Net's rights or obligations with respect to subcontractors, including without limitation delegated providers, or (iii) disclosures to counsel or a consultant of a party for the purpose of monitoring regulatory compliance or rendering legal advice pertaining only to this Agreement or disclosures to internal or independent auditors of a party for audit purposes pertaining to this Agreement, provided that in either case the counsel or consultant agrees in writing to comply with the provisions of this Section 7.4 and agrees that the terms of this Agreement may not be disclosed to any other person or entity or used in any manner whatsoever in connection with any other agreement involving Health Net. The terms of this Section 7.4 shall survive termination of this Agreement.

Nothing in this provision or this Agreement shall be construed to prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to an enrollee, Member or subscriber of Health Net, to a qualified entity, as defined in Section 1395kk(e)(2) of Title 42 of the United States Code. All disclosures of data made under this provision shall comply with all applicable state and federal laws for the protection of the privacy and security of the data, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the federal Health Information Technology for Economic and Clinical Health Act, Title XIII of the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and implementing regulations.

**7.5 Provider Dispute Resolution Procedure.** The parties agree to use the dispute resolution process set forth in this Section 7.5, and binding arbitration as described in Section 7.6, as the final steps in resolving any Dispute. The parties each understand and agree that any and all Health Net internal appeals processes (including without limitation as set forth in Section 4.2.3 hereof) must be properly pursued and exhausted before engaging in the dispute resolution process set forth in this Section 7.5.

(i) Meet and Confer Process:

Initiation: If the parties are unable to resolve any Dispute through applicable Health Net internal appeal processes, if any, the parties agree to meet and confer within thirty (30) days of a written request by either party in a good faith effort to informally settle any Dispute. The parties each agree and understand that the meet and confer requirements set forth herein may be satisfied only by meeting each of the following requirements: (a) an actual meeting must occur between executive level employees of the parties who have authority to resolve the Dispute and are each prepared to discuss in good faith the Dispute and proposed resolution(s) to the Dispute, and (b) such meeting may take place either in person or on the telephone at a mutually agreeable time, and (c) unless otherwise mutually agreed by the parties, neither party is allowed to have legal counsel present at the meeting or to substitute legal counsel for the executive level employee, and (d) such meeting and all related discussions between the parties shall be treated in the same manner as confidential protected settlement discussions under the State Rules of Civil Procedure.

Confidentiality: All documents created for the purpose of, and exchanged during, the meet and confer process and all meet and confer discussions, negotiations and proceedings shall be treated as compromise and settlement negotiations subject to applicable State law. To the extent the parties produce or exchange any documents, the parties agree that such production or exchange shall not waive the protected nature of those documents and shall not otherwise affect their inadmissibility as evidence in any subsequent proceedings.

(ii) Voluntary Mediation:

If the parties are unable to resolve any Dispute through the meet and confer process set forth above, and desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, a joint request for such services may be made to the American Arbitration Association ("AAA"), or the Judicial Arbitration and Mediation Services ("JAMS") prior to submitting a Dispute to arbitration, or the parties may initiate such other procedures as they may mutually agree upon.

**7.6 Binding Arbitration.** If the parties are unable to resolve a Dispute through the dispute resolution process set forth in Section 7.5, the parties agree that such Dispute shall be settled by final and binding arbitration, upon the motion of either party, under the appropriate rules of the AAA or JAMS, as agreed by the parties. Any Arbitrator must be either a judge, or an attorney licensed to practice law in the State of California, who is in good standing with the State Bar, and has at least ten (10) years of experience with health care matters and the arbitration of managed care disputes. The parties each understand and agree that the exhaustion of any Health Net internal appeals processes and the Meet and Confer Process set forth in Section 7.5 (i) hereof are conditions precedent to binding arbitration under this Section 7.6. Notwithstanding the foregoing, nothing contained herein is intended to require binding arbitration of disputes alleging medical malpractice between a Beneficiary and Provider or to Disputes between the parties alleging breaches of confidentiality of Beneficiary information, trade secret or intellectual property obligations. The arbitration shall be conducted in San Francisco, California or Los Angeles, California, or another location mutually agreeable to the parties that is not more than one hundred miles from Provider's principal office. The written demand shall contain a detailed statement of the matter and facts and include copies of all material documents supporting the demand. Arbitration must be initiated within one year after the date the Dispute arose by submitting a written notice to the other party.

The parties expressly agree that the deadlines to file arbitration set forth above shall not be subject to waiver, tolling, alteration or modification of any kind or for any reason except for fraud. The failure to initiate arbitration before such deadlines shall mean the complaining party shall be barred forever from initiating such proceedings.

All such arbitration proceedings shall be administered by the AAA or JAMS, as agreed by the parties; however, the arbitrator shall be bound by applicable State and federal law, and shall issue a written opinion setting forth findings of fact and conclusions of law. The parties agree that the decision of the arbitrator shall be final and binding as to each of them. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. The arbitrator shall have no authority to make material errors of law or to award punitive damages or to add to, modify, or refuse to enforce any agreements between the parties. The arbitrator shall make findings of fact and conclusions of law and shall have no authority to make any award, which could not have been made by a court of law. The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of the entry of judgment on the award. The parties waive their right to a jury or court trial.

The parties recognize and agree that theirs is an ongoing business relationship, which may lead to sensitive issues with respect to the exchange of information related to any Dispute. The parties agree, therefore, to enter into such protective orders (including without limitation creating a category of discovery documents "for attorney's eyes only" to the extent feasible given the nature of the evidence and the Dispute). All discovery information shall be used solely and exclusively for arbitration of the Dispute between the parties and may not be used for any other purpose. After the arbitration award becomes final, each party shall return or destroy all documents obtained from the other party during the course of the arbitration that are subject to a protective order, and within thirty (30) days of such date shall provide to the other party an officer's certificate signed under penalty of perjury indicating that all such information has been returned or destroyed.

In all cases submitted to arbitration, the parties agree to share equally the administrative fee as well as the arbitrator's fee, if any, unless otherwise assessed by the arbitrator. The administrative fees shall be advanced by the initiating party subject to final apportionment by the arbitrator in this award. The parties agree that the content and decision of any arbitration proceeding shall be confidential unless disclosure is required by applicable State or federal statutes or regulations. The terms of Section 7.5 and Section 7.6 shall survive termination of this Agreement.

**7.7 Entire Agreement.** This Agreement represents the entire agreement between the parties hereto with respect to the subject matter hereof and supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding.

**7.8 Governing Law.** This Agreement shall be governed by and construed and enforced in accordance with the laws of the State, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern. Health Net is subject to the requirements of various local, State, and federal laws, rules and regulations including, but not limited to, the requirements of Chapter 2.2 of Division 2 of the California Health & Safety Code (the Knox-Keene Health Care Service Plan Act) and of Chapters 1 and 2, of Division 1 of Title 28 of the California Code of Regulations (“C.C.R.”) and Title 10 of the C.C.R as well as the California Insurance Code. Any provision required to be in this Agreement by any of the above shall bind Provider and Health Net whether or not expressly set forth herein.

**7.9 Indemnification.**

7.9.1 Responsibility for Own Acts. Each party shall be responsible for its own acts or omissions and for any and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that party or its employees or representatives in the performance or omission of any act or responsibility of that party under this Agreement.

7.9.2 Provider agrees to indemnify, defend, and hold harmless Health Net, its agents, officers, and employees from and against any and all liability expense including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from Provider's performance or failure to perform its obligations hereunder.

7.9.3 Health Net agrees to indemnify, defend, and hold harmless Provider, its agents, officers, and employees from and against any and all liability expense, including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from Health Net's performance or failure to perform its obligations hereunder.

**7.10 Non-Exclusive Contract.** This Agreement is non-exclusive and shall not prohibit Provider or Health Net or Payor from entering into agreements with other health care providers or purchasers of health care services.

**7.11 No Third Party Beneficiary.** Nothing in this Agreement is intended to, or shall be deemed or construed to, create any rights or remedies in any third party, including a Beneficiary. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to increase the rights of any such Beneficiary or the duties or responsibilities of Provider or Health Net or Payor with respect to such Beneficiaries.

**7.12 Notice.** Notices regarding the breach, term, termination or renewal of this Agreement shall be given in writing in accordance with this Section 7.12 and shall be deemed given five (5) days following deposit in the U.S. mail, postage prepaid. If sent by hand delivery, overnight courier, or facsimile, notices shall be deemed given upon documentation of delivery. All notices shall be addressed as follows:

Health Net:

Health Net of California, Inc.  
Attn: Provider Contracts Administration - Direct  
21281 Burbank Blvd.  
Woodland Hills, CA 91367

Electronic copy to: [DirectContractNotices@healthnet.com](mailto:DirectContractNotices@healthnet.com)

Provider: See Provider Mailing Address in Exhibit I, Listing of Facilities

The addresses to which notices are to be sent may be changed by written notice given in accordance with this Section. Notwithstanding the previous paragraph, Health Net may provide all other notices by electronic mail, through its provider newsletter, or on its provider website.

**7.13 Severability.** If any provision of this Agreement is rendered invalid or unenforceable by any local, State, or federal law, rule or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.

**7.14 Status as Independent Entities.** None of the provisions of this Agreement is intended to create, nor shall be deemed or construed to create any relationship between Provider and Health Net or a Payor other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither Provider nor Health Net/Payor, nor any of their respective agents, employees or representatives shall be construed to be the agent, employee or representative of the other.

**7.15 Addenda.** Each Addendum to this Agreement is made a part of this Agreement as though set forth fully herein. Any provision of an Addendum that is in conflict with any provision of this Agreement shall take precedence and supersede the conflicting provision of this Agreement with respect to the subject matter of the Addendum.

**7.16 Calculation of Time.** The parties agree that for purposes of calculating time under this Agreement, any time period of less than ten (10) days shall be deemed to refer to business days and any time period of ten (10) days or more shall be deemed to refer to calendar days unless the term “business” precedes the term “days”.

**7.17 Waiver of Breach.** The waiver of any breach of this Agreement by either party shall not constitute a continuing waiver of any subsequent breach of either the same or any other provision(s) of this Agreement. Further, any such waiver shall not be construed to be a waiver on the part of such party to enforce strict compliance in the future and to exercise any right or remedy related thereto.

**THIS CONTRACT CONTAINS A BINDING ARBITRATION CLAUSE, WHICH MAY BE ENFORCED BY THE PARTIES.**

IN WITNESS WHEREOF, the parties have executed this Agreement.

**PROVIDER**

**HEALTH NET OF CALIFORNIA, INC.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Health Net Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Valentina Shabanian  
Print Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Regional Health Plan Officer  
Title

\_\_\_\_\_  
Group Name (If Applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Tax Identification Number

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature Date

## EXHIBIT I LIST OF FACILITIES

The information below is mandatory. Please complete all applicable fields.

“Provider must submit all National Provider Identifiers (NPI number/information) and a sample billing form (CMS 1500 or successor form) for each as directed by Health Net. In addition, as directed by Health Net, the corresponding Tax Identification Number shall be indicated, with a completed W-9 for each TIN as directed by Health Net. The Tax Identification Number on the billing form must be consistent with the TIN on the W-9 form.”

Please enter individual information if sole provider.

\_\_\_\_\_  
Provider Name (use Group name if applicable)

\_\_\_\_\_  
Provider / Group Tax Identification Number

\_\_\_\_\_  
Primary / Group NPI Number

<b>Primary Location</b>	
Address:	STREET: _____ SUITE: _____
	CITY: _____ STATE: _____ ZIP CODE: _____
Telephone #:	Fax #:

<b>Remit Address</b>	
Address:	STREET: _____ SUITE: _____
	CITY: _____ STATE: _____ ZIP CODE: _____
Telephone #:	Fax #:

<b>Mailing Address</b>	
Address:	STREET: _____ SUITE: _____
	CITY: _____ STATE: _____ ZIP CODE: _____
Telephone #:	Fax #:

*Note: Please attach a list of additional locations on a separate sheet of paper if required.*

**EXHIBIT II  
LIST OF PROFESSIONAL PROVIDERS**

INSERT ROSTER HERE

**Provider Practice Groups must complete the information below, or you may attach as an Exhibit a complete Physician Roster including Physician Name, License number, Specialties, Individual NPI number, CAQH number (if applicable), and appointment availability for in-person and/or Telehealth which is the use of electronic information and telecommunications technologies to extend care to Members.**

**Group/Individual Tax Identification #:** \_\_\_\_\_

FIRST NAME	MI	LAST NAME	LICENSE NUMBER
PRIMARY SPECIALTY		SECONDARY SPECIALTY	
CAQH #	INDIVIDUAL NPI #		MEDICARE CERTIFIED (Y/N)

FIRST NAME	MI	LAST NAME	LICENSE NUMBER
PRIMARY SPECIALTY		SECONDARY SPECIALTY	
CAQH #	INDIVIDUAL NPI #		MEDICARE CERTIFIED (Y/N)

FIRST NAME	MI	LAST NAME	LICENSE NUMBER
PRIMARY SPECIALTY		SECONDARY SPECIALTY	
CAQH #	INDIVIDUAL NPI #		MEDICARE CERTIFIED (Y/N)

FIRST NAME	MI	LAST NAME	LICENSE NUMBER
PRIMARY SPECIALTY		SECONDARY SPECIALTY	
CAQH #	INDIVIDUAL NPI #		MEDICARE CERTIFIED (Y/N)

FIRST NAME	MI	LAST NAME	LICENSE NUMBER
PRIMARY SPECIALTY		SECONDARY SPECIALTY	
CAQH #	INDIVIDUAL NPI #		MEDICARE CERTIFIED (Y/N)

FIRST NAME	MI	LAST NAME	LICENSE NUMBER
PRIMARY SPECIALTY		SECONDARY SPECIALTY	
CAQH #	INDIVIDUAL NPI #		MEDICARE CERTIFIED (Y/N)

## ADDENDUM A

### COMMERCIAL BENEFIT PROGRAMS

**I. Applicability.** This Addendum A and accompanying exhibits apply to Covered Services delivered to Beneficiaries covered by commercial Benefit Programs that include but are not limited, to HMO, PPO, EPO, POS, and any leased networks. All Covered Services delivered to a Beneficiary covered by a commercial Benefit Program shall be paid in accordance with this Addendum A regardless of product specific name unless otherwise specifically agreed by the parties and set forth in a separate rate exhibit.

**II. Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Point of Service (POS), Leased PPO Benefit Programs, and Payor Disclosures.** Provider understands and agrees that Health Net may sell, lease, transfer or convey a list, including Provider, to Payors.

Payors shall actively encourage subscribers to use the list of contracted providers when obtaining medical care. Active encouragement includes offering subscribers direct financial incentives to use the list of contracted providers when obtaining medical care (such as reduced Copayments, Coinsurance and Deductibles), or providing or causing the provision of information to subscribers advising such subscribers of the existence of a list of contracted providers through a variety of advertising or marketing approaches that supply the names, addresses and telephone numbers of contracted providers to subscribers in advance of their selection of a health care provider. Nothing in this Addendum A shall be construed to require a Payor to actively encourage such Payor's subscribers to use the list of contracted providers, including Provider, when obtaining medical care in the event of an Emergency.

Health Net shall not permit Payors to access this Agreement and pay Provider's contracted rate for the Benefit Programs covered by this Addendum unless Payor, or Health Net on Payor's behalf, has actively encouraged Payor's subscribers to use the list of contracted providers in obtaining medical care.

Provider agrees that the following commercial Benefit Program Payors are eligible to pay Provider's contracted rate under this Addendum A as of the effective date of this Agreement:

#### **NO PAYORS**

Health Net may modify the above list periodically. Provider may request in writing, and Health Net shall have thirty (30) days from the date of such request, to provide Provider with an updated listing of Payors.

Provider understands and agrees that any Health Net subsidiary or affiliate, including, but not limited to, Health Net Life Insurance Company, are not Payors under this Addendum A but shall access this Agreement as Health Net.

**III. Payment.** As compensation for rendering Contracted Services to Beneficiaries covered by commercial HMO, PPO, EPO, POS and Leased PPO Benefit Programs under this Addendum A, Health Net shall pay and Provider shall accept as payment in full the rates set forth in Exhibit A-1, subject to the payment conditions set forth in Addendum D, the terms of this Agreement and applicable State and federal law. Notwithstanding any other provision in this Agreement, the parties acknowledge that each Payor is solely responsible for paying Provider for Covered Services rendered to those individuals for whom Payor provides health care coverage. For self-insured Payors, Health Net shall not be obligated to pay all or any portion of any Provider claim on a Payor's behalf unless and until Health Net has received sufficient funds from the applicable Payor to cover such claim. In the event such Payor fails to provide funds to Health Net, Provider may seek payment from Beneficiary up to the rates specified in this Exhibit, unless prohibited by applicable law.

**EXHIBIT A-1**

**COMMERCIAL BENEFIT PROGRAMS**

**DIRECT NETWORK FEE-FOR-SERVICE  
RATE EXHIBIT**

Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Addendum D, Health Net or Payor shall pay and Provider shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered under commercial Benefit Programs pursuant to this Addendum, the lesser of: (i) the rates listed below, or (ii) 100% of Provider's Allowable Charges.

<b>Category of Service</b>	<b>Compensation</b>
Covered Services delivered or arranged by Provider, MDs, DOs, and DPMs, excluding Laboratory services	100% of CMS Allowable
Covered Services delivered or arranged by non-MDs, DOs, and DPMs, excluding Laboratory services. Not subject to CMS Medicare allowable tiered reductions.	100% of CMS allowable
Anesthesia Services when provided by an Anesthesiologist or Certified Registered Nurse Anesthetist (American Society of Anesthesiology (ASA) unit scale)	\$39 / ASA unit
Medical/Surgical Services by an Anesthesiologist or Certified Registered Nurse Anesthetist	100% of CMS Allowable
Laboratory Services performed in Provider or Professional Provider office	100% of CMS Allowable
Pharmaceuticals	
- With an established Medicare Value	100% of CMS Allowable
- Without an established Medicare Value	90% of the Average Wholesale Price (AWP)
OB Services	
- CPT 59400: Global Obstetric care with vaginal delivery	\$1,700.00
- CPT 59510: Global Obstetric care with cesarean delivery	\$1,700.00
- CPT 59610: Vaginal Delivery after previous cesarean delivery	\$1,700.00
- CPT 59618: Attempted vaginal delivery, resulting in cesarean	\$1,700.00
Immunizations	
- With an established Medicare Value	100% of CMS Allowable
- Without an established Medicare Value	90% of the Average Wholesale Price (AWP)
By Report (BR) Procedures, Procedures not Listed and Procedures with Relativities not Established, and Pharmaceuticals/Immunizations without an established Medicare or AWP value	75% of Provider's Allowable Charges

## **ADDENDUM B**

### **MEDICARE ADVANTAGE PROGRAM**

**I. Applicability.** Provider and Health Net agree that this Addendum shall apply only to Contracted Services delivered to Beneficiaries covered by the Medicare Advantage (MA) Program, and this Addendum B may be accessed by those Health Net entities holding a valid Medicare Advantage agreement with CMS at the time Contracted Services are delivered.

**II. Payment.** Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Addendum D, Health Net shall pay and Provider shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered under Health Net's MA Program pursuant to this Addendum.

#### **III. Definitions**

For purposes of this Addendum, the definitions included herein shall have the meaning required by law governing the Medicare Advantage (MA) Program.

**(a) Medicare Advantage (MA).** The statutory name applicable to the federal program of prepaid health care services for Medicare beneficiaries established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

**(b) Medicare (MA) Member or Beneficiary.** A Medicare Beneficiary who has elected to enroll in and receive coverage through a Health Net MA or MAPD Benefit Program, under the terms and conditions of the Benefit Program's MA or MAPD Evidence of Coverage, and whose enrollment has been confirmed by the Centers for Medicare and Medicaid Services ("CMS"), an agency of the U.S. Department of Health and Human Services ("HHS") that administers the Medicare Advantage program.

**(c) Contract Period.** The term of the contract between Health Net and CMS.

**(d) Delegation.** Delegation to Provider of a certain contractual obligation of Health Net under Health Net's contract with CMS.

**(e) MA Benefit Program.** A Health Net Medicare Advantage Benefit Program that provides coverage for certain health care services.

**(f) MAPD Benefit Program.** An MA Benefit Program that includes Medicare Part D prescription drug coverage.

**(g) MA/MAPD Evidence of Coverage.** A legally binding statement of coverage, revised annually, between a Medicare Member and Health Net under which a Medicare Member is entitled to receive coverage for certain hospital, medical and other associated health care services.

**(h) Downstream Providers.** A Participating PROVIDER who or which is contracted with PROVIDER to render services to Beneficiaries.

#### **IV. Obligations**

**4.1 Provider Obligations.** Provider agrees to render Contracted Services to MA Members, in accordance with the terms and conditions of Health Net's MA Programs. Health Net shall provide Provider with the Benefit Program Requirements of such Benefit Programs not set forth in this Addendum. Such Benefit Program Requirements include the provisions of the applicable MA or MAPD Evidence of Coverage, and Health Net Policies. Provider acknowledges that the determination of Covered Services shall be governed by coverage guidelines established by Health Net and the MA Program, with Health Net being solely responsible for final coverage determinations, subject to applicable appeal procedures.

**4.2 Member Services.** Provider shall cooperate fully with Health Net in the investigation and resolution of complaints by MA Members regarding Provider, or the services Provider provides or arranges, in compliance with CMS and state regulatory requirements.

**4.3 Reports and Administration.** Health Net shall have sole responsibility for filing reports, obtaining approval from, and complying with the applicable laws and regulations of federal, state and local governmental agencies having jurisdiction over Health Net. Provider shall cooperate in providing Health Net with such information and assistance regarding MA Members and Provider's performance under this Agreement and Addendum as Health Net may reasonably require in filing such reports and complying with applicable laws and regulations.

**4.4 Health Net Policies and Procedures.** Health Net shall promptly communicate any material change in Health Net's policies and procedures affecting Provider in accordance with Section 3.2 of this Agreement.

**4.5. Prompt Payment.** Health Net and Provider agree to: (i) Process contracted Provider claims received at Health Net within sixty (60) calendar days of receipt, and (ii) Process non-contracted provider clean claims received by Provider within thirty (30) calendar days and sixty (60) calendar days for all other claims.

**V. Regulatory Obligations.**

A. Health Net and Provider agree and Provider will require its subcontractors to agree to

(1) HHS, CMS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems, including medical records and documentation of Provider and any Provider subcontractor, involving transactions related to CMS' contract with Health Net through ten (10) years from the final date of the final Contract Period of the contract entered into between CMS and Health Net or from the date of completion of any audit, whichever is later. This right can be exercised directly with any first tier, downstream, or related entity. For records subject to review under this provision, except in exceptional circumstances, CMS will provide notification to Health Net that a direct request for information has been initiated. [\*See 42 CFR §422.504(i)(2)(i-iv) ; Ch. 11. §100.4, Medicare Managed Care Manual "MMCM"]

(2) Cooperate in assist in, and provide information as requested for audits, evaluations and inspections performed under Section A(1) above. [\*See Ch. 11. §100.4, MMCM]

(3) Safeguard each MA Beneficiary's privacy and comply with the confidentiality and MA Beneficiary record accuracy requirements, including: 1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records , or other health and enrollment information, 2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by MA Beneficiaries to the records and information that pertain to them. [\*See 42 CFR §422.504(a)(13); 42 CFR §422.118; Ch. 11. §100.4, MMCM].

(4) Contracts or other written agreements between Provider and Provider subcontractors must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. [\*See 42 CFR §422.520(b)(1); Ch. 11, §100.4, MMCM].

(5) Hold each MA Beneficiary harmless for payment of any fees that are the legal obligation of Health Net in the event of, but not limited to, insolvency of, breach by or billing of Provider by Health Net. [\*See 42 CFR §422.504(g)(1)(i) and (i)(3)(i); Ch. 11 §100.4 MMCM].

(6) Comply with all applicable Medicare laws, regulations, reporting requirements and CMS instructions. [\*See 42 CFR §422.504(i)(4)(v)]

(7) Perform each service or other activity under this Agreement in a manner consistent and in compliance with Health Net's contractual obligations to CMS. [\*See 42 CFR §422.504(i)(3)(iii)]

(8) Maintain all records relating to this contract for a minimum of ten (10) years from the final date of the Contract Period or the date of the completion of any audit, whichever is later. [\*See Ch. 11. §110.4.3, MMCM]

(9) Health Net oversees and is ultimately responsible to CMS for any functions and responsibilities described in the Medicare Advantage regulations. Provider understands that this accountability provision also applies to this Addendum. [\*See 42 CFR §§422.504 (i)(4)(iii); Ch 11 § 100.4, MMCM].

(10) Comply with Health Net Policies. [\*See Ch. 11. §100.4, MMCM]

(11) For all MA Beneficiaries eligible for both Medicare and Medicaid (includes Medi-Cal), such MA Beneficiaries will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider and Provider subcontractors may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept Health Net payment as payment in full, or (2) bill the appropriate State source. [\*See 42 CFR §§422.504(g)(1)(i) and (iii); 42 C.F.R. §422.504(i)(3)(i)].

**B.** Provider and Health Net agree:

(1) Health Net is obligated to pay Provider promptly under the terms of the Agreement between Health Net and the Provider, as well as in accordance with Health Net Policies and Section 4.5 of this Addendum. [\*See 42 CFR §§422.520(b)(1) and (2); Ch. 11. §100.4 MMCM]

**C.** Provider and its subcontractors further agree to the following:

- (a) To pay for emergency and urgently needed services consistent with federal regulations, if such services are Provider's liability.
- (b) To pay for renal dialysis services for Beneficiaries temporarily outside the service area, if such services are Provider's responsibility.
- (c) To direct access to mammography screening and influenza vaccinations.
- (d) To direct access to in-network women's health specialist for women for routine and preventative services.
- (e) To have approved procedures to identify, assess and establish a treatment plan for Beneficiaries with complex or serious medical conditions.
- (f) To provide access to benefits in a manner described by CMS.
- (g) To protect Beneficiaries who are hospitalized from loss of benefits through the period of time CMS premiums are paid.
- (h) To work with Health Net in conducting a health assessment of all new Beneficiaries within ninety (90) days of the effective date of enrollment.

- (i) That Provider must notify any Professional Provider being terminated, in writing, of the reason(s) for denial, suspension or termination determinations.
- (j) To not employ or contract with individuals excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act.
- (k) To adhere to Medicare's appeals, expedited appeals and expedited review procedures for Medicare HMO Beneficiaries, including gathering and forwarding information on appeals to Health Net, as necessary.
- (l) That Medicare Beneficiaries' health services are being paid for with Federal funds, and as such, payments for such services are subject to laws applicable to individuals or entities receiving Federal funds.
- (m) To assume the financial responsibility for any failure to comply with Medicare Regulations, including, but not limited to, failure to provide records when requested and failure to provide or document Notice(s) of Non-Coverage to Beneficiaries.
- (n) That for purposes of Medicare Beneficiaries, retroactive eligibility changes shall be limited to thirty six (36) months or as otherwise required by CMS
- (o) To not collect any co-payment or other cost sharing for influenza vaccine and pneumococcal vaccines.

**D. DELEGATION.**

The parties acknowledge that none of Health Net's MA Program contract obligations to CMS have been delegated by Health Net to Provider.

**EXHIBIT B-1**

**MEDICARE ADVANTAGE PROGRAM  
DIRECT NETWORK FEE-FOR-SERVICE  
RATE EXHIBIT**

**I. Payment Rates**

Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Addendum D, Health Net shall pay and Provider shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered under Medicare Advantage Benefit Programs pursuant to this Addendum, the lesser of: (i) the rates listed below, or (ii) 100% of Provider's Allowable Charges.

<b>Category of Service</b>	<b>Compensation</b>
Covered Services delivered or arranged by Provider, MDs, DOs, and DPMs, excluding Laboratory services	100% of CMS Allowable
Covered Services delivered or arranged by non-MDs, DOs, and DPMs, excluding Laboratory services. Subject to CMS Medicare allowable tiered reductions.	100% of CMS allowable
By Report (BR) Procedures, Procedures not Listed and Procedures with Relativities not Established	75% of Provider's Allowable Charges

## ADDENDUM C

### **MEDI-CAL BENEFIT PROGRAM**

Provider understands and agrees that the obligations of Health Net, LLC set forth in this Addendum shall be solely the obligations of Health Net Community Solutions, Inc. and not the obligations of Health Net, LLC or any other Affiliate of Health Net, LLC. Health Net has entered into one or more Medi-Cal prepaid health plan agreements with the California Department of Health Care Services ("DHCS"). For the purposes of this Addendum, Health Net's Medi-Cal agreements with the DHCS and any subcontracts with Medi-Cal prepaid health plans, are hereinafter collectively referred to as the "Medi-Cal Agreement". Health Net has agreed, under the Medi-Cal Agreement, to provide medical services covered under California's Medi-Cal Program, including Provider risk services, to Medi-Cal HMO Beneficiaries enrolled in or otherwise assigned to Health Net, on a prepaid basis. The provisions of the Addendum are required to appear in all subcontracts under the Medi-Cal Agreement by the terms of the Medi-Cal Agreement and by Medi-Cal law and may not be altered. When required under Medi-Cal law, the Agreement shall be effective upon approval by DHCS in writing or operation of law where DHCS has acknowledged receipt of the Agreement and failed to approve or disapprove within sixty (60) calendar days.

Provider understands and agrees that Health Net Community Solutions, Inc. is an Affiliate of Health Net and of Health Net of California, Inc. and has entered into an agreement with the Fresno-Kings-Madera Regional Health Authority (CalViva Health) to provide Covered Services to Medi-Cal beneficiaries in Fresno, Kings and Madera Counties who enroll in CalViva Health. Provider understands and agrees that Health Net of California, Inc. is providing Covered Services as a subcontractor to Health Net Community Solutions, Inc. for the CalViva Health Medi-Cal membership. Provider further understands and agrees that it will provide Covered Services to CalViva Health Medi-Cal members pursuant to the Agreement and that all terms and conditions of the Agreement, including reimbursement, shall apply to the provision of Covered services to the CalViva Health Medi-Cal members.

Health Net has or may enter into contracts with certain Payors, including local initiatives such as Cal Viva Health in Fresno, Kings and Madera Counties, to provide or arrange for Covered Services to Medi-Cal beneficiaries enrolled in the Medi-Cal plans of such Payors. Provider understands and agrees that a Payor may have adopted policies and procedures, including, but not limited to, quality assurance and quality improvement programs. Provider further understands and agrees that Provider and its Participating Providers shall comply with all the policies and procedures adopted by a Payor and shall participate in the Payor's quality assurance and quality improvement programs.

#### **A. COMPENSATION PROVISIONS.**

**1. Compensation.** Provider shall arrange and provide Contracted Services to Medi-Cal HMO Beneficiaries of Health Net's Benefit Programs covered under this Addendum on a fee-for-service basis. As compensation for providing such Contracted Services, Provider shall be paid in accordance with the rates set forth on Exhibit C-1, subject to the payment conditions set forth in Addendum D. Such compensation shall be paid within forty-five (45) working days of receipt of a complete and accurate claim for Covered Services rendered to a Medi-Cal HMO Beneficiary.

Notwithstanding anything to the contrary contained in this Agreement, if Provider is decertified, suspended and/or terminated by the California Department of Health Care Services ("DHCS"), or other governmental agencies ("DHCS Notice"), Provider acknowledges that it will not be eligible to receive reimbursement for Contracted Services following the date of the DHCS Notice and Health Net will have no liability to pay Provider under this Agreement upon receipt of the DHCS Notice.

**2. Billing.** Notwithstanding anything to the contrary to the Agreement, if Provider is compensated on a fee-for-service basis, Provider shall submit to Health Net, via Health Net's electronic claims submission program or hardcopy as determined by Health Net, Complete Claims within one hundred eighty (180) days after the month in which the Covered Service is rendered unless Provider demonstrates good cause pursuant to applicable State law.

Where Health Net is the secondary payor under Coordination of Benefits, Provider shall submit Complete Claims for Covered Services accompanied by the explanation of benefits (EOB) or explanation of payment (EOP) from the primary payor to Health Net within one hundred eighty (180) days of the date of the EOB/EOP.

If the Provider fails to comply with the timely claims submission/filing requirements set forth above, Health Net shall reimburse the Provider at the following rates: 75% of usual allowance for claims submitted during the seventh through ninth month after the month of service; 50% of usual allowance for claims submitted during the tenth through the twelfth month after the month of service. Health Net shall not be liable for payment to Provider for any Complete Claims received after the twelfth month after the month of service.

## **B. GENERAL PROVISIONS**

**1. Provider Certification.** Provider is certified to participate in Medicaid/Medi-Cal under Title XIX of the Social Security Act or other applicable State law pertaining to Title XIX of the Social Security Act.

**2. Provision of Covered Services.** Provider shall arrange Covered Services for assigned Beneficiaries. For the purposes of this Addendum, "Covered Services" means those health care services, supplies and items that are specified as being covered under the Medi-Cal Agreement. Provider and its subcontractors shall arrange Covered Services for Beneficiaries, in accordance with the following, each of which is hereby incorporated by reference as if set out in full herein:

- a) The terms and conditions of this Addendum and the Agreement.
- b) The terms and conditions of the Medi-Cal Agreement and the applicable Evidence of Coverage.
- c) Health Net Medi-Cal policies and procedures and physician bulletins.
- d) DHCS Medi-Cal Managed Care Division (MMCD) Policy Letters.
- e) All laws applicable to Provider and Health Net.
- f) Health Net's Utilization Care Management Program and Quality Improvement Program.
- g) Standards requiring services to be provided in the same manner, and with the same availability, as services are rendered to other patients.
- h) No less than the minimum clinical quality of care and performance standards that are professionally recognized and/or adopted, accepted or established by Health Net.

**3. Preparation and Retention of Records; Access to Records; Audits.** Provider shall prepare and maintain medical and other books and records required by law in a form maintained in accordance with the general standards applicable to such book or record keeping. Provider shall maintain such financial, administrative and other records as may be necessary for compliance by Health Net with all applicable local, State and federal laws. Provider shall retain such books and records for a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later; and, shall retain all encounter data for a period of at least ten (10) years. Provider shall make Provider's premises, facilities, equipment, books, records, contracts, computer and other electronic systems and encounter data pertaining to the goods and services furnished under the terms of the Agreement available for the purpose of an audit, inspection, evaluation, examination or copying by Health Net, DHCS, the Centers for Medicare & Medicaid Services (CMS), the United States Department of Health and Human Services (DHHS), the California Department of Managed Health Care (DMHC), Inspector General, the Comptroller General, the United States Department of Justice (DOJ), or their designees and any other regulatory agency having jurisdiction over Health Net. The records shall be available at Provider's place of business, or at such

other mutually agreeable location in California. When such entities request Provider's records, Provider shall produce copies of the requested records at no charge. Provider shall permit Health Net, and its designated representatives, and designated representatives of local, State, and federal regulatory agencies having jurisdiction over Health Net, to conduct site evaluations and inspections of Provider's offices and service locations. Provider shall comply with all monitoring provisions of the Medi-Cal Agreement and any monitoring requests by DHCS. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. [22 CCR § 53250(e)(1); W & I § 14452(c); Medi-Cal Agreement] Furthermore, Provider shall timely gather, preserve and make available to DHCS, CMS, the Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in Provider's possession related to the recovery for litigation, pursuant to the Medi-Cal Agreement.

**4. Subcontracting Under the Agreement.** Provider shall not subcontract for the performance of services under the Agreement without the prior written consent of Health Net. Every such subcontract shall be in writing and provide that it is terminable with respect to Beneficiaries by Provider upon Health Net's request. Provider shall furnish Health Net or DHCS with copies of such subcontracts, and amendments thereto, within ten days of execution or upon request. Each such subcontracting Provider shall meet Health Net's credentialing requirements, prior to the subcontract becoming effective. Provider shall be solely responsible to pay any health care Provider permitted under the subcontract, and shall hold, and ensure that health care Providers hold, Health Net, Beneficiaries and the State harmless from and against any and all claims which may be made by such subcontracting Providers in connection with services rendered to Beneficiaries under the subcontract. Provider shall maintain and make available to Health Net, DHCS, the Centers for Medicare & Medicaid Services (CMS), the United States Department of Health and Human Services (DHHS), the California Department of Managed Health Care (DMHC), Inspector General, the Comptroller General, the United States Department of Justice (DOJ), or their designees and any other regulatory agency having jurisdiction over Health Net, copies of all Provider's subcontracts under the Agreement and to ensure that all such subcontracts are in writing and require that the subcontractor: (1) make premises, facilities, equipment, books, records, contracts, computer and other electronic systems available for the purpose of an audit, inspection, evaluation, examination, or copying by said entities; (2) retain such books and records for a term of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later; (3) maintain such books and records in a form maintained in accordance with the general standards applicable to such book or record keeping. [22 CCR § 53250(e)(3)]

**5. Federal Disclosure Form.** Provider shall submit to Health Net a completed Disclosure Form, attached to this Addendum, for officers and other persons associated with Provider as required by 42 CFR 455.104, 455.105 and 455.106 and California Welfare and Institutions Code § 14452(a).

**6. Medi-Cal HMO Beneficiary Education.** Provider shall make health education materials and programs available to Medi-Cal HMO Beneficiaries on the same basis that it makes such materials and programs available to the general public, and shall use its best efforts to encourage Medi-Cal HMO Beneficiaries to participate in such health education programs. [Medi-Cal Agreement].

**7. Medi-Cal HMO Beneficiaries and State Held Harmless.** Provider agrees that in no event, including, but not limited to, non-payment by Health Net, the insolvency of Health Net, or breach of the Agreement, shall Provider or a subcontractor of Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Medi-Cal HMO Beneficiaries, the State of California, or persons other than Health Net acting on their behalf for services provided pursuant to the Agreement. Provider agrees: (1) this provision shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Medi-Cal HMO Beneficiaries; and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Medi-Cal HMO Beneficiaries or persons acting on their behalf. Any modification, addition, or deletion of or to the provisions of this clause shall be effective on a date no earlier than fifteen (15) days after the DHCS has received written notice of such proposed change and has approved such change. [22 CCR § 53250(e)(6)].

**8. No Surcharges and No Copayments.** Provider shall not charge a Medi-Cal HMO Beneficiary any fee, surcharge or Copayment for health care services rendered pursuant to the Agreement except when explicitly allowed by the Medi-Cal Benefit Program, for covered services rendered pursuant to the Agreement. In addition, Provider shall not collect a sales, use or other applicable tax from Medi-Cal HMO Beneficiaries for the sale or delivery of medical services. If Health Net receives notice of any additional charge, Provider shall fully cooperate with Health Net to investigate such allegations, and shall promptly refund any payment deemed improper by Health Net to the party who made the payment. [Knox-Keene Act and Medi-Cal Agreement].

**9. Grievances and Appeals.** Provider agrees to work with Health Net to resolve all grievances and appeals relating to the provision of services to Medi-Cal HMO Beneficiaries in accordance with the Health Net Medi-Cal grievance and appeal procedures.

**10. Provider Patient Relationship.** Provider shall be solely responsible, without interference from Health Net or its agent, for providing Hospital Services to Medi-Cal HMO Beneficiaries, and shall have the right to object to treating any individual who makes onerous the relationship between Provider and Medi-Cal HMO Beneficiary. In the event of a breakdown in such relationship, Health Net shall make reasonable efforts to assign the Medi-Cal HMO Beneficiary to another Participating Provider. If reassignment is unsuccessful, a request may be filed with the DHCS to permit termination of services to such Medi-Cal HMO Beneficiary. Approval from the DHCS must be obtained before Provider terminates services to such Medi-Cal HMO Beneficiary.

**11. Fair Employment Requirements.** During the term of this Agreement, Provider and its subcontractors shall not unlawfully discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military or veteran status. Provider and its subcontractors also shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination. Provider and its subcontractors shall comply with the provisions of the Fair Employment and Housing Act (California Government Code, Section 12990 *et seq.*) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0 *et seq.*). The applicable regulations of the Fair Employment & Housing Council implementing Government Code, Section 12990, set forth in Subchapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider and its subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreements.

**12. Governing Law.** The Agreement shall be governed by and construed and enforced in accordance with all laws and contractual obligations incumbent upon Health Net. Provider shall comply with all applicable local, State, and federal laws, now or hereafter in effect, to the extent that they directly or indirectly affect Provider or Health Net, and bear upon the subject matter of the Agreement. Provider shall comply with the provisions of the Medi-Cal Agreement, and Chapters 3 and 4 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations. In addition, Health Net is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations. Any provision required to be in the Agreement by either of the above laws shall bind the parties whether or not provided in the Agreement. [22 CCR § 53250(c)(2)]; W & I § 14452(a); Knox-Keene Act].

**13. Notice.** Provider shall notify DHCS in the event this Agreement is amended or terminated. Notice to DHCS is considered given when properly addressed and deposited with the United States Postal Service as first class registered mail, postage attached. [Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13, and Title 22, CCR, Sections 53250(e)(4) and 53867.]

**14. Reports:** Provider shall provide Health Net, within the time requested by Health Net, with all such reports and information as Health Net may require to allow it to meet the reporting requirements under the Medi-Cal Agreement or any applicable law or regulatory directive. [Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867]. Furthermore, Provider shall submit to Health Net, complete, accurate, reasonable, and timely provider data requested by Health Net in order for Health Net to meet its provider data reporting requirements to DHCS. [Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.]

**15. Confidentiality of Information.** Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 45, Code of Federal Regulations, Section 205.50 and Section 14100.2 of the California Welfare and Institutions Code and the regulations adopted thereunder. For the purposes of this Agreement, all information, records, data, and data elements collected and maintained for or in connection with performance under this Agreement and pertaining to Medi-Cal HMO Beneficiaries shall be protected by Provider from unauthorized disclosure. With respect to any identifiable information concerning a Medi-Cal HMO Beneficiary under this Agreement that is obtained by Providers or its subcontractors, Provider: (1) will not use any such information for any purpose other than carrying out the express terms of this Agreement; (2) will promptly transmit to Health Net all requests for disclosure of such information; (3) will not disclose, except as otherwise specifically permitted by this Agreement, any such information to any party other than Health Net without Health Net's prior written authorization specifying that the information is releasable under applicable law, and (4) will, at the expiration or termination of this Agreement, return all such information to Health Net or maintain such information according to written procedures provided Provider by Health Net for this purpose. Provider shall ensure that its subcontractors comply with the provisions of this paragraph.

**16. Third Party Tort Liability.** Provider shall make no claim for recovery for health care services rendered to a Medi-Cal HMO Beneficiary when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance, including workers' compensation awards and uninsured motorist coverage. Within five (5) days of discovery, Provider shall notify Health Net of cases in which an action by the Medi-Cal HMO Beneficiary involving the tort or workers' compensation liability of a third party could result in a recovery by the Medi-Cal HMO Beneficiary. Provider shall promptly provide: (1) all information requested by Health Net in connection with the provision of health care services to a Medi-Cal HMO Beneficiary who may have an action for recovery from any such third party; (2) copies of all requests by subpoena from attorneys, insurers or Medi-Cal HMO Beneficiaries for copies of bills, invoices or claims for health care services; and (3) copies of all documents released as a result of such requests. Provider shall ensure that its subcontractors comply with the requirements of this provision.

**17. Amendments.**

17.1 When required under Medi-Cal law, Amendments to the Agreement shall be submitted by Health Net to the DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes, which are neither approved nor disapproved by the Department, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later. Subcontracts between a prepaid health plan and a subcontractor shall be public records on file with the DHCS. [22 CCR §§ 53250(a), (c)(3), & (e)(4); W & I § 14452(a)].

17.2 Notwithstanding the foregoing and any provisions to the contrary in this Agreement, the parties understand and agree that an amendment to the material terms of this Agreement shall be permitted without the consent of Provider if: (i) Provider is a non-institutional provider; (ii) the amendment applies to the Medi-Cal product; (iii) Provider is compensated on a fee-for-service basis; (iv) Health Net gives the Provider a minimum of ninety (90) business days' notice of its intent to amend the Agreement; (v) Provider has the right to exercise its intent to negotiate and agree to the amendment within thirty (30) business days of Provider's receipt of the notice of amendment; and (vi) Provider has the right to terminate the Agreement within ninety (90) business days from the date of receipt of such notice if Provider does not exercise the right to negotiate the amendment and no agreement is reached. In such event, the amendment becomes effective ninety (90) days from the date of the notice set forth in this paragraph if Provider does not exercise its right to negotiate the amendment or to terminate the Agreement as described in this paragraph.

**18. Notice of Change in Availability or Location of Covered Services.** Health Net is obligated to ensure Medi-Cal HMO Beneficiaries are notified in writing of any changes in the availability or location of Covered Services at least thirty (30) days prior to the effective date of such changes, or within fourteen (14) days prior to the change in cases of unforeseeable circumstances. Such notifications must be approved by DHCS prior to the release. In order for Health Net to meet this requirement, Provider is obligated to notify Health Net in writing of any changes in the availability or location of Covered Services at least forty (40) days prior to the effective date of such changes.

19. **Transfer of Care Upon Termination of the Agreement.** Provider shall, pursuant to the requirements of the Medi-Cal Agreement, assist in the orderly transfer of care of all Medi-Cal HMO Beneficiaries under the care of Provider in the event of the termination of the Agreement for any reason.

20. **Assignment and Delegation.** Assignment or delegation of an obligation or responsibility under the Agreement shall be void unless prior written approval is obtained from the DHCS, in the instances where approval by the DHCS is required.

21. **Carve-out of California Children’s Services (CCS) Program Services.** The parties acknowledge that health care services to treat CCS-eligible conditions are “carved out” of Health Net’s coverage obligations under the Medi-Cal Benefit Programs. Provider shall identify and timely refer Beneficiaries with possible CCS-eligible conditions to the appropriate County CCS Program. Upon referral, Provider shall inform the Beneficiary’s parent or guardian and shall notify Health Net of any such referral. The CCS Program requires eligible children to be treated at CCS-certified facilities by CCS-paneled providers. The CCS Program may require transfer to CCS-certified facilities with CCS-paneled providers. The CCS Program is financially responsible for payment of health care costs to treat a CCS-eligible condition. The parties understand and agree that Health Net is not financially responsible for payment of services to treat CCS-eligible conditions. In the event Health Net inadvertently pays a claim for such services, Health Net may recover the amount paid pursuant to Section 4.3 of the Agreement.

22. **Cultural and Linguistic Services.** Provider shall: (1) not require or encourage Beneficiaries to utilize family Beneficiaries or friends as interpreters; (2) record the language needs of Beneficiaries in the medical record; and (3) document Beneficiary requests or refusals of interpreter services in the Beneficiary’s medical record. Provider shall arrange interpreter services for Beneficiaries either through telephone language services or face-to-face interpreters. Provider is encouraged to directly make these interpretive services available. However, upon request, Health Net’s Member Services Department is available to provide certain interpretive assistance to facilitate communications. Health Net shall: (1) Provide cultural competency/humility, sensitivity, health equity, and diversity training to Health Net’s contracted providers. Provider must ensure that cultural competency, sensitivity, health equity, and diversity training is provided for its employees and staff at key points of contact with Beneficiaries in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C (Cultural and Linguistic Programs and Committees) of the Medi-Cal Agreement.

23. **EPSDT Supplemental Services.** Provider shall arrange for Early and Periodic Screening, Diagnosis and Treatment Supplemental Services for Beneficiaries under the age of 21 in accordance with the requirements of the Medi-Cal Agreement.

24. **CCS (California Children’s Services).** Provider is responsible for timely referral of children with potential CCS eligible conditions. Failure to appropriately refer will result in Provider assuming financial responsibility for any related charges.

25. **CPSP (Comprehensive Perinatal Services Program).** Provider is required to refer members to DHCS-certified CPSP providers to ensure that all pregnant women have access to care in accordance with DHCS requirements.

26. **Sensitive Services.** Sensitive Services are those health care services, which are covered by more restrictive confidential treatment rules. In accordance with the Medi-Cal Agreement, Medi-Cal Members may self-refer anywhere to obtain Sensitive Services and no referral or prior authorization shall be required. Access to Sensitive Services shall not be limited in any way geographically or by provider network participation.

The Sensitive Services are as follows:

- abortion (pregnancy termination) services,
- family planning services, inclusive of all methods of birth control covered by the Department of Health Care Services for the Medi-Cal Program.

- sexually transmitted disease testing and treatment, and
- Human Immunodeficiency Virus (HIV) testing and counseling.

27. **Vaccines for Children Program (VFC).** Provider shall not seek reimbursement from Health Net for immunizations covered by the State of California under the Vaccines for Children Program (VFC), where a Provider, or Professional Provider who is a participant in the VFC program, rendered the immunization.

28. **Local Health Department Coordination.** As more fully set out in the Medi-Cal Agreement, Health Net or a contracting Medi-Cal plan has (or will) entered into agreements for specified public health services with certain county health departments. The public health agreements specify the scope and responsibilities of the local health departments and Health Net, billing and reimbursements, reporting responsibilities, and medical record management to ensure coordinated health care services. The public health services specified under the agreements are as follows:

- 28.1 Family planning services;
- 28.2 Sexually transmitted disease ("STD") services diagnosis and treatment of disease episode of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale;
- 28.3 Confidential HIV testing and counseling;
- 28.4 Immunizations;
- 28.5 Child Health and Disability Prevention Program;
- 28.6 California Children Services;
- 28.7 Maternal and Child Health;
- 28.8 Refugee assessments;
- 28.9 Tuberculosis Direct Observed Therapy;
- 28.10 Women, Infants, and Children Supplemental Food Program;
- 28.11 Population based Prevention Programs: collaborate in local health department community based prevention programs.

Provider shall, in accordance with the terms and conditions of the public health agreements with the local health departments and Health Net's related policies and procedures, be responsible for the coordination and arrangement of the public health services for its assigned Beneficiaries. The services specified in Sections 29.1 through 29.5 above require reimbursement to the applicable local health department. The services specified in Sections 29.6 through 29.11 above do not require reimbursement to the applicable local health department. [Medi-Cal Agreement]

29. **Provider Preventable Conditions.** Health Net and Provider shall comply with the Patient Protection and Affordable Care Act (PPACA), as amended, including any reporting requirements and non-payment for Provider Preventable Conditions. Provider shall comply with Health Net's Policies regarding any reporting requirements and non-payment for Provider Preventable Conditions.

30. **Reviews and/or Investigations.** Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of

payments made to the Provider; impose other sanctions provided under the State Plan, and direct Health Net to terminate Provider's Agreement due to fraud.

**31. Prospective Requirements.** Health Net shall inform Provider of prospective requirements added by DHCS to the agreement between Health Net and DHCS, before the effective date of such requirements. Provider agrees to comply with any changes to such requirements within thirty (30) days of the effect of said requirements from DHCS, unless DHCS instructs otherwise and to the extent possible.

**32. Immunization Services.** Provider shall ensure that all Participating Providers and/or Professional Providers, who render any Immunization services, of any kind, are registered with, and submit applicable information to a CA immunization registry and shall provide evidence of such, upon request or audit, by Health Net or any designee.

**33. Coordination of Care.** To the extent that Provider is responsible for the coordination of care for Members, Health Net shall share with Provider any utilization data that DHCS has provided to Health Net to use for the purpose of Member care coordination.

**34. Emergency Service Providers.** Health Net is responsible for coverage and payment of emergency services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has an agreement with Health Net. Post-stabilization care services following an emergency inpatient admission are covered and paid for in accordance with provisions set forth in 42 CFR 422.113 (c) .

**35. Provider's Performance.** This Agreement is subject to termination, or other remedies, if DHCS or Health Net determine that Provider has not performed satisfactorily.

**36. Suspected Fraud, Waste, or Abuse.** Provider must notify Health Net, and Health Net Subcontractors or Downstream Subcontractors Provider also contracts with, within ten Working Days of any suspected Fraud, Waste, or Abuse. Health Net shall share such information with DHCS in accordance with the Medi-Cal Agreement.

**37. Emergency Preparedness.** Provider shall i.) annually submit to Health Net evidence of adherence to CMS Emergency Preparedness Final Rule 81 FR 63859; ii.) advise Health Net as part of Provider's Emergency plan; and iii.) notify Health Net within 24 hours of an Emergency if Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency. Emergency for purposes of this section shall include any natural or manmade disaster or public health crisis.

**38. Quality Improvement (QI) and Health Equity.** Provider will supply reports as needed to support the QI Health Equity Committee's ability to assess QI and Health Equity activities.

**EXHIBIT C-1**

**MEDI-CAL BENEFIT PROGRAMS  
DIRECT NETWORK FEE-FOR-SERVICE RATE EXHIBIT**

Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Addendum D, Health Net shall pay and Provider shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered pursuant to this Addendum, the lesser of: (i) the rates listed below, or (ii) 100% of Provider's Allowable Charges.

<b>Category of Service</b>	<b>Compensation</b>
Covered Services delivered or arranged by Provider	100% of the State of California Medi-Cal Fee Schedule rates
Pharmaceuticals Without an established Medi-Cal Value	82% of the Average Wholesale Price (AWP)
Immunizations Without an established Medi-Cal Value	82% of the Average Wholesale Price (AWP)
By Report (BR) Procedures and Procedures not Listed -Procedures with Medi-Cal Units not Established but with a Medicare Value	80% of the Current Medicare Allowable
-Procedures without Medi-Cal Units or a Medicare Established Value	15% of Provider's Allowable Charges

**EXHIBIT C-2**

**DISCLOSURE FORM**

(Required by California Welfare and Institutions Code Section 14452)

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency;

- 1) the identity of all owners with a control interest of five (5) percent or greater,
- 2) certain business transactions as described in 42 CFR 455.105, and
- 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity.

If there are any changes to the information disclosed in this form, an updated form should be completed and submitted to Health Net Community Solutions, Inc. within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you:		
<input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity		
Name of Individual, Group Practice, or Disclosing Entity		
DBA Name		
Federal Tax Identification Number	NPI	CAQH Number

Section I

Please list the name, title address, date of birth, and Social Security Number for each individual having an ownership or control interest in this provider of five (5) percent or greater.			
Please list the name, Tax Identification Number, business address or each organization, corporation, or entity having an ownership or control interest of five (5) percent or greater. (42 CFR 455.104) Please attach a separate sheet if necessary.			
Name of individual or entity	DOB	Address	SSN (for individual) or TIN (for entity)

Section II

Are any of the individuals listed in Section one related to each other?

Yes  
 No

If yes, list the individual's name above who are related to each other (spouse, sibling, parent, child). 42 CFR 455.104

Name	Relationship

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of five (5) percent or more?

Yes  
 No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of five (5) percent or more. 42 CFR 455.104

Name of individual or entity	DOB	Address	SSN (for individual) or TIN (for entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program?

Yes  
 No

If yes, list those persons below. 42 CFR 455.106

Name and Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more of than \$25,000 or any significant business transactions with any subcontractors?

Yes  
 No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than \$25,000 during the previous twelve (12) month period; and any significant business transactions

between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past five (5) year period. 42 CFR 455.105

Name of Supplier or Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information) as a Disclosing Entity?

Yes

No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth, Address, Social Security Number, and percent of interest.

Name and Title	DOB	Address	SSN	% of Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title (indicate if authorized Agent)

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date

## ADDENDUM D

### **DIRECT NETWORK FEE-FOR-SERVICE PAYMENT CONDITIONS**

The Payment Conditions set forth in this Addendum supplement Health Net Policies, and are applicable to Commercial Benefit Programs, Medicare Advantage Benefit Program, and the Medi-Cal Benefit Program.

1. Provider shall utilize valid CPT/HCPCS/ICD10 diagnosis codes, or successor codes, when submitting Complete Claims for Covered Services under this Agreement. The parties acknowledge that applicable coding agencies periodically issue coding modifications. Such modifications may be implemented by Health Net within sixty (60) days of the date Health Net receives the modification from the applicable coding agency. The parties agree that in the event such coding modifications have the effect of changing a payment amount in this Agreement, the resulting payment amount change shall be effective on a prospective basis. The parties further agree to reasonably and in good faith discuss any contract rate amendment that may be appropriate based on comprehensive and substantive coding changes by the applicable coding agency within ninety (90) days of written notification by either party. Any and all rate modifications that may result from such contract amendment shall be effective on a prospective basis.

2. Pharmaceuticals shall include inhaled/infused/injected medications provided by, and delivered in Provider/Professional Provider office. Support drugs and injection supplies for patient self-administered injections shall be supplied only through a Health Net preferred specialty pharmacy provider. AWP pricing shall be determined by Health Net utilizing a nationally recognized source for pharmaceutical pricing to be updated at least quarterly. Provider shall bill administered dosage in accordance with applicable HCPCS codes. Multi-dose vials shall be reimbursed on a per dose basis.

3. Immunizations shall include procedure codes for immune globulins, vaccines and toxoids that identify the product only. The administration for immune globulins, vaccines and toxoids are separate from the product itself and are not considered immunizations. AWP pricing shall be determined by Health Net utilizing a nationally recognized source for pharmaceutical pricing to be updated at least quarterly. Provider shall bill administered dosage in accordance with applicable HCPCS codes. Multi-dose vials shall be reimbursed on a per dose basis.

4. The rates set forth in this Agreement apply to all current and future locations billed under this and future Tax Identification Numbers indicated by Provider through a signed W-9 form and subject to terms of this Agreement.

**CALIFORNIA  
PROVIDER PARTICIPATION AGREEMENT  
FEE-FOR-SERVICE FACILITY TEMPLATE**

This Provider Participation Agreement (“Agreement”) is made and entered into as of the \_\_\_\_ day of \_\_\_\_\_, 200\_\_ (the “Effective Date”) by and between **INSERT NAME OF PROVIDER** (“Provider”), and Health Net of California, Inc. on behalf of itself and its subsidiaries and affiliates (collectively, “Health Net”).

**RECITALS**

A. Provider has the legal authority to enter into this Agreement, and to deliver or arrange for the delivery of Contracted Services.

B. Health Net has the legal authority to enter into this Agreement, and to perform the obligations of Health Net hereunder with respect to the Benefit Programs.

C. The parties desire to enter into this Agreement to arrange for Provider to participate in one or more of Health Net’s networks of Participating Providers that render Contracted Services to Beneficiaries of various Benefit Programs.

D. Provider’s primary consideration shall be the quality of the health care services rendered to Beneficiaries, pursuant to Title 10 CCR 2240.4.

**AGREEMENT**

NOW, THEREFORE, in consideration of the above recitals and the covenants contained herein, the parties hereby agree as follows:

**I. DEFINITIONS**

Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Article I.

**1.1 Allowable Charges.** Allowable Charges is defined as Provider’s billed charges for Contracted Services.

**1.2 Beneficiary.** A person who is properly enrolled in and eligible to receive Covered Services under a Benefit Program at the time Covered Services are rendered. The parties acknowledge that the term ‘member’ may be used by Health Net in certain related materials, such as Benefit Program documents covering various products, marketing materials, and Health Net Policies. For reference purposes, the term Beneficiary includes the term ‘member’ wherever used.

**1.3 Benefit Program.** The group agreement, evidence of coverage, certificate of insurance, summary plan description or similar documents in effect at the time Covered Services are rendered for lines of business offered through Health Net. The Benefit Programs in which Provider participates and terms and conditions such as payment rates relating to such Benefit Programs, are set forth in the Addenda to this Agreement.

**1.4 Coinsurance.** That portion of the cost of Covered Services that a Beneficiary is obligated to pay under a particular Benefit Program which is calculated as a percentage of the contracted reimbursement rate for such services. Coinsurance does not include Copayments or Deductibles.

**1.5 Complete Claim.** A Complete Claim means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides reasonably relevant information as

defined by applicable State or federal statutes and regulations, and which is submitted to Health Net or a Payor by Provider for payment of Contracted Services that may be processed by Health Net or a Payor without obtaining additional information from Provider or from a third party.

**1.6 Contracted Services.** Covered Services that are (i) those services which Provider is licensed to provide, and which Provider customarily provides to its patients, and (ii) to be provided to a Beneficiary under the terms of the applicable Benefit Program in effect at the time such services are rendered or as required by State or federal law, and (iii) compensated in accordance with this Agreement except as otherwise may be required by State or federal law.

**1.7 Coordination of Benefits.** The allocation of financial responsibility between two or more payors of health care services, each with a legal duty to pay for or provide Covered Services to a Beneficiary at the same time.

**1.8 Copayment.** That portion of the cost of Covered Services that a Beneficiary is obligated to pay under a particular Benefit Program, which is a fixed dollar amount and is paid at the time Covered Services are rendered. Copayments do not include Coinsurance or Deductibles.

**1.9 Covered Services.** The health care services, equipment and supplies that are covered as determined by the Benefit Program and by applicable State and federal law and regulations, including without limitation decisions issued as a result of independent medical review conducted under applicable State and federal law.

**1.10 Deductible.** The amount of money that a Beneficiary must pay before the Benefit Program pays certain benefits for Covered Services. Deductibles do not include Coinsurance or Copayments.

**1.11 Dispute.** The term “Dispute”, as used in this Agreement, including Sections 7.5 and 7.6, shall mean any controversy or disagreement that may arise out of or relate to this Agreement, or the breach thereof, whether involving a claim in tort, contract, or other applicable area of law.

**1.12 Emergency.** The term “Emergency” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient’s health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Active labor is considered an Emergency. “Active labor” means labor at the time that either of the following could reasonably occur: (1) There is inadequate time to effect safe transfer to another hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the Enrollee or unborn child.

Certain benefit plans require adherence to the federal and government program standard for defining an Emergency, which defines an Emergency as : a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the patient’s health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

**1.13 Excluded Services.** Those health care services, equipment and supplies that are determined by Health Net or a Payor to be non-Covered Services under the applicable Benefit Program in effect at the time such services are rendered and for which Provider may bill the Beneficiary.

**1.14 Facility(ies).** All service locations owned, operated, leased, or subcontracted by Provider at which Contracted Services are provided under this Agreement. Provider’s service locations as of the date this Agreement is executed by the parties are listed on the signature page of this Agreement.

**1.15 Health Net.** A network of managed health care delivery or indemnity companies, owned, controlled, controlling, under common control with, managed or administered in whole or in part now or hereafter, by Health Net, LLC, its successors, and assigns.

**1.16 Health Net Policies.** The policies, procedures and programs established by Health Net and applicable to Participating Providers in effect at the time Covered Services are rendered, including without limitation Health Net's grievance and appeal procedures, provider dispute and/or appeal process, drug formulary or preferred drug list, fraud detection, recovery procedures, eligibility verification, billing and coding guidelines, payment and review policies, anti-discrimination requirements, medical management programs, continuity of care policies, provider manuals and/or operations manuals. The medical management program includes policies regarding topics such as credentialing, utilization management, quality improvement, catastrophic care management, peer review, medical and other record reviews, outcome rate reviews, Prior Authorization, and Referral.

**1.17 Inpatient Services.** An inpatient day is a measure of time during which a Beneficiary receives hospital services, and which occurs when a Beneficiary occupies a bed as of twelve o'clock midnight and is admitted to Provider's Facility. Inpatient Services include, but are not limited to: a) bed and board; b) all medical, nursing, surgical, pharmacy and dietary services; c) all diagnostic and therapeutic services required by a Beneficiary when ordered by an attending physician with appropriate medical and clinical staff privileges; d) use of facilities, and medical, mental health, social services, and discharge planning services required for the provision of Contracted Services; e) drugs while an inpatient, implants, supplies, appliances and equipment; f) transportation services subsequent to admission and prior to discharge required in providing Inpatient Services; g) Covered Services delivered by Professional Providers in Provider's Facility where Provider bills for these services on a CMS UB04 or successor form.

**1.18 Medically Necessary.** A Medically Necessary service or supply is one that meets the following criteria: it is an otherwise covered category of service, not specifically excluded and is recommended by the treating physician and determined by Health Net's Medical Director or physician designee to be: (i) for the purpose of treating a medical condition; (ii) the most appropriate supply or level of service, considering potential benefits and harm to the Beneficiary; not furnished primarily for the convenience of the Beneficiary or Provider; not required solely for custodial, comfort or maintenance reasons; consistent with Health Net Policies and furnished in the most appropriate place of service consistent with nationally recognized review criteria and/or guidelines, such as, for example, Milliman or Interqual criteria; and (iii) known to be effective and safe in improving health outcomes. For new treatments, services or supplies, effectiveness is determined by scientific evidence. For existing treatments, services or supplies, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. The fact that a physician or other provider may prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary or make it a Covered Service.

**1.19 Outpatient Services.** Those services customarily provided at a Facility, and/or a Professional Provider's office, to a Beneficiary who is not admitted as an inpatient, including without limitation Emergency Services, observation services, outpatient and short stay surgery, day program, clinic care, urgent care, and related nursing, surgical, pharmaceutical, dietary, diagnostic, and ancillary services.

**1.20 Participating Provider.** A facility, physician, physician organization, physician group, independent practice association, health care provider, supplier, or other organization which has met applicable credentialing requirements, if any, and has, or is governed by, an effective written agreement directly with Health Net or indirectly through another entity, such as a PPG, to provide Covered Services.

**1.21 Payer.** Any public or private entity contracted with Health Net which provides, administers, funds, insures or is responsible for paying Participating Providers for Covered Services rendered to Beneficiaries under a Benefit Program, including self-funded health plans.

**1.22 PPG.** A participating physician group that has entered into an agreement with Health Net to deliver or arrange for the delivery of certain Covered Services to Beneficiaries.

**1.23 Primary Care Physician (PCP).** A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who: (i) is duly licensed and qualified under the laws of the relevant jurisdiction to render certain Covered Services; (ii) is a Participating Provider; and (iii) meets the credentialing standards of Health Net for designation as a PCP; and (iv) is responsible for coordinating the provisions of health care services and providing for continuity of care and twenty-four (24) hours a day, seven (7) days a week availability to Beneficiaries.

**1.24 Prior Authorization.** The written or electronically issued prior approval by Health Net or its designee for the provision of Covered Services which may be required under a Benefit Program or a Health Net Policy.

**1.25 Professional Provider.** The physicians, allied health professionals and other health care providers who contract with Provider, or are employed by Provider, and who have been accepted by Health Net to provide Contracted Services to Beneficiaries under the terms and conditions of this Agreement and billed through Provider's federal tax identification number and/or national provider identifier.

**1.26 Records.** Books, documents, contracts, subcontracts, and records prepared and/or maintained by a party that relate to this Agreement whether in written or electronic format, including without limitation medical records, Beneficiary billing and payment records, financial records, policies and procedures, and other books and records that may be required by applicable federal and State law.

**1.27 Referral.** The written or electronically issued referral of a Beneficiary by a Participating Provider to another health care provider that may be required under a Benefit Program or a Health Net Policy prior to the rendition of Covered Services, usually for a specified number of visits or type or duration of treatment.

**1.28 State.** The State of California.

**1.29 Surcharge.** An additional fee which is charged to a Beneficiary for a Covered Service, but which is not approved by the applicable State and federal regulatory authority, and is neither disclosed, nor provided for in a Benefit Program.

## **II. DUTIES OF PROVIDER**

**2.1 General Obligations.** Provider agrees on behalf of itself, and each of its Facilities and Professional Providers, as applicable, that during the term of this Agreement and any renewal terms, each of them is:

- 2.1.1 licensed without restriction or limitation by the State to provide Contracted Services to the extent required by the State;
- 2.1.2 operating and providing Contracted Services in compliance with applicable local, State, and federal laws, rules, regulations and legal standards of care;
- 2.1.3 either certified to participate or has not been excluded from participation in Medicare under Title XVIII of the Social Security Act, and in Medicaid/Medi-Cal under Title XIX of the Social Security Act or other applicable State law pertaining to Title XIX of the Social Security Act;
- 2.1.4 accredited or certified by the accrediting or certifying organization(s) listed on the signature page of this Agreement, if any;
- 2.1.5 delivering Contracted Services to Beneficiaries in the same manner and with the same availability, as services are delivered to other patients;
- 2.1.6 maintaining such physical plant, equipment, patient service personnel and allied health personnel as may be necessary to provide Contracted Services;
- 2.1.7 available to Beneficiaries twenty four (24) hours per day, seven (7) days per week on an emergency basis.

- 2.1.8 Provider shall notify Health Net in writing, thirty (30) days in advance, of any changes to federal tax identification numbers and/or national provider identifier numbers.
- 2.1.9 National Committee for Quality Assurance (“NCQA”) Accreditation of Health Plans Standards. Provider agrees to i) cooperate with Quality Management and Improvement (“QI”) activities; ii) maintain the confidentiality of Member information and records pursuant to this Agreement; and iii) allow Health Net to use Provider’s performance data.
- 2.1.10 Provider agrees to cooperate and implement the California Health and Human Services Data Exchange Framework data sharing that requires the real time exchange of health information for members as outlined in California Assembly Bill 133 and Health Net Policies.

**2.2 Provision of Services.** Provider agrees to render Contracted Services to Beneficiaries of Benefit Programs under the terms and conditions of this Agreement. Notwithstanding the foregoing, Provider understands and agrees that Health Net or a Payor does not have an obligation under this Agreement to assign or refer to Provider any minimum amount of Beneficiaries. Health Net has not represented or guaranteed to Provider that any Beneficiaries shall receive Covered Services from Provider or that Provider shall participate in all networks of Participating Providers offered by or through Health Net.

Provider acknowledges that Health Net or a Payor shall not be liable for, nor will exercise control or direction over, the manner or method by which Provider, Facilities, and/or Professional Providers render any Covered Services to Beneficiaries under this Agreement.

**2.3 Verification of Eligibility.** Except in an Emergency, Provider shall verify the eligibility of Beneficiaries using Health Net’s telephonically or electronically available system before providing Contracted Services, in compliance with the timeframes and procedures set forth in Health Net Policies.

**2.4 Non-Discrimination.** Provider shall not discriminate against any Beneficiary in the provision of Contracted Services hereunder, whether on the basis of the Beneficiary's coverage under a Benefit Program, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, source of payment, utilization of medical or mental health services, equipment, pharmaceuticals or supplies, health status (including without limitation, Beneficiaries who are, were, or may be victims of domestic violence, or have or may have conditions that are caused by domestic violence ), genetic information, or other unlawful basis including, without limitation, the filing by such Beneficiary of any complaint, grievance or legal action against Provider, Health Net or Payor. Provider agrees to make reasonable accommodations for Beneficiaries with disabilities or handicaps, including but not limited to, providing such auxiliary aides and services to Beneficiaries as are reasonable, necessary, and appropriate for the proper rendering of Contracted Services at the Provider’s expense.

**2.5 Professional Providers and Facilities.** The following provisions apply when Provider utilizes Professional Providers or Facilities to deliver Contracted Services to Beneficiaries:

- 2.5.1 Provider binds its Facilities and Professional Providers, if any, covered by this Agreement, to the terms and conditions of this Agreement, to the extent Contracted Services and/or contractual provisions are performed by, or apply to, such Facilities and Professional Providers;
- 2.5.2 Health Net and Provider agree to meet and confer in the event Provider desires to add a new or satellite facility to this Agreement. No new or satellite facility shall be added to or allowed to deliver Covered Services under this Agreement until Health Net has approved such Facility. Health Net may deny participation under this Agreement to any new or satellite facility without any obligation to provide a right to appeal except as may be required by applicable State and federal law.

Provider additionally shall comply with the terms of Section 2.6 hereof with respect to its Facilities and Professional Providers, to the extent Facilities are not owned, and/or Professional Providers are not employed, by Provider.

**2.6 Subcontracting.** The following requirements shall survive termination of this Agreement with respect to Contracted Services rendered during the term of the Agreement and apply when Contracted Services are provided by a subcontractor, such as a reference laboratory:

- 2.6.1 Provider shall furnish Health Net with copies of its subcontracts within ten (10) days of Health Net's written request.
- 2.6.2 Every subcontract shall comply with all applicable local, State, and federal laws, including privacy/confidentiality and medical record accuracy laws, be consistent with the terms and conditions of this Agreement, and shall not be used by Provider with respect to Beneficiaries, Benefit Programs and/or Contracted Services upon the reasonable request of Health Net.
- 2.6.3 Provider shall not subcontract either directly or indirectly, with any provider that has been excluded from participation in the Medicare Advantage Program under Section 1128 or 1128A [42 U.S.C. 1320a-7] of the Social Security Act or in the State Medi-Cal program.
- 2.6.4 Each such subcontractor shall meet applicable Health Net credentialing requirements, if any, prior to the subcontract becoming effective with respect to Contracted Services.
- 2.6.5 (i) Provider shall be solely responsible to pay the subcontractor and (ii) Provider shall hold Health Net, Payors and Beneficiaries harmless from and against any and all claims which may be made by subcontractors in connection with Covered Services provided to Beneficiaries by the subcontractor; and (iii) Provider shall require that the subcontractor hold Health Net, Payors, and Beneficiaries harmless from and against any and all claims for payment for such services and shall not attempt to collect any sums owed by Provider from Health Net or a Beneficiary.
- 2.6.6 Subcontracts shall not restrict the rights and obligations of a healthcare provider to communicate freely with Beneficiaries regarding their medical condition and treatment alternatives including medication treatment options, regardless of benefit coverage limitations.
- 2.6.7 In the event that any of Provider's subcontracts fail to comply with the requirements set forth herein, Health Net or Payor shall not be required to recognize the existence or validity of the subcontract with respect to Beneficiaries, Benefit Programs and/or Covered Services. Health Net or a Payor shall further have the right, but not the obligation, to directly pay subcontractors submitting claims for Contracted Services, and to recoup any compensation otherwise due by Health Net or a Payor to Provider pursuant to the terms and conditions of this Agreement. Provider shall indemnify and hold harmless Health Net or a Payor for all such payments and related costs.

**2.7 Participating Providers.** Except in an Emergency, as otherwise permitted in the applicable Benefit Program Requirements, or as otherwise required by applicable federal or State law, if Provider refers a Beneficiary for Covered Services, Provider shall refer Beneficiary only to Participating Providers and Provider shall coordinate such referrals with Health Net or its designee to facilitate the utilization of the most appropriate Participating Provider based upon the Medical Necessary level of care required for the Beneficiary. Provider shall use reasonable efforts to assist Health Net or Payor in their efforts to contract with Provider's Facility-based physicians.

Prior to rendering any non-emergency episode of care, Provider shall determine and disclose to EPO and PPO Beneficiaries the out-of-network providers who are likely to be involved in providing care and the estimated cost of that non-participating provider's care (e.g. for a surgery, Provider shall disclose to the Beneficiary prior to the surgery, all non-participating providers, such as anesthesiologists, radiologists, and pathologists, who are anticipated to be involved in the Beneficiary's care, and the estimated cost of such out-of-network services). Provider's disclosure shall be made sufficiently in advance of the scheduled episode of care to afford the Beneficiary a reasonable opportunity to explore alternate arrangements.

**2.8 Health Net Policies.** Provider shall participate in and comply with all Health Net Policies in effect on the effective date of this Agreement and as modified periodically by Health Net in accordance with Section 3.2 of this Agreement. Provider hereby acknowledges that it has had the opportunity to review Health Net Policies regarding

quality improvement and utilization management that pertain to Health Net and Provider's rights and obligations under this Agreement at least fifteen (15) business days prior to the date Provider has executed this Agreement.

**2.9 Prior Authorization/Referral.** When either Prior Authorization and/or a Referral is required for the rendition of a health care service, the receipt of the required Prior Authorization and/or the required Referral, each being separate and distinct requirements, is a prerequisite to payment of Complete Claims for Covered Services in addition to confirming eligibility prior to delivering service as required by this Agreement and Health Net Policies. Health Net (or its designee as applicable) may rescind or modify its Prior Authorization, in a manner consistent with Health Net Policies, based on variety of factors, including but not limited to the eligibility of the Beneficiary and whether the rendered service is a Covered Service. However, when Health Net or its designee issues a Prior Authorization for a specific service under a Benefit Program regulated by the California Department of Managed Health Care or the California Department of Insurance, Health Net (or its designee as applicable) shall not rescind or modify its Prior Authorization after Provider has rendered the specified and authorized service in good faith and pursuant to the terms of the Prior Authorization for any reason, including, but not limited to, Health Net's subsequent rescission, cancellation, or modification of the Beneficiary's contract or Health Net's subsequent determination that it did not make an accurate determination of the Beneficiary's eligibility; provided, however that this section shall not be construed to expand or alter benefits available to a Beneficiary under such Benefit Program.

**2.10 Notification.** Provider shall notify Health Net or a Payor and the appropriate PCP or PPG as applicable, as soon as possible, but no later than 24 hours or by the next business day after a Beneficiary is admitted to a Facility. Provider shall provide electronic notifications of Health Net members inpatient and emergency room admissions and discharges (ADT data) in near real time to Health Net via Health Net's preferred receiver of Admission and Discharge data.

**2.11 Credentialing Program.** Provider shall submit to Health Net or its designee any applicable Credentials Application, which meets minimum requirements of Health Net. This Agreement will not be executed by Health Net, nor will Provider or any Professional Provider or subcontractor begin performing Provider's obligations under this Agreement, until Provider and/or Professional Provider and/or Facility has satisfied applicable credentialing or re-credentialing requirements, if any.

**2.12 Insurance.** Provider shall maintain insurance in amounts and types as required by Health Net Policies. Provider agrees to provide Health Net with a Certificate of Insurance from Provider's insurance carrier or other mutually agreeable written evidence of such insurance coverage within three (3) days of such request by Health Net. Provider also agrees to notify Health Net in writing at least thirty (30) days prior to any termination, cancellation, or material modification of any policy for all or any portion of the coverage required herein.

**2.13 Trade names, Trademarks, Directories.** Provider shall not use or display the trade names, trademarks, or other identifying information of Health Net without Health Net's prior written approval of both form and content, which approval shall not be unreasonably withheld. However, this provision shall not prohibit Provider from posting a reasonable notice on its website or in its Facilities listing by name those insurance carriers that are accepted by Provider so long as the notice lists each name in substantially similar format. Provider shall supply all printed materials and other information requested by Health Net in connection with the production of provider directories within seven (7) days of Health Net's request. Provider agrees that Health Net may list the name, address, telephone number and other factual information of Provider, each Facility and Professional Provider, and of Provider's subcontractors and their facilities in its provider directories, marketing and informational materials, and electronic media.

**2.14 Non-Solicitation.** Neither Provider nor any employee, agent or subcontractor of Provider shall solicit or attempt to convince or otherwise persuade any Beneficiary to discontinue participation in any Benefit Program or in any other manner interfere with Health Net's contract and/or property rights; provided, however, that this provision does not prohibit Provider from posting a reasonable notice on its website or in its Facilities listing by name those insurance carriers that are accepted by Provider so long as the notice lists each name in substantially similar format. Notwithstanding the foregoing, Health Net in no way restricts Provider from discussing medical treatment options with Beneficiaries regardless of Benefit Program coverage options. Further, Health Net and Provider, and its employees and subcontractors shall portray each other in a positive light to Beneficiaries and the public.

**2.15 Additional Rights and Obligations.** Any additional rights or obligations of Provider or Health Net shall be set forth in the Addenda to this Agreement.

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**2.16 Federal Lobbying Restriction.** Health Net is obligated under 31 U.S.C. § 1352 to obtain certain information from subcontractors engaged to fulfill part or all of Health Net’s obligations under its health maintenance contracts with state and local governments, the proceeds of which are funded by federal grants or federal appropriations. To that end, Provider certifies and agrees as follows:

**Certification:** Provider certifies that it has not and will not use any funds received from Health Net under this Agreement to lobby Congress or any employee or member of Congress, or any federal agency or federal government employee or official (hereinafter “the federal government”) for the award of any federal contract, grant, appropriation or loan (or the continuation, extension, renewal, amendment, or modification of the same) or for the ability to participate in any federal cooperative agreement.

**Required Disclosures:** Provider also agrees that if it engages any person to lobby the federal government for the award to Health Net of a federal contract, grant, appropriation, or loan (or the continuation, extension, renewal, amendment, or modification of the same) or for the ability to participate in any federal cooperative agreement involving Health Net, the undersigned will fully and truthfully execute Standard Form LLL as set forth in Health Net Policies, and will provide such executed form to Health Net. Provider understands that Health Net is legally obligated to provide such information to certain federal grant and contract recipients with which it contracts, and further understands that all executed Standard Form LLLs will be supplied to the federal government. Provider agrees to supplement its disclosure under this paragraph promptly if there is a change in any of the information therein.

**Subcontracting Obligation:** If Provider engages any subcontractor to perform all or part of its obligations under this Agreement, it will require the subcontractor (1) to sign a certification stating that it will not use funds earned under the subcontract to lobby for the award of a federal contract, grant, appropriation or loan (or the continuation, extension, renewal, amendment, or modification of the same) or for the ability to participate in any federal cooperative agreement, and (2) to execute Standard Form LLL, in the event that it engages any person to lobby the federal government for such purposes. Provider will promptly provide to Health Net any Standard Form LLLs executed by its subcontractor(s).

**NOTE TO NEGOTIATOR:** This language is non-negotiable. Changes require VP and Legal approval

**2.17 Benefit Programs Funded with Federal Funds.** Provider shall, for Benefit Programs funded in whole or in part with federal funds, ensure compliance with all State and/or federal laws, rules, regulations, and other mandates governing payment to providers whose names appear on one or more excluded provider lists maintained by State and/or federal agencies. Such agencies include, but are not limited to, the U.S. Office of the Inspector General (OIG), the CA Department of Healthcare Services (DHCS), and the General Services Administration (GSA). Where any such law, rule, regulation, and/or mandate impose a compliance obligation on a party, and where such compliance depends upon the other party's cooperation, the other party shall not unreasonably withhold such cooperation, sought on reasonable notice.

### III. DUTIES OF HEALTH NET

**3.1 Payment.** Health Net shall, or Health Net shall require Payor to, make payment to Provider for Contracted Services in accordance with Article IV and the applicable addenda, schedules and exhibits of this Agreement.

**3.2 Health Net Policies.** Health Net Policies are set forth in references and forms available to Provider through the Provider Section of Health Net’s website at “<https://providerlibrary.healthnetcalifornia.com>” or by other means which Health Net will communicate to Provider periodically. Health Net Policies in existence as of the effective date of this Agreement are hereby incorporated into this Agreement by reference. Notwithstanding the foregoing and/or any other provision of this Agreement, the parties agree that a formal amendment to this Agreement shall not be required to effectuate modifications to Health Net Policies. Modifications to Health Net Policies may be made

periodically as determined by Health Net in accordance with the procedures set forth in applicable State law (including without limitation the California Health Care Providers' Bill of Rights). Such modifications shall be deemed incorporated in this Agreement as of the effective date of such modification unless otherwise mutually agreed by the parties in writing at the time of the modification in accordance with applicable State law (including without limitation the California Health Care Providers' Bill of Rights).

**3.3 Insurance.** Health Net shall maintain appropriate insurance programs or policies including bodily injury and personal injury coverage, which includes persons serving on Health Net committees as insured by definition. In the event that a policy or program is terminated, or the coverage of committee persons is materially changed, Health Net shall so notify Provider.

**3.4 Reporting to Regulators.** Health Net and/or Payor shall accept sole responsibility for filing reports, obtaining approvals and complying with applicable laws and regulations of State, federal and other regulatory agencies having jurisdiction over Health Net and/or Payor; provided, however, that Provider agrees to cooperate in providing Health Net and/or Payor with any information and assistance reasonably required in connection therewith, including without limitation, permitting the regulatory agencies to conduct periodic site evaluations of Provider, Facilities, Professional Providers and any of their equipment, operations, and billing and medical records of Beneficiaries. Such records shall be located in the State.

**3.5 Access to This Agreement.**

**3.5.1 Access by Health Net.** As of the effective date of this Agreement, the following Health Net subsidiaries and affiliates may at their option access this Agreement: Health Net of California, Inc., Health Net Life Insurance Company, Health Net Community Solutions, Inc., Wellcare of California, Inc., Arizona Complete Plan, Health Net Health Plan of Oregon, Inc., Health Net Insurance Services, Inc., Health Net Federal Services, LLC., and Network Providers LLC. Notwithstanding the foregoing, Provider agrees that any other subsidiary or affiliate of Health Net not listed above may access the rates and terms set forth in this Agreement. This would include members of non-California based health plan affiliates who may be treated by Provider. To the extent Health Net allows a Health Net subsidiary or affiliate to access this Agreement, Health Net binds such subsidiaries and/or affiliates to the terms and conditions of this Agreement.

**3.5.2 Access by Payors.** To the extent Health Net allows a self-funded Payor to access this Agreement, Health Net has obligated such self-funded Payor to fund a claims payment account in a sufficient and timely manner to pay claims for services provided by health care providers like Provider. In the event a self-funded Payor accessing this Agreement fails to sufficiently and timely fund a claims payment account to the material detriment of Provider, Provider may terminate this Agreement as to such self-funded Payor in accordance with Section 5.3 hereof, and, notwithstanding the provisions of Section 4.6 of this Agreement, take legal action against the self-funded Payor and/or Beneficiary as may be permitted by law. Additional information regarding Payors and conditions for accessing this Agreement is set forth in Addendum A of this Agreement.

**3.6 Language Assistance Program.** Health Net shall maintain an ongoing language assistance program to ensure Limited English Proficient ("LEP") Beneficiaries have appropriate access to language assistance while accessing Provider services, pursuant to Health and Safety Code §§ 1367(e)(3), 1367.04 and 1367.07 and Insurance Code §§ 10133.8 and 10133.9 Provider shall cooperate and comply with Health Net's Language Assistance Program.

**IV. FINANCIAL OBLIGATIONS.** The terms of this Article IV shall survive termination of this Agreement with respect to Covered Services rendered during the term of this Agreement:

**4.1 Payment Rates.** Health Net shall pay (or shall require Payor to pay), and Provider shall accept as payment in full for Contracted Services, the rates payable by Health Net or Payor under the terms and conditions of this Agreement (including the payment conditions, chargemaster and other provisions set forth in the applicable addenda, schedules and exhibits to this Agreement), less Copayments, Coinsurance and Deductibles payable by Beneficiaries in accordance with the applicable Benefit Program or as otherwise permitted by the section of this Agreement covering Third Party Lien Recoveries. Any overpayment, inaccurate payment or other payment error made

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by Health Net or Payor shall not be deemed or construed or otherwise operate to change the payment terms or rates provided for under this Agreement.

#### **4.2 Billing and Payment.**

4.2.1 Billing. If Provider is compensated for a Complete Claim for a Covered Service on a fee-for-service basis, Provider shall submit to Health Net/Payor, via Health Net's/Payor's electronic claims submission program or hardcopy as determined by Health Net/Payor, Complete Claims within one hundred twenty (120) days after Provider renders Contracted Services unless Provider demonstrates good cause pursuant to applicable State law. Where Health Net and/or Payor is the secondary payor under Coordination of Benefits, Provider shall submit Complete Claims for Covered Services accompanied by the explanation of benefits (EOB) or explanation of payment (EOP) from the primary payor to Health Net or a Payor within one hundred twenty (120) days of the date of the EOB/EOP. If Provider fails to comply with the timely claims submission/filing requirements set forth herein, Health Net shall have no obligation to pay for such claims, and Provider shall be prohibited from billing the Beneficiary as set forth in Section 4.6 hereof.

Provider agrees that Health Net or a Payor shall have the right to determine the accuracy of all Complete Claims submitted to it prior to payment, including verification of diagnostic codes, DRG assignment, and whether Provider has delivered the Covered Service in good faith and pursuant to the terms of an applicable Prior Authorization.

4.2.2 Payment. Health Net or Payor, as applicable, shall make payment on each of Provider's timely-submitted Complete Claims in accordance with this Agreement and pursuant to the timeframes, procedures and other requirements of applicable State and federal law, including without limitation the calculation and payment of interest on overdue payments. Payment of interest plus the amount of any Complete Claim payment deficiency shall be Provider's sole measure of damages (i.e., claims for consequential or incidental damages do not apply) for failure of Health Net or Payor to make timely and accurate payments. In no event shall Health Net be under any obligation to pay Provider for any claim or expense, which is the responsibility of a self-funded Payor.

4.2.3 Appeals. In addition to the dispute resolution and arbitration rights described in Section 7.5 and Section 7.6 herein, Provider may dispute any Health Net action that adjusts, denies, or contests a claim, billing practice, or other contractual provision so long as Provider submits a written dispute to the Health Net Provider Appeals Unit. Unless Provider demonstrates good cause pursuant to applicable State or federal law, Health Net or Payor shall not grant Provider reconsideration or appeal of a claims payment for Covered Services that exceed three hundred sixty-five (365) days of Health Net's action or in the case of inaction, within three hundred sixty-five (365) days after the time for contesting or denying claims (as defined in applicable State or federal law) has expired. Appeals shall be submitted by Provider in accordance with the procedures, and to the address for Health Net's Provider Appeals Unit, listed in Health Net Policies. If Provider fails to comply with the timely appeals submission/filing requirements set forth herein, Health Net shall have no obligation to pay for such claims except as otherwise required by applicable State and federal law, and Provider shall be prohibited from billing the Beneficiary as set forth in Section 4.6 hereof. Provider and Health Net agree to comply with all timeliness and procedural requirements for submitting and responding to disputes submitted to Health Net's Provider Appeals Unit as set forth in Health Net Policies.

#### **4.3 Recoupment of Overpayments; Right of Offset.**

4.3.1 Provider shall inform Health Net of any overpayment made to Provider and shall return any such overpayment to Health Net within thirty (30) business days from the date Provider first becomes aware of any such overpayment.

4.3.2 In the event Health Net determines that it has overpaid a claim, either in connection with an audit or otherwise, Health Net shall notify Provider in writing through a separate overpayment notice

clearly identifying the claim, the name of the Beneficiary, the date of service and explanation of the basis upon which Health Net or Payor believes the amount paid on the claim was in excess of the amount due, including any interest and penalties that may be due on the claim. Such overpayment notice shall be issued within (i) three hundred sixty-five (365) days of the date of payment on the overpaid amount for claims arising from Benefit Programs regulated by the California Department of Managed Health Care or the California Department of Insurance, or within (ii) three (3) years from the date of payment on the overpaid amount for claims arising from other types of Benefit Programs that are not regulated by the California Department of Managed Health Care or the California Department of Insurance, or (iii) at any time, in the event of fraud and/or misrepresentation. Such notice shall be sent to Provider's address of record with Health Net for the receipt of claim related correspondence and payments unless Provider informs Health Net in writing of an alternative address to which such notices are to be sent at least thirty (30) days in advance of the address change.

- 4.3.3 If Provider does not contest Health Net's overpayment notice, Provider shall reimburse Health Net or Payor within thirty (30) business days from the date Provider receives the overpayment notice. If Provider fails to reimburse Health Net or Payor within those thirty (30) business days, then, beginning on the first calendar day after the expiration of this thirty (30) business day time period, Health Net shall commence offsetting, as set forth herein and interest shall accrue on any and all unpaid amounts at the rate of ten percent (10%) per annum.
- 4.3.4 In the event Provider wishes to contest the overpayment notice, it must do so within thirty (30) business days from the date Provider receives the overpayment notice, by sending to Health Net's Provider Appeals Unit (at the address listed in Health Net Policies) a written appeal clearly stating the basis upon which Provider believes that the claim was not overpaid. Health Net shall review and make a decision with respect to Provider's appeal and shall notify Provider of its decision in writing within forty-five (45) business days from the date Health Net receives Provider's written appeal. In the event Health Net denies Provider's appeal and upholds Health Net's determination that an overpayment has been made, Provider shall reimburse Health Net or Payor for the overpayment within thirty (30) business days from the date it receives the written notice of Health Net's denial of Provider's written appeal. If Provider fails to reimburse Health Net or Payor within those thirty (30) business days, then beginning on the first calendar day after the expiration of this thirty (30) business day time period, Health Net may commence offsetting as set forth herein, and interest shall accrue on any and all unpaid amounts at the rate of ten percent (10%) per annum.
- 4.3.5 If Health Net or Payor exercises offset rights hereunder against Provider's current claims payments, Health Net or Payor shall give Provider a detailed written explanation identifying the specific overpayments that have been offset against the specific current claims payments.
- 4.3.6 If Provider desires to continue to contest the overpayment, it shall do so by following the dispute resolution process set forth in Sections 7.5 and 7.6 of this Agreement.

**4.4 Eligibility.** The parties acknowledge that verification of eligibility by Health Net is based on information available to Health Net from its customers on the date Provider seeks verification. Health Net shall use reasonable efforts to discourage its customers from retroactively canceling or adding Beneficiaries to a Benefit Program and encourage its customers to timely and accurately provide eligibility information. In the event Contracted Services are provided to an individual who is not a Beneficiary, based on an erroneous or delayed enrollment/eligibility list the following shall apply: (i) when the individual is enrolled in a substitute or replacement health care service or insurance plan which is obligated under applicable law to make payment to Provider for services delivered to the individual, Provider shall seek payment from the substitute or replacement carrier; and (ii) when the individual does not have substitute or replacement coverage, Health Net shall pay Provider for Contracted Services delivered to the individual by Provider prior to the time Provider received notice of that individual's ineligibility pursuant to the terms and conditions of this Agreement, provided, however, for those Benefit Programs that are not regulated by the California Department of Managed Health Care or the California Department of Insurance, as an additional prerequisite for payment pursuant to this Section 4.4(ii), Provider shall submit to Health Net evidence that Provider

has unsuccessfully sought payment through two billing cycles for all or a portion of such charges from the patient or the person having legal responsibility for the patient, or from the entity having financial responsibility for such payment. In the event Health Net pays Provider pursuant to this Section 4.4, Provider shall have no further right and shall not attempt to collect any additional payment from the individual for said services (except for applicable Copayments, Coinsurance and Deductibles) and Provider hereby assigns and transfers all legal rights of collection and Coordination of Benefits for services to Health Net.

**4.5 Collection of Copayments, Coinsurance and Deductibles.** Provider shall collect all Copayments, Coinsurance and Deductibles due from Beneficiaries, and shall not waive or fail to pursue such collection except when otherwise permitted through Provider's established patient financial assistance policy. Provider shall not charge Beneficiary any fees or Surcharges for Contracted Services rendered pursuant to this Agreement (except for Copayments, Coinsurance and Deductibles). In addition, Provider shall not collect a sale, use or other applicable tax from Beneficiaries for the sale or delivery of Contracted Services unless required by applicable State or federal law. If Health Net or any Payor receives notice of any attempt to collect or the receipt of any inappropriate additional charges, including without limitation Surcharges, Health Net or Payor shall take appropriate action. Provider shall cooperate with Health Net or such Payor to investigate such allegations and shall promptly refund to the party who made the payment, any payment reasonably determined to be improper by Health Net or a Payor. Notwithstanding the foregoing, nothing in this Section 4.5 is intended to alter any obligation of Provider to establish written financial assistance and emergency care policies, limit the amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the financial assistance policy, and to make reasonable efforts to determine whether an individual is eligible for assistance before starting collection actions.

**4.6 Beneficiary Held Harmless.** Provider agrees that in no event, including, but not limited to, non-payment by Health Net or a Payor, insolvency of Health Net or a Payor, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries or persons acting on their behalf other than Health Net or a Payor for Contracted Services provided pursuant to this Agreement except for Copayments, Coinsurance, Deductibles, Excluded Services or permitted third party liens under this Agreement and as permitted under Section 3.5.2 hereof. This provision shall not prohibit collection of Copayments, Coinsurance or Deductibles or Excluded Services or permitted third party liens under this Agreement made in accordance with applicable Benefit Program Requirements. Provider agrees that: (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Beneficiaries; and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Beneficiaries or persons acting on their behalf. Provider agrees to (iii) address any and all concerns it has with claims payment through Health Net's provider appeal process pursuant to Health Net Policies and (iv) give the Beneficiary and Health Net confirmation that Provider has rescinded the collection notice and taken any other actions necessary to clear the Beneficiary's credit record of the collection matter.

**4.7 Conditions for Compensation for Excluded Services.** Provider may bill a Beneficiary for Excluded Services rendered by Provider to such Beneficiary only if the Beneficiary is notified in advance that the services to be provided are not Covered Services under the Beneficiary's Benefit Program, and the Beneficiary requests in writing that Provider render the Excluded Services, prior to Provider's rendition of such services.

**4.8 Coordination of Benefits.** Provider agrees to conduct Coordination of Benefits in accordance with federal and State laws and regulations and Health Net Policies ("Coordination of Benefit Rules"), including but not limited to, the prompt notification to Health Net or a Payor of any third-party entity who may be responsible for payment and collection of Copayments. Provider shall not bill Beneficiaries for any portion of Contracted Services not paid by the primary carrier when Health Net or a Payor is the secondary carrier but shall seek payment from Health Net/Payor. When Health Net or a Payor is secondary under the Coordination of Benefits Rules, Health Net or a Payor shall pay Provider an amount up to Beneficiary's primary plan's copayment, coinsurance, or deductibles as applicable, where that payment does not exceed Health Net's contracted rate under this Agreement. In the event that Medicare is the primary carrier and Health Net Commercial Benefit Program is secondary, Health Net shall pay Provider only up to Medicare's allowable amount and/or the Beneficiary's Copayment, Coinsurance or Deductibles as applicable. When Health Net Medi-Cal is the secondary Payor, Health Net will not pay more than the Provider would receive if DHCS

were paying secondary in accordance with Medi-Cal Coordination of Benefits. Such recoveries shall be performed in accordance with the applicable Benefit Program requirements and Health Net Policies.

**4.9 Third Party Recoveries.** In the event Provider provides Covered Services to Health Net Beneficiaries for injuries resulting from the acts of third parties, or resulting from work related injuries, Provider shall have the right to recover from any settlement, award, or recovery from any responsible third-party the reasonable and necessary charges for such Contracted Services using the procedures for such recovery provided by the Hospital Lien Act, Civ. Code section 3045.1 et. seq., and shall have all rights and benefits afforded by that statute. Provider shall notify Health Net of any such recovery and shall provide Health Net with an accounting of all such sums recovered. In the event Health Net has compensated Provider for such Contracted Services and Provider has recovered sums from a third party, Provider agrees to pay such recovered sums to Health Net up to the amounts that Health Net paid to Provider, to the extent that Health Net has not recovered such amounts from its own third-party recovery efforts. Provider shall pay these amounts to Health Net within sixty (60) days of Health Net's written request, which request shall inform Provider of the amounts Health Net recovered from its own third-party recovery efforts, if any. This section 4.9 does not obligate, nor does it prohibit, either Health Net or Provider to undertake such third-party recovery efforts.

**4.10 Reciprocity.** Provider agrees that Health Net may allow the compensation rates set forth in this Agreement to be used by other Participating Providers who may from time to time be responsible for compensating Provider for Covered Services rendered by Provider to a Beneficiary.

**4.11 Telehealth.** Health Net shall reimburse Provider for the diagnosis, consultation, or treatment of a commercial Beneficiary appropriately delivered through Telehealth services, on the same basis and to the same extent as the reimbursement for the same service through in-person diagnosis, consultation, or treatment. Telehealth shall be defined as applicable in California law and regulations, California Health and Safety Code Sections 1374.14 and 1374.141, California Insurance Code Sections 10123.855 and 10123.856, and California Business and Professions Code Section 2290.5.

## V. **TERM AND TERMINATION**

**5.1 Term.** The term of this Agreement shall commence on the Effective Date and shall continue for a period of two (2) years thereafter (the "Initial Term"). Either party may terminate this Agreement effective as of the end of the Initial Term by providing at least one hundred eighty (180) days prior written notice to the other party. This Agreement shall automatically renew for successive one (1) year periods (the "Renewal Terms").

**5.2 Immediate Termination.** Either party may terminate this Agreement immediately upon notice to the other party, in the event of: (i) a party's violation of material law, rule or regulation; (ii) a party's failure to maintain the insurance coverage specified hereunder; or (iii) a felony conviction or a plea of guilty, nolo contendere or no contest related to the medical and/or financial practices of a party. Health Net may terminate this Agreement immediately upon notice to Provider in the event of (iv) action taken by a State or federal regulator that results in a material restriction upon Provider's ability to operate a Facility or reportable discipline against Provider's license, accreditation, or certification; (v) Health Net's determination that the health, safety or welfare of any Beneficiary may be in jeopardy if this Agreement is not terminated; (vi) any material adverse finding as a result of a lawsuit or claim, related to the medical and/or financial practices of Provider.

**5.3 Termination Due to Material Breach.** In the event either party believes the other party has committed a material breach of this Agreement, the non-breaching party shall send the other party a written Notice of Breach and Demand to Cure ("Notice"). Without limiting either party's other termination rights under this Article V, in the event that either party fails to cure a material breach of this Agreement within thirty (30) days of receipt of the Notice from the other party (the "Cure Period"), the non-defaulting party may terminate this Agreement by providing the defaulting party thirty (30) days prior written notice of termination. The non-defaulting party may exercise this termination option, if at all, within thirty (30) days of the date the Cure Period expires. If the breach is cured within the Cure Period, or if the breach is one which cannot reasonably be corrected within the Cure Period, and the defaulting party is making substantial and diligent progress toward correction during the Cure Period to the reasonable

satisfaction of the non-defaulting party, this Agreement shall remain in full force and effect. The provisions of this Section 5.3 shall not apply to Health Net claims payment timeliness issues which are governed by Article IV of this Agreement, unless and until the parties have completed the dispute resolution process set forth in Sections 7.5 and 7.6 of this Agreement, and the dispute relates to habitual, chronic, and material claims payment timeliness issues. In the event a Payor fails in its obligations under the terms of this Agreement to make Complete Claim payments to Provider when due, Provider may terminate the specific delinquent Payor without terminating this Agreement in its entirety, but only after all of the following conditions have been met: (i) Payor has failed to make a payment to Provider within the applicable time frame set forth in this Agreement; (ii) Provider provides written notice to Payor that such payment has not been made; (iii) Payor fails to remit payment to Provider within ten (10) days following Payor's receipt of Provider's written notice; (iv) Provider has made a good-faith attempt to meet with Health Net and Payor to resolve the payment issue(s).

**5.4 Termination Upon Notice.** Either party may terminate this Agreement during a Renewal Term for any reason or no reason upon one hundred eighty (180) days prior written notice to the other party. In the event either party provides the other party with such notice and following Health Net's completion of any regulatory filing requirements, Health Net may, at its option, begin to transition Beneficiaries under this Agreement to another Participating Provider.

**5.5 Information to Beneficiaries.** The parties each agree not to disparage the other in any information supplied by either party to Beneficiaries or other third parties in connection with any expiration, termination, or non-renewal of this Agreement. Health Net shall assume sole responsibility for notifying Beneficiaries, and Health Net may commence transferring Beneficiaries to alternate providers, prior to the effective date of any expiration, termination, or non-renewal of this Agreement in accordance with State and federal law. If Beneficiaries seek services or Participating Providers order tests or seek services from Provider after the effective date of any expiration, termination or non-renewal, Provider shall inform such Beneficiaries and Participating Providers only that Provider no longer has an agreement with Health Net to render Covered Services and shall direct them to Health Net's customer service department. Provider shall not otherwise initiate communications with Beneficiaries or other third parties, verbally or in writing, concerning the expiration, termination or non-renewal of this Agreement and Provider's participation in Health Net's Participating Provider network, unless the parties have agreed in writing to the content of such communications in the context of a mutually agreed communication plan. Nothing in this provision is intended nor shall it be construed to prohibit or restrict Provider, Professional Provider, or other Participating Providers from (i) disclosing to any Beneficiary information regarding treatment options available, the risks, benefits and alternatives thereto, or (ii) disclosing to any Beneficiary the decision or process of Health Net or a Payor to Prior Authorize or deny benefits under a Benefit Program, or (iii) posting a reasonable notice on Provider's website or in Provider's Facilities listing by name those insurance carriers that are accepted by Provider, provided that the notice lists each name in substantially similar format. The terms of this Section 5.5 shall survive termination of this Agreement.

**5.6 Effect of Termination.** In the event that a Beneficiary is receiving Contracted Services on the date this Agreement expires, non-renews, and/or terminates, upon the request of Beneficiary and Health Net, Provider shall continue to provide Contracted Services to the Beneficiary until the later of: (i) treatment is completed; (ii) the Beneficiary is discharged if Provider is an inpatient facility; (iii) the Beneficiary is assigned to another Participating Provider; or (iv) the anniversary date of the Beneficiary's Benefit Program. Provider's compensation for such Contracted Services shall be at the rates contained in the applicable Addendum hereto. If Provider's services are continued beyond the expiration, non-renewal, and/or termination of this Agreement, Provider shall be subject to the same contractual terms and conditions that were imposed on Provider prior to the expiration/non-renewal/termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.

## **VI. RECORDS, AUDITS AND REGULATORY REQUIREMENTS**

**6.1 Medical and Other Records.** Provider shall prepare and maintain Records in accordance with the general standards applicable to such Record-keeping and in compliance with all applicable federal and State confidentiality and privacy laws. Provider shall maintain such Records for at least ten (10) years after the rendition of Contracted Services, and Records of a minor child shall be kept for at least three (3) years after the minor has reached the age of eighteen (18), but in no event less than ten (10) years after the rendition of Contracted Services. Additionally, Provider shall maintain such Records as may be necessary and reasonably requested by Health Net to

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comply with applicable federal and State law, and accrediting agency reporting requirements, rules, and regulations. Provider shall comply with and require Professional Providers and Facilities to comply with all confidentiality and Beneficiary records accuracy requirements. Provider's Records shall be and remain the property of Provider. Provider shall provide Electronic Health Record (EHR) logon access to Health Net associates to view and extract complete medical records for Health Net members.

**6.2 Access to Records and Audits by Regulatory Agencies.** Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit designated representatives of local, State, and federal regulatory agencies having jurisdiction over Health Net or Payor and designated representatives of public and private exchanged-based purchasers and accreditation agencies having jurisdiction over Health Net or Payor (collectively referred to as "Regulatory Agencies"), access to Provider's Records, at Provider's place of business in this State during normal business hours, in order to audit, inspect and review and make copies of such Records. Such Regulatory Agencies shall include, but not be limited to, the State Department of Health Care Services, the State Department of Insurance, the State Department of Managed Healthcare, the United States Justice Department, CMS, the United States Department of Health and Human Services, Covered California, the National Committee for Quality Assurance, and any of their representatives. When requested by Regulatory Agencies, Provider shall produce copies of any such Records at no charge. Additionally, Provider agrees to permit Regulatory Agencies or their representatives, to conduct site evaluations, inspections and audits of Provider's Records, offices, and service locations at no cost to Health Net, Payor, and/or Regulatory Agencies, and within a reasonable time period, but not more than five (5) days after the request is submitted to Provider.

**6.3 Access to Records and Audits by Health Net.** Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit Health Net or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, in order to audit, inspect, review, perform chart reviews, and duplicate such Records unless Provider agrees to a remote audit of such records. If performed on site, access to Records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least thirty (30) business days prior written notice by Health Net or its designated representative, but not more than sixty (60) days following such written notice. Provider shall attend an exit interview upon completion of the audit for the purpose of obtaining a mutually agreed upon reconciliation of the initial audit findings. Such exit interview shall be conducted at a mutually agreeable time at Provider's place of business in this State during normal business hours upon at least ten (10) days prior written notice by Health Net or its designated representative, but not more than thirty (30) days following such written notice. In the event Provider fails to attend the scheduled exit interview, Provider shall be deemed to have accepted the audit findings. If the audit was performed remotely, such exit interview shall consist of Health Net or its designated representative sharing its audit findings with Provider via written or electronic communications as determined by Health Net. Provider shall be allowed ten (10) days to contest the audit results. If not contested within ten (10) days, then Provider shall be deemed to have accepted the audit findings. Except when Health Net or its designated representative requests Provider Records that are related to care management or claims, Provider may require reasonable fees associated with the retrieval of Provider's Records and or duplication and preparation of requested Provider Records. Such fees shall not be more than those provided in California Health and Safety code Section 123110. Actions taken as a result of audit findings shall include adjustments for late charges, overcharges, and undercharges. Any such adjustments shall be the net amounts as reflected in the audit findings. Any payments owed by one party to the other as the result of an audit shall be paid within thirty (30) days of the exit interview for such audit.

**6.4 Continuing Obligation.** The obligations of Provider under this Article VI shall not be terminated upon termination of this Agreement, whether by rescission, non-renewal or otherwise. After such termination of this Agreement, Health Net, Payors and Regulatory Agencies shall continue to have access to Provider's Records as necessary to fulfill the requirements of this Agreement and to comply with all applicable laws, rules, and regulations.

**6.5 Regulatory Compliance.** Each party agrees to comply with all applicable local, State, and federal laws, rules and regulations, now or hereafter in effect, regarding the performance of the party's obligations hereunder, including without limitation, laws or regulations governing Beneficiary confidentiality, privacy, appeal and dispute resolution procedures to the extent that they directly or indirectly affect Provider, Provider's Facility(ies), Provider's Professional Providers, a Beneficiary, Health Net, or Payor, and bear upon the subject matter of this Agreement. If Health Net is sanctioned by any Regulatory Agency for non-compliance that is caused by Provider, Provider shall

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compensate Health Net for amounts tied to this sanction incurred by Health Net including Health Net's costs of defense and fees.

## VII. GENERAL PROVISIONS

**7.1 Amendments.** This Agreement may be amended by mutual written agreement of the parties. Notwithstanding the foregoing, amendments required to comply with State or federal laws or regulations, requirements of Regulatory Agencies, or requirements of Accreditation Agencies, shall not require the consent of Provider or Health Net and shall be effective immediately on the effective date of the requirement. The parties acknowledge that changes to Health Net Policies that may affect a party's rights or obligations under this Agreement are addressed in Section 3.2 hereof.

**7.2 Separate Obligations.** The rights and obligations of Health Net under this Agreement shall apply to each Health Net subsidiary or affiliate and/or Payor accessing this Agreement only to the extent such Health Net subsidiary or affiliate and/or Payor has accessed this Agreement with respect to the Benefit Programs of such Health Net subsidiary or affiliate or Payor. A Health Net subsidiary or affiliate or Payor shall not be responsible for the obligations of any other Health Net subsidiary or affiliate or Payor under this Agreement with respect to the other's Benefit Programs. The terms of this Section 7.2 shall survive termination of this Agreement.

**7.3 Assignment.** Provider shall not assign this Agreement in whole or in part without Health Net's prior written consent, which consent shall not be unreasonably withheld, conditioned, or delayed. Any change in control of Provider resulting from a merger, consolidation, stock transfer or asset sale shall be deemed an assignment or transfer for purposes of this Agreement that requires Health Net's prior written consent. Health Net expressly reserves the right to assign, delegate or transfer any or all of its rights, obligations, or privileges under this Agreement to an entity controlling, controlled by, or under common control with Health Net, LLC.

**7.4 Confidentiality.** The Parties each agree that, unless disclosure is required by state or federal law, they shall hold Beneficiary health information and all confidential or proprietary information or trade secrets of each other, in trust and confidence. The Parties each agree that, unless disclosure is required by state or federal law, they shall keep strictly confidential all customized, non-template terms and rates set forth in this Agreement (including without limitation all addenda, exhibits, and any past or future amendments to this Agreement). The Parties further agree that in the event a disclosure is required by state or federal law, they shall disclose only the specific information mandated by such law in order to comply with the applicable legal requirements. Notwithstanding the foregoing, the Parties acknowledge and agree that this provision does not preclude disclosure by Health Net to Beneficiaries, customers, Regulatory Agencies and exchanges of certain financial terms of this Agreement, including without limitation detailed information contained in the Explanation of Benefits, Records under the conditions set forth in Article VI of this Agreement, and/or information regarding the method of compensation used by Health Net with respect to Health Net's Participating Provider networks, e.g., fee-for-service, capitation, shared risk pool, DRG or per diem. Health Net, Payors and Provider agree that such information shall be used only for the purposes contemplated herein, and not for any other purpose. Health Net, Payors and Provider agree that nothing in this Agreement shall be construed as a limitation of (i) Provider's rights or obligations to discuss with the Beneficiaries matters pertaining to the Beneficiaries' health regardless of Benefit Program coverage options or (ii) Health Net's rights or obligations with respect to subcontractors, including without limitation delegated providers, or (iii) disclosures to counsel or a consultant of a party for the purpose of monitoring regulatory compliance or rendering legal advice pertaining only to this Agreement or disclosures to internal or independent auditors of a party for audit purposes pertaining to this Agreement, provided that in either case the counsel or consultant agrees in writing to comply with the provisions of this Section 7.4 and agrees that the terms of this Agreement may not be disclosed to any other person or entity or used in any manner whatsoever in connection with any other agreement involving Health Net. The terms of this Section 7.4 shall survive termination of this Agreement.

*Note to Negotiator: the following language must be added and is non-negotiable.*

Nothing in this provision or this Agreement shall be construed to prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to an enrollee, Member, or subscriber of Health Net, to a qualified entity, as defined in Section 1395kk(e)(2) of Title 42 of the United States Code. All disclosures of

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data made under this provision shall comply with all applicable state and federal laws for the protection of the privacy and security of the data, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the federal Health Information Technology for Economic and Clinical Health Act, Title XIII of the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and implementing regulations.

*Note to Negotiator: The following language must be added if Provider is a public entity.*

If Provider is a public institution, subject to the provisions of the California Public Records Act ("PRA"), Provider shall notify Health Net promptly upon determining that confidential information from Health Net may be subject to a pending PRA request. Such notification shall include a reasonably specific description of the confidential information potentially subject to disclosure pursuant to the pending PRA request. To the extent permitted by law, Provider shall then give Health Net a reasonable time period to demonstrate to Provider that some or all such records are: (i) not relevant to the pending PRA request and/or (ii) protected from disclosure pursuant to an exception codified in the PRA. If Provider thereafter concludes that some or all such records must be disclosed, Provider shall so notify Health Net and, to the extent permitted by law, give Health Net a reasonable opportunity to seek a court order protecting such records. Unless such a court order is secured in a timely fashion, Provider may disclose those records it reasonably determines must by law be released pursuant to the pending PRA request.

**7.5 Provider Dispute Resolution Procedure.** The parties agree to use the dispute resolution process set forth in this Section 7.5, and binding arbitration as described in Section 7.6, as the final steps in resolving any Dispute. The parties each understand and agree that any and all Health Net internal appeals processes (including without limitation as set forth in Section 4.2.3 hereof) must be properly pursued and exhausted before engaging in the dispute resolution process set forth in this Section 7.5.

(i) Meet and Confer Process:

Initiation: If the parties are unable to resolve any Dispute through applicable Health Net internal appeal processes, if any, the parties agree to meet and confer within thirty (30) days of a written request by either party in a good faith effort to informally settle any Dispute. The parties each agree and understand that the meet and confer requirements set forth herein may be satisfied only by meeting each of the following requirements: (a) an actual meeting must occur between executive level employees of the parties who have authority to resolve the Dispute and are each prepared to discuss in good faith the Dispute and proposed resolution(s) to the Dispute, and (b) such meeting may take place either in person or on the telephone at a mutually agreeable time, and (c) unless otherwise mutually agreed by the parties, neither party is allowed to have legal counsel present at the meeting or to substitute legal counsel for the executive level employee, and (d) such meeting and all related discussions between the parties shall be treated in the same manner as confidential protected settlement discussions under the State Rules of Civil Procedure.

Confidentiality: All documents created for the purpose of, and exchanged during, the meet and confer process and all meet and confer discussions, negotiations and proceedings shall be treated as compromise and settlement negotiations subject to applicable State law. To the extent the parties produce or exchange any documents, the parties agree that such production or exchange shall not waive the protected nature of those documents and shall not otherwise affect their inadmissibility as evidence in any subsequent proceedings.

(ii) Voluntary Mediation:

If the parties are unable to resolve any Dispute through the meet and confer process set forth above, and desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, a joint request for such services may be made to the American Arbitration Association ("AAA"), or the Judicial Arbitration and Mediation Services ("JAMS") prior to submitting a Dispute to arbitration, or the parties may initiate such other procedures as they may mutually agree upon.

**7.6 Binding Arbitration.** If the parties are unable to resolve a Dispute through the dispute resolution process set forth in Section 7.5, the parties agree that such Dispute shall be settled by final and binding arbitration, CALIFORNIA

upon the motion of either party, under the appropriate rules of the AAA or JAMS, as agreed by the parties. Any Arbitrator must be either a judge, or an attorney licensed to practice law in the State of California, who is in good standing with the State Bar, and has at least ten (10) years of experience with health care matters and the arbitration of managed care disputes. The parties each understand and agree that the exhaustion of any Health Net internal appeals processes, and the Meet and Confer Process set forth in Section 7.5 (i) hereof are conditions precedent to binding arbitration under this Section 7.6. Notwithstanding the foregoing, nothing contained herein is intended to require binding arbitration of disputes alleging medical malpractice between a Beneficiary and Provider or to Disputes between the parties' alleging breaches of confidentiality of Beneficiary information, trade secret or intellectual property obligations. The arbitration shall be conducted in San Francisco, California or Los Angeles, California. The written demand shall contain a detailed statement of the matter and facts and include copies of all material documents supporting the demand. Arbitration must be initiated within one year after the date the Dispute arose by submitting a written notice to the other party.

The parties expressly agree that the deadlines to file arbitration set forth above shall not be subject to waiver, tolling, alteration, or modification of any kind or for any reason except for fraud. The failure to initiate arbitration before such deadlines shall mean the complaining party shall be barred forever from initiating such proceedings.

All such arbitration proceedings shall be administered by the AAA or JAMS, as agreed by the parties; however, the arbitrator shall be bound by applicable State and federal law and shall issue a written opinion setting forth findings of fact and conclusions of law. The parties agree that the decision of the arbitrator shall be final and binding as to each of them. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. The arbitrator shall have no authority to make material errors of law or to award punitive damages or to add to, modify, or refuse to enforce any agreements between the parties. The arbitrator shall make findings of fact and conclusions of law and shall have no authority to make any award, which could not have been made by a court of law. The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of the entry of judgment on the award. The parties waive their right to a jury or court trial.

The parties recognize and agree that theirs is an ongoing business relationship, which may lead to sensitive issues with respect to the exchange of information related to any Dispute. The parties agree, therefore, to enter into such protective orders (including without limitation creating a category of discovery documents "for attorney's eyes only" to the extent feasible given the nature of the evidence and the Dispute). All discovery information shall be used solely and exclusively for arbitration of the Dispute between the parties and may not be used for any other purpose. After the arbitration award becomes final, each party shall return or destroy all documents obtained from the other party during the course of the arbitration that are subject to a protective order, and within thirty (30) days of such date shall provide to the other party an officer's certificate signed under penalty of perjury indicating that all such information has been returned or destroyed.

In all cases submitted to arbitration, the parties agree to share equally the administrative fee as well as the arbitrator's fee, if any, unless otherwise assessed by the arbitrator. The administrative fees shall be advanced by the initiating party subject to final apportionment by the arbitrator in this award. The parties agree that the content and decision of any arbitration proceeding shall be confidential unless disclosure is required by applicable State or federal statutes or regulations. The terms of Section 7.5 and Section 7.6 shall survive termination of this Agreement.

**7.7 Entire Agreement.** This Agreement represents the entire agreement between the parties hereto with respect to the subject matter hereof and supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding.

**7.8 Governing Law.** This Agreement shall be governed by and construed and enforced in accordance with the laws of the State, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern. Health Net is subject to the requirements of various local, State, and federal laws, rules and regulations including, but not limited to, the requirements of Chapter 2.2 of Division 2 of the California Health & Safety Code (the Knox-Keene Health Care Service Plan Act) and of Chapters 1 and 2 of Division 1 of Title

28 of the California Code of Regulations (“C.C.R.”) and Title 10 of the C.C.R. Any provision required to be in this Agreement by any of the above shall bind Provider and Health Net whether or not expressly set forth herein.

**7.9 Indemnification.**

7.9.1 Responsibility for Own Acts. Each party shall be responsible for its own acts or omissions and for any and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that party or its employees or representatives in the performance or omission of any act or responsibility of that party under this Agreement.

7.9.2 Provider agrees to indemnify, defend, and hold harmless Health Net, its agents, officers, and employees from and against any and all liability expense including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from Provider's performance or failure to perform its obligations hereunder.

7.9.3 Health Net agrees to indemnify, defend, and hold harmless Provider, its agents, officers, and employees from and against any and all liability expense, including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from Health Net's performance or failure to perform its obligations hereunder.

**7.10 Non-Exclusive Contract.** This Agreement is non-exclusive and shall not prohibit Provider or Health Net or Payor from entering into agreements with other health care providers or purchasers of health care services.

**7.11 No Third-Party Beneficiary.** Nothing in this Agreement is intended to, or shall be deemed or construed to, create any rights or remedies in any third party, including a Beneficiary. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to increase the rights of any such Beneficiary or the duties or responsibilities of Provider or Health Net or Payor with respect to such Beneficiaries.

**7.12 Notice.** Notices regarding the breach, term, termination, or renewal of this Agreement shall be given in writing in accordance with this Section 7.12 and shall be deemed given five (5) days following deposit in the U.S. mail, postage prepaid. If sent by hand delivery, overnight courier, or facsimile, notices shall be deemed given upon documentation of delivery. All notices shall be addressed as follows:

Health Net:

Health Net of California, Inc.  
Attn: Provider Contracts Administration - Regional  
21281 Burbank Blvd.  
Woodland Hills, CA 91367

Electronic copy to: [RegionalContractNotices@healthnet.com](mailto:RegionalContractNotices@healthnet.com)

Provider:

\_\_\_\_\_  
\_\_\_\_\_

Facsimile number: \_\_\_\_\_

The addresses to which notices are to be sent may be changed by written notice given in accordance with this Section. Notwithstanding the previous paragraph, Health Net may provide all other notices by electronic mail, through its provider newsletter, or on its provider website.

**7.13 Severability.** If any provision of this Agreement is rendered invalid or unenforceable by any local, State, or federal law, rule, or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.

**7.14 Status as Independent Entities.** None of the provisions of this Agreement is intended to create, nor shall be deemed or construed to create any relationship between Provider and Health Net or a Payor other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither Provider nor Health Net/Payor, nor any of their respective agents, employees or representatives shall be construed to be the agent, employee, or representative of the other.

**7.15 Addenda.** Each Addendum to this Agreement is made a part of this Agreement as though set forth fully herein. Any provision of an Addendum that is in conflict with any provision of this Agreement shall take precedence and supersede the conflicting provision of this Agreement with respect to the subject matter of the Addendum.

**7.16 Calculation of Time.** The parties agree that for purposes of calculating time under this Agreement, any time period of less than ten (10) days shall be deemed to refer to business days and any time period of ten (10) days or more shall be deemed to refer to calendar days unless the term "business" precedes the term "days".

**7.17 Waiver of Breach.** The waiver of any breach of this Agreement by either party shall not constitute a continuing waiver of any subsequent breach of either the same or any other provision(s) of this Agreement. Further, any such waiver shall not be construed to be a waiver on the part of such party to enforce strict compliance in the future and to exercise any right or remedy related thereto.

**THIS CONTRACT CONTAINS A BINDING ARBITRATION CLAUSE, WHICH MAY BE ENFORCED BY THE PARTIES.**

IN WITNESS WHEREOF, the parties have executed this Agreement.

Note to Negotiator: Insert full Legal Name of Provider here as set forth in the first paragraph of the Agreement above and delete word "Provider"

**PROVIDER**

**HEALTH NET OF CALIFORNIA, INC.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

Regional Health Plan Officer  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Federal Tax Identification Number

\_\_\_\_\_  
Name of Tax Identification Number Owner

\_\_\_\_\_  
Provider Type (PPG, Hospital, Ancillary, Physician)

NPI #

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The information below is mandatory. Please complete all applicable fields.

**(Applicable to all Facility (Hospital, SNF, Dialysis, ASC, Lab, Radiology) templates.)**

**Provider must submit all National Provider Identifiers and a populated billing form (e.g. UB 04 or successor form) for each as directed by Health Net. In addition, the corresponding Tax Identification Number, with a completed W-9 for each TIN, shall be attached. The billing information on the billing form must be consistent with the W-9 form.**

Provider/Facility Name, Address, Telephone and Facsimile Phone	State License Number	Federal Tax Identification Number	Medicare Provider Number	National Provider Identifier	Accrediting Body (If Applicable)
<i>Additional Location(s):</i>					
<i>Billing/Remit Address:</i>					

## ADDENDUM A

### COMMERCIAL BENEFIT PROGRAMS

**I. Applicability.** This Addendum A and accompanying exhibits apply to Covered Services delivered to Beneficiaries covered by commercial Benefit Programs that include but are not limited to HMO, PPO, EPO, POS, Salud Con Health Net (state-wide network), and any leased networks. All Covered Services delivered to a Beneficiary covered by a commercial Benefit Program shall be paid in accordance with this Addendum A regardless of product specific name unless otherwise specifically agreed by the parties and set forth in a separate rate exhibit.

**II. Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Point of Service (POS), Leased PPO Benefit Programs, and Payor Disclosures.** Provider understands and agrees that Health Net may sell, lease, transfer or convey a list, including Provider, to Payors.

Payors shall actively encourage subscribers to use the list of contracted providers when obtaining medical care. Active encouragement includes offering subscribers direct financial incentives to use the list of contracted providers when obtaining medical care (such as reduced Copayments, Coinsurance and Deductibles), or providing or causing the provision of information to subscribers advising such subscribers of the existence of a list of contracted providers through a variety of advertising or marketing approaches that supply the names, addresses and telephone numbers of contracted providers to subscribers in advance of their selection of a health care provider. Nothing in this Addendum A shall be construed to require a Payor to actively encourage such Payor's subscribers to use the list of contracted providers, including Provider, when obtaining medical care in the event of an Emergency.

Health Net shall not permit Payors to access this Agreement and pay Provider's contracted rate for the Benefit Programs covered by this Addendum unless Payor, or Health Net on Payor's behalf, has actively encouraged Payor's subscribers to use the list of contracted providers in obtaining medical care.

Provider agrees that the following commercial Benefit Program Payors are eligible to pay Provider's contracted rate under this Addendum A as of the effective date of this Agreement:

#### **NO PAYORS**

Health Net may modify the above list periodically. Provider may request in writing, and Health Net shall have thirty (30) days from the date of such request, to provide Provider with an updated listing of Payors.

Provider understands and agrees that any Health Net subsidiary or affiliate, including, but not limited to, Health Net Life Insurance Company, are not Payors under this Addendum A but shall access this Agreement as Health Net.

**III. Payment.** As compensation for rendering Contracted Services to Beneficiaries covered by commercial HMO, PPO, EPO, POS and Leased PPO Benefit Programs under this Addendum A, Health Net shall pay and Provider shall accept as payment in full the rates set forth in Exhibit A-1, subject to the compensation conditions set forth in Exhibit A-2, the terms of this Agreement and applicable State and federal law. Notwithstanding any other provision in this Agreement, the parties acknowledge that each Payor is solely responsible for paying Provider for Covered Services rendered to those individuals for whom Payor provides health care coverage. For self-insured Payors, Health Net shall not be obligated to pay all, or any portion of any Provider claim on a Payor's behalf unless and until Health Net has received sufficient funds from the applicable Payor to cover such claim. In the event such Payor fails to provide funds to Health Net, Provider may seek payment from Member up to the rates specified in this Exhibit, unless prohibited by applicable law.

**IV. Salud Con Health Net (narrow network) [NOTE FOR NEGOTIATOR: Include this Article IV only if Provider participates in Salud Narrow Network; otherwise, delete]** As compensation for rendering Contracted Services to Beneficiaries covered by the Salud Con Health Net (narrow network) Benefit Program under this addendum, Health Net shall pay and Provider shall accept as payment in full the rates set forth in Exhibit A-1.1, CALIFORNIA

subject to the Salud Con Health Net (narrow network) Benefit Program payment conditions set forth in Exhibit A-2, the terms of this Agreement, and applicable State and federal law.

**EXHIBIT A-1**

**FACILITY FEE-FOR-SERVICE RATE EXHIBIT  
COMMERCIAL BENEFIT PROGRAMS**

Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Exhibit A-2 Health Net shall pay and Provider shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered under commercial Benefit Programs pursuant to Addendum A, the lesser of: (i) the rates listed below, or (ii) 65% - 100% of Provider's Allowable Charges.

**NOTE TO NEGOTIATOR: Remove services listed as "included in inpatient case rate", before sending to Provider during Negotiations.**

**NOTE TO NEGOTIATOR,**

**ALL CODES CONTAINED IN THIS EXHIBIT ARE SUBJECT TO CHANGE AT ANY TIME, AND WITHOUT PRIOR NOTICE. TEMPLATES ARE NOT UPDATED UPON CHANGES TO CODES, WHEN THEY ARE IMPLEMENTED BY THE APPROPRIATE CODING ENTITIES, UPDATES ARE MADE ONCE NOTICE OF SUCH CHANGES HAVE BEEN COMMUNICATED TO CONTRACTS ADMINISTRATION, IN ANY FORM. THEREFORE, YOU SHOULD ALWAYS VERIFY WITH FINANCE, THE ACCURACY AND WHETHER CODES CONTAINED HEREIN NEED TO BE UPDATED, WHEN YOU DRAFT YOUR PROVIDER AGREEMENT(S).**

<b>COMMERCIAL BENEFIT PROGRAMS</b>		
<b>Category of Service</b>	<b>Applicable codes (Revenue, CPT, ICD, DRG)</b>	<b>Payment Rate</b>
<b>Inpatient Services</b>		
Medical/Surgical/Pediatric	Rev codes 0100-0113, 0119-0123, 0129-0133, 0139-0142, 0149-0153, 0159-0169	/day
ICU/CCU/PICU	Rev Codes 0200-0203, 0209, 0210-0213, 0219	/day
Post ICU/ Post CCU / Telemetry	Rev Codes 0206, 0214	/day
Subacute	Rev Codes 0190-0194, 0199	/day
OB/Vaginal (Mom and Baby)	MS-DRGs 768, 796-798, 805-807	/case
OB/C-Section (Mom and Baby)	MS-DRGs 783-788	/case
NICU	Rev Codes	
Level I	0170, 0171, 0179	/day
Level II	0172	/day
Level III	0173	/day
Level IV	0174	/day
Surgical Implants/Prosthetics	Rev Codes 0274, 0275, 0276 or 0278	Included in case rate or per diem
Durable Medical Equipment	Rev Code 0290-0294	Included in case rate or per diem
Pharmaceuticals	Rev Code 0636 and applicable HCPC code	Included in case rate or per diem

COMMERCIAL BENEFIT PROGRAMS		
Category of Service	Applicable codes (Revenue, CPT, ICD, DRG)	Payment Rate
<b>Inpatient Services</b>		
Surgical Supplies	Rev Codes 0270-0273, 062X	Included in case rate or per diem
Trauma Inpatient	Type of Bill: 11 X or 12X; and Rev Codes 068x; and Type of Admission = 05	/day for days 1 to 3 and level of care thereafter

COMMERCIAL BENEFIT PROGRAMS		
Category of Service	Applicable codes (Revenue, CPT, ICD, DRG)	Payment Rate
<b>Outpatient Services</b>		
Outpatient / Ambulatory Surgery	Rev codes 0360, 0369, 0490, 0499, 0750, and applicable CPT code(s)	_____ % of Medicare Allowable
Emergency Room Services (Facility)	Rev Codes 0450, 0451, 0452, 0459	/case
Emergency Room – Urgent Care Services (Facility)	Rev Code 0456	/case
Outpatient Therapy – PT, OT, ST, Respiratory and Cardiac	Rev Codes 0410, 0412, 0413, 0419, 0420-0424, 0429, 0430-0434, 0439, 0440-0444, 0449, 0943 and applicable CPT code	
Radiology (Technical Component)	Rev Codes 032X, 0330-0332, 0335-0339, 0400, 0401, 0403, 0409 and applicable CPT code	
Laboratory	Rev codes 030X, 031X, 0923 and applicable CPT code	
Observation	Rev Codes 0760, 0762	/case
Surgical Implants/Prosthetics	Rev Codes 0274, 0275, 0276, or 0278	Included in case rate
Trauma Outpatient	Type of Bill: 13X and Rev Codes 068x	/case
Durable Medical Equipment	Rev Code 0290-0294	Included in case rate
Pharmaceuticals	Rev Code 0636 and applicable HCPC code	Included in case rate
Surgical Supplies	Rev Codes 0270-0273, 062X	Included in case rate
All Other Outpatient		_____ % of Allowable Charges NTE \$XXXX

**NOTE TO NEGOTIATOR. STOP LOSS AVL. PREFERRED OPTION; 1) NO STOP LOSS, 2) 2nd dollar, 3) 1<sup>st</sup> Dollar. If you negotiate stop loss, use one of the standard options below.**

**Stop Loss Provisions:**

For any single admission Provider shall be reimbursed for Allowable Charges for Covered Services at the per diem or case rates set forth in this Exhibit until such time such reimbursement totals \$ \_\_\_\_\_. (“Inpatient Stop Loss

Threshold”). Beginning the day after such Inpatient Stop Loss Threshold is met, Provider shall be reimbursed: *(In the order of preference, RND to choose one)*

- a) 50% of the actual daily Allowable Charges for Covered Services not to exceed \$\_\_\_\_\_ per day
- b) 50% of the Allowable Charges for Covered Services

For the purposes of Inpatient Stop Loss Threshold calculations and reimbursements, inpatient sub-acute, Skilled Nursing Facility (SNF), rehabilitation, transplants, bariatric surgery, trauma, emergency room and any carve-outs and exclusions as stated above shall be excluded.

**EXHIBIT A-1.1**

**FACILITY FEE-FOR-SERVICE RATE EXHIBIT  
SALUD CON HEALTH NET (narrow network) BENEFIT PROGRAM**

**[NOTE TO NEGOTIATOR: USE THIS EXHIBIT IF: (1) PROVIDER IS PART OF THE SALUD CON HEALTH NET NARROW NETWORK AND (2) FEE FOR SERVICE RATES WILL BE PAID]**

**NOTE TO NEGOTIATOR,**

**ALL CODES CONTAINED IN THIS EXHIBIT ARE SUBJECT TO CHANGE AT ANY TIME, AND WITHOUT PRIOR NOTICE. TEMPLATES ARE NOT UPDATED UPON CHANGES TO CODES, WHEN THEY ARE IMPLEMENTED BY THE APPROPRIATE CODING ENTITIES, UPDATES ARE MADE ONCE NOTICE OF SUCH CHANGES HAVE BEEN COMMUNICATED TO CONTRACTS ADMINISTRATION, IN ANY FORM. THEREFORE, YOU SHOULD ALWAYS VERIFY WITH FINANCE, THE ACCURACY AND WHETHER CODES CONTAINED HEREIN NEED TO BE UPDATED, WHEN YOU DRAFT YOUR PROVIDER AGREEMENT(S).**

Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Exhibit A-2, Health Net shall pay and Provider shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered under the Salud Con Health Net (narrow network) Benefit Program pursuant to this Addendum A, the lesser of: (i) the rates listed below, or (ii) **65% - 100%** of Provider’s Allowable Charges.

<b><u>Category of Service</u></b>	<b>Applicable codes (Revenue, CPT, ICD, DRG)</b>	<b>Payment Rate</b>
Inpatient Services	Applicable Codes	\$900.00 per day
Outpatient / Ambulatory Surgery	Rev codes 0360, 0369, 0490, 0499, 0750, 0759 and applicable CPT code(s)	<b>(80%-100%)</b> of Medicare Allowable.

Emergency Room Services (Facility)	Rev Codes 0450, 0451, 0452, 0456, 0459	\$50.00 per visit for Triage. All Other Emergency Room Services: 60% of Provider's Allowable Charges not to exceed \$800.00 (Per )
All Other Outpatient		60% of Provider's Allowable Charges not to exceed \$800.00 (Per )
Inpatient and Outpatient Exclusions	<b>NOTE: RND TO INSERT APPLICABLE CODES</b>	Joint implants, AICD, and pacemakers are excluded from the rates noted above and are reimbursed at Cost. Hospital shall be responsible for identifying exclusions.

## EXHIBIT A-2

### COMMERCIAL RATE EXHIBIT PAYMENT CONDITIONS

The Payment Conditions set forth in this Exhibit A-2 supplement Health Net Policies.

**I. PAYMENT CONDITIONS APPLICABLE TO: (1) PAYMENT RATES, FOR COMMERCIAL BENEFIT PROGRAMS, INCLUDING SALUD CON HEALTH NET, NOT BASED ON MEDICARE/CMS ALLOWABLE; AND (2) PAYMENT RATES, FOR COMMERCIAL BENEFIT PROGRAMS, BASED ON MEDICARE/CMS ALLOWABLE:**

**1.1.** The codes listed in the applicable Rate Exhibit shall be used by the parties for the purpose of defining the services for which payment will be made under this Agreement. Provider shall utilize the specified codes listed in the applicable Rate Exhibit when submitting Complete Claims for Covered Services under this Agreement.

**1.2** The parties acknowledge that applicable coding agencies periodically issue coding modifications. Such modifications may be implemented by Health Net within sixty (60) days of the date Health Net receives the modification from the applicable coding agency or notification from Provider. The parties agree that in the event such coding modifications have the effect of changing a payment amount in this Agreement, the resulting payment amount change shall be effective on a prospective basis. The parties further agree to reasonably and in good faith discuss any contract rate amendment that may be appropriate based on comprehensive and substantive coding changes by the applicable coding agency within ninety (90) days of written notification by either party. Any and all rate modifications that may result from such contract amendment shall be effective on a prospective basis.

**1.3.** Only one per diem or case rate shall be payable a) for each Beneficiary who is admitted prior to midnight and remains past midnight; b) if a Beneficiary is admitted and discharged during the same day, provided that such admission and discharge is not within forty-eight (48) hours of a prior discharge; c) for mother and newborn child (children) when both mother and newborn child (children) are in the facility on the same day, unless the child (children) is in the neonatal intensive care unit. Pre-admission testing completed within three (3) days of admission will be included in the per diem and will not be billed separately by Provider. A per diem is an all-inclusive daily payment, including but not limited to observation services, supplies, implants, prosthetics, durable medical equipment, and pharmaceuticals with the exception of specific carve-outs or exclusions identified on the applicable rate exhibit. Inpatient Professional services billed by the Provider on behalf of the hospital-based physician(s) are included in the per diems or case rates. Admission kits are included in the per diem rate. Any Outpatient Services delivered to a Beneficiary within twenty-four (24) hours prior to an admission for Inpatient Services for the same medical condition at the same facility are included in the inpatient rate.

**1.4.** The rates set forth in this Agreement apply only to inpatient admissions commencing on or after the Effective Date of this Agreement. The applicable rate of payment that is in effect on the date an inpatient admission commences shall apply to the entire length of stay regardless of any rate change that may occur during the length of stay. Notwithstanding the foregoing, inpatient case rates are applicable beginning the first day of admission if a case rate procedure is performed at any time during the inpatient stay.

**1.5.** All inpatient rates shall include any readmission charges if the patient is readmitted within thirty (30) days following discharge for complications related to the prior admission. Should non-standard conditions occur, the second admission within thirty (30) days may be eligible for reimbursement, provided such admission is in accordance with Health Net Policies.

**1.6.** If a Beneficiary is admitted to the hospital from the emergency room and/or observation room, separate reimbursement for the emergency room, observation room and other outpatient charges shall not be paid; however, the applicable inpatient reimbursement shall be reimbursed as all-inclusive reimbursement.

The rate payable for Emergency Services is an all-inclusive case rate, including but not limited to supplies, implants, prosthetics, durable medical equipment, observation charges, diagnostic services, therapeutic services,

pharmaceuticals, and other services incidental to the emergency room visit, with the exception of specific exclusions identified on the applicable rate exhibit. (Remove if ER reimb on % of BC without NTE.)

1.7 The all-inclusive procedure rate payable for outpatient surgery (including Cardiac Cath/PTCA, etc., when applicable) is an all-inclusive case rate, including but not limited to supplies, implants, prosthetics, durable medical equipment, emergency room charges, observation charges, diagnostic services, therapeutic services, and pharmaceuticals with the exception of specific exclusions identified on the applicable rate exhibit. Only one (1) case rate shall be paid for each Beneficiary per date of service. [NOTE: Include any other significant case rates in this paragraph.]

1.8. Other Outpatient case rates are an all-inclusive payment, including but not limited to supplies, diagnostic services, therapeutic services, and pharmaceuticals with the exception of specific exclusions identified on the applicable rate exhibit. Only one (1) case rate shall be paid for each Beneficiary per date of service; provided, however, that if one or more unique case rate procedure is performed on different body parts, each applicable case rate shall be reimbursed.

1.9. Provider shall be reimbursed for multiple and bilateral procedures, or when more than one surgical procedure is performed under the same anesthesia during an operative session:

[NOTE TO NEGOTIATOR: Only use Multiple Procedures hierarchy below when not using case rate. If using case rate, delete section below.]

- (i) The procedure in the highest payment category shall be paid at 100% of the applicable contract rate;
- (ii) The second-ranking procedure shall be paid at 50% of the applicable contract rate;
- (iii) All other procedures are paid at 50% of the applicable contract rate.

1.10. In the event that a Beneficiary is transported either within Provider's Facility or to another facility for a service that is within Provider's customary scope of practice, but due to malfunction or other cause cannot be delivered, Provider shall be solely financially responsible for claims incurred for such transportation.

1.11. For purposes of this Agreement, New Service/Technology is defined as a service, procedure, device, test, or other item that, as of the effective date of this Agreement: (i) is not performed by Provider, or (ii) is not Covered by Health Net under the applicable Benefit Program, or (iii) for which there is no assigned CPT or other relevant code defined. New Service/Technology does not include a new code that is assigned as a change to an existing service, procedure, device, test, or other item. If Provider offers a New Service/Technology after the effective date of this Agreement for which Provider desires reimbursement under this Agreement, Provider agrees to give Health Net sixty (60) days prior written notice that Provider requests that such New Service/Technology be included in Contracted Services, and that Provider receive a different reimbursement rate for the use of such New Service/Technology for Beneficiaries. Health Net agrees to determine whether such New Service/Technology qualifies as a Covered Service and whether Health Net desires to include such New Service/Technology in Contracted Services within thirty (30) days of the date of Provider's notice hereunder. Health Net's determination of whether a New Service/Technology qualifies as a Covered Service shall be made in Health Net's sole discretion and shall be final and binding on Provider with respect to this Agreement. Only if Health Net agrees that such New Service/Technology is a Covered Service and desires to include such New Service/Technology in Contracted Services, the parties shall enter into good faith negotiations to modify Provider's rates to reflect the New Service/Technology. Any rate modification shall be made only prospectively.

1.12. The lowest room and board allowable charge rate shall apply to all days billed within the same revenue code level of care.

1.13. If any payment rates are based on Provider's Allowable charges, upon Health Net's written request, Provider shall make Provider's current Charge Master available to Health Net within ten (10) days in electronic format. Provider shall notify Health Net in writing via certified letter at least sixty (60) days prior to making any changes to Provider's Charge Master ("Notice"). The rates in Provider's Charge Master before (insert contract effective date),

shall be the “Baseline Charge Master”. Changes to the Baseline Charge Master shall be measured during the twelve (12) month period immediately preceding the date of the Notice (“Measurement Period”). The Notice shall be signed by Provider’s Chief Financial Officer (or equivalent) and shall include a statement of any and all changes made to the Baseline Charge Master during the Measurement Period together with the effective date of such change. All changes included in the Notice shall be calculated using the methodology set forth herein. Any change to Provider’s Charge Master during the term of this Agreement shall result in a proportional change to reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the stop-loss threshold (if applicable) set forth in the applicable addendum and/or exhibit to this Agreement. The terms of this section shall survive termination of this Agreement with respect to Contracted Services rendered during the term of the Agreement. The methodology for calculating Changes to the Charge Master and rates pursuant to this section is as follows:

a) First Year: Provider agrees that any Notice delivered during the first year of this Agreement shall reflect no changes made to the Baseline Charge Master. In the event Provider has made changes to its Baseline Charge Master, any such change shall result in a proportional change to reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the stop-loss threshold (if applicable) set forth in the applicable addendum and/or exhibit to this Agreement, such that there will not be a change to Health Net’s reimbursement to Provider during the first year of this Agreement.

In the event Health Net exercises its right to reconcile and adjust payment, Health Net shall give Provider at least thirty (30) days prior written notice, which notice shall be attached to the applicable rate exhibit in this Agreement and any subsequent addendums and/or exhibits. Any such change in rates shall be implemented upon thirty (30) days prior written notice to Provider and shall be applicable to all claims with dates of service on or after the date of the Charge Master increase in excess of the contractual allowance. Health Net shall use the above methodology for calculating changes to the Charge Master and rates pursuant to this section.

b) Subsequent Years: For each subsequent Measurement Period, Provider shall not change Provider’s Baseline Charge Master in a manner that results in an increase in reimbursement under this Agreement by more than (insert percentage, in words) percent (xx%) in the aggregate, unless expressly agreed upon in writing by the parties hereto. Upon request, Provider shall promptly provide Health Net with a Notice that completely and accurately sets forth any and all changes during the Measurement Period. Health Net shall have the right to reconcile and reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the stop-loss threshold (if applicable) set forth in the applicable addendum and/or exhibit to this Agreement. In the event Health Net exercises its right to reconcile and adjust payment, Health Net shall give Provider at least thirty (30) days prior written notice, which notice shall be attached to the applicable rate exhibit in this Agreement- and any subsequent addendums and/or exhibits. Any such change in rates shall be implemented upon thirty (30) days prior written notice to Provider and shall be applicable to all claims with dates of service on or after the date of the Charge Master increase in excess of the contractual allowance.

c) Both parties agree that Charge Master changes shall be calculated using Provider’s aggregate weighted average charge increase where weights equal volume for specific charges.

Health Net may periodically review Provider’s Charge Master filed with the State or Health Net’s historical claims data. If Health Net determines as a result of such review that Provider has made changes to the Baseline Charge Master but has failed to give Health Net Notice, the parties agree that such changes shall result in a proportional change to reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the stop-loss threshold (if applicable) set forth in the applicable addendum and/or exhibit to this Agreement and any subsequent addendum and/or exhibits. Any such change in rates shall be implemented upon thirty (30) days prior written notice to Provider and shall be applicable to all claims with dates of service on or after the date of the Charge Master increase in excess of the contractual allowance.

**NOTE TO NEGOTIATOR: IF YOU ARE CONTRACTING FOR TRAUMA CARE, THE FOLLOWING MUST BE INCLUDED:**

**1.14. Trauma Provisions.** Trauma Care is defined as inpatient or outpatient services provided during one uninterrupted inpatient admission or outpatient service initiated in the Hospital Emergency Department of a Beneficiary, who is treated directly by the hospital-based Trauma Team. The Beneficiary's condition must meet the Trauma Triage Criteria as adopted by the American College of Surgeons Committee on Trauma or the Provider's County specific Emergency Medical Services criteria. Additionally, the activation of the Trauma Team must be in response to notification of key hospital personnel by pre-hospital caregivers (e.g., Paramedics, EMTs or transferring hospital) and be in accord with applicable triage guidelines and criteria. Beneficiaries who are Emergency Room walk-ins or who arrive without pre-arrival notification by pre-hospital caregivers or are admitted to the Emergency Department or hospital for chronic conditions cannot be charged for activation of the Trauma Team.

Trauma activation is defined as on-site active participation of members of the Trauma Team, including a trauma surgeon, in the care of the Beneficiary from admission in the Hospital Emergency Department, in accordance with the applicable triage guidelines and criteria and in response to pre-arrival notification. Initial evaluation of the Beneficiary by the Trauma Team must take place within 30 minutes of the patient's arrival at the Emergency Department; this evaluation must also take place within eight (8) hours of the traumatic event, should the Beneficiary have been transferred from another receiving facility. Trauma rates will not be paid if the Beneficiary is accepted in transfer more than eight (8) hours after the traumatic event or if the initial evaluation occurs more than thirty (30) minutes after the Beneficiary arrives at the Emergency Department.

Beneficiaries who die prior to arriving at the hospital, hospital cannot charge for Trauma Team activation, regardless of whether pre-hospital caregiver notification was provided to the receiving hospital. For Beneficiaries who die within 24 hours of arriving at the Emergency Room, and meet Trauma criteria, hospital can charge the Outpatient Trauma Rate. Beneficiaries who meet the Trauma Criteria as defined herein who die within the 24 hours of arriving at the Emergency, and are admitted, hospital can charge the inpatient trauma rate.

Hospitals must be "trauma certified", meaning that the facility has a designation as a Trauma Center by the local or regional Emergency Medical System Agency or is recognized by the American College of Surgeons Committee on Trauma to be reimbursed at the trauma rates. State Department of Health hospital licensing designation of Emergency Department Level of Care (Stand-by, Basic or Comprehensive) may not be used in lieu of a designation as a Trauma Center by the Emergency Medical System Agency or the American College of Surgeons Committee on Trauma designations. For Trauma designated hospitals, failure to maintain the designation will automatically revoke the applicability of rates.

Claims for Trauma Care are subject to detailed claims review and must have supporting documentation available for Health Net review upon request. Health Net reserves the right to base the final claim disposition based on a complete record review. Documents for review include but are not limited to: trauma team activation records, clinical records, Beneficiary admission, pre-hospital admission records, pre-hospital caregiver records, detailed billing records and other relevant documentation, as needed to substantiate applicability of the Trauma Care definition including level of care changes and charges. Provider shall submit the trauma team activation records prior to submitting a claim. Health Net reserves the right to recognize charges for drugs and other like services at rates that consider external information, for example, at an average wholesale price, as determined by Health Net. Trauma clinical records shall be attached to the claim by Provider to substantiate applicability of the Trauma Care definition including level of care changes. The Trauma Inpatient rate is a global rate and separate charges for Emergency Department, Observation or other charges incurred prior to the Beneficiary's admission as an inpatient are included in the Trauma Care Per Diem Reimbursement Rate and other applicable inpatient rates. The Trauma Outpatient rate is a global rate and it includes all services incurred by the Beneficiary for the date of service. This includes but is not limited to Emergency Department services, ancillary services such as Lab, Radiology or other Diagnostic Tests, and operating room services, recovery room services and observation room services.

**II. PAYMENT CONDITIONS APPLICABLE TO PAYMENT RATES BASED ON MEDICARE/CMS ALLOWABLE**

The following payment conditions are in addition to those set forth in Article I above and apply to payment rates based upon a percentage of Medicare/CMS allowable rates, and methodology. Notwithstanding the foregoing, to the extent any payment condition set forth in this Article II conflicts with a payment condition in Article I, the payment condition set forth in this Article II shall control with respect to payment based upon a percentage of Medicare/CMS allowable rates, and methodology:

**2.1.** Only one DRG/case rate shall be payable (i) for each Beneficiary who is admitted provided that such admission is not within 48 hours of a prior discharge; (ii) for mother and newborn child (children) when both mother and newborn child (children) are in the facility on the same day, unless the child (children) is in the neonatal intensive care unit. Any outpatient services delivered to a Beneficiary within 48 hours prior to an admission for Inpatient Services at the same facility are included in the inpatient rate.

***NOTE TO NEGOTIATOR:***

***Option 1: If you have a commercial Benefit Program with reimbursements that fall under Medicare rules, i.e. a DRG, then Payment Condition 2.1 remains as is.***

***Option 2: If only the Medicare Benefit Program rates are based on Medicare Allowable rules, then section (ii) must be deleted from the condition which will then be set forth as follows:***

**2.1 Only one DRG/case rate shall be payable for each Beneficiary who is admitted provided that such admission is not within 48 hours of a prior discharge. Any outpatient services delivered to a Beneficiary within 48 hours prior to an admission for Inpatient Services at the same facility are included in the inpatient rate.**

***Option 3: If both the Medicare and any other Benefit Programs have reimbursement that falls under Medicare rules, i.e. a DRG, then the condition should be stated as follows:***

**2.1 Only one DRG/case rate shall be payable (i) for each Beneficiary who is admitted, provided that such admission is not within 48 hours of a prior discharge; (ii) For Benefit Program Beneficiaries other than Medicare Beneficiaries, for mother and newborn child (children) when both mother and newborn child (children) are in the facility on the same day, unless the child (children) is in the neonatal intensive care unit. Any outpatient services delivered to a Beneficiary within 48 hours prior to an admission for Inpatient Services at the same facility are included in the inpatient rate.**

**2.2.** Provider shall be reimbursed in accordance with CMS guidelines for all Outpatient Services.

**2.3** Medicare/CMS allowable for Inpatient Services is defined as Medicare DRG including, DME, DSH, Capital (including Capital IME), and other Medicare payments, and including outliers as defined by Medicare/CMS, but excluding Operating IME and pass-throughs.

**2.4** Provider agrees to adhere to CMS/Medicare billing and compensation guidelines for all services.

## ADDENDUM B

### MEDICARE ADVANTAGE PROVISIONS

**I. Applicability.** Provider and Health Net agree that this Addendum B shall apply only to Contracted Services delivered to Beneficiaries covered by the Medicare Advantage (MA) Program, and this Addendum B may be accessed by those Health Net entities holding a valid Medicare Advantage agreement with CMS at the time Contracted Services are delivered.

**II. Payment.** Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Exhibit B-2, Health Net shall pay, and Provider shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered under Health Net's MA Program pursuant to this Addendum B and accompanying Exhibit B-1 and B-2.

### **III. Obligations.**

#### **A. Definitions**

For purposes of this Addendum, the definitions included herein shall have the meaning required by law governing the Medicare Advantage (MA) Program.

- (a) **Medicare Advantage (MA).** The statutory name applicable to the federal program of prepaid health care services for Medicare beneficiaries established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
- (b) **Medicare or MA Member.** A Medicare Beneficiary who has elected to enroll in and receive coverage through a Health Net MA or MAPD Benefit Program, under the terms and conditions of the Benefit Program's MA or MAPD Evidence of Coverage, and whose enrollment has been confirmed by the Centers for Medicare and Medicaid Services ("CMS"), an agency of the U.S. Department of Health and Human Services ("HHS") that administers the Medicare Advantage program.
- (c) **Contract Period.** The term of the contract between Health Net and CMS.
- (d) **Delegation.** Delegation to Provider of a certain contractual obligation of Health Net under Health Net's contract with CMS.
- (e) **MA Benefit Program.** A Health Net Medicare Advantage Benefit Program that provides coverage for certain health care services.
- (f) **MAPD Benefit Program.** An MA Benefit Program that includes Medicare Part D prescription drug coverage.
- (g) **MA/MAPD Evidence of Coverage.** A legally binding statement of coverage, revised annually, between a Medicare Member and Health Net under which a Medicare Member is entitled to receive coverage for certain hospital, medical and other associated health care services.

#### **B. Medicare Advantage Program Obligations.**

**1. Provider Obligations.** Provider agrees to render Contracted Services to MA Members, in accordance with the terms and conditions of Health Net's MA Programs. Health Net shall provide Provider with the Benefit Program Requirements of such Benefit Programs not set forth in this Addendum. Such Benefit Program Requirements include the provisions of the applicable MA or MAPD Evidence of Coverage, and Health Net policies and procedures. Provider acknowledges that the determination of Covered Services shall be governed by coverage

guidelines established by Health Net and the MA Program, with Health Net being solely responsible for final coverage determinations, subject to applicable appeal procedures.

2. **Member Services.** Provider shall cooperate fully with Health Net in the investigation and resolution of complaints by MA Members regarding Provider, or the services Provider provides or arranges, in compliance with CMS and state regulatory requirements.
3. **Reports and Administration.** Health Net shall have sole responsibility for filing reports, obtaining approval from, and complying with the applicable laws and regulations of federal, state, and local governmental agencies having jurisdiction over Health Net. Provider shall cooperate in providing Health Net with such information and assistance regarding MA Members and Provider's performance under this Agreement and Addendum as Health Net may reasonably require in filing such reports and complying with applicable laws and regulations.
4. **Health Net Policies and Procedures.** Health Net shall promptly communicate any material change in Health Net's policies and procedures affecting Provider in accordance with Section 3.2 of this Agreement.
5. **Prompt Payment.** Health Net and Provider agree to: Process contracted Provider claims received at Health Net within sixty (60) calendar days of receipt, and (ii) Process non-contracted provider clean claims received by Provider within thirty (30) calendar days and sixty (60) calendar days for all other claims.

### C. **Regulatory Obligations**

***NOTE TO NEGOTIATORS: ALL LANGUAGE UNDER THE REGULATORY OBLIGATIONS SECTION IS NON-NEGOTIABLE AND MUST REMAIN IN THE CONTRACT/AMENDMENT AS IS.***

1. Health Net and Provider agree, and Provider shall require its subcontractors to agree to:

(a) HHS, CMS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems, including medical records and documentation of Provider and any Provider subcontractor, involving transactions related to CMS' contract with Health Net through ten (10) years from the final date of the final Contract Period of the contract entered into between CMS and Health Net or from the date of completion of any audit, whichever is later. This right can be exercised directly with any first tier, downstream or related entity. For records subject to review under this provision, except in exceptional circumstances, CMS will provide notification to Health Net that a direct request for information has been initiated. [\*See 42 CFR §§422.504(i)(2)(i-iv); Ch. 11. §100.4, Medicare Managed Care Manual "MMCM"]

(b) Cooperate in, assist in, and provide information as requested for audits, evaluations and inspections performed under Section C.1(a) above. [\*See Ch. 11. §100.4, MMCM]

(c) Safeguard each MA Beneficiary's privacy and comply with the confidentiality and MA Beneficiary record accuracy requirements, including: 1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, 2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and 4) ensuring timely access by MA Beneficiaries to the records and information that pertain to them. [\*See 42 CFR §422.504(a)(13); 42 CFR §422.118(a); Ch. 11. §100.4, MMCM].

(d) Contracts or other written agreements between Provider and Provider subcontractors must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. [\*See 42 CFR §422.520(b)(1); Ch. 11, §100.4, MMCM]

(e) Hold each MA Beneficiary harmless for payment of any fees that are the legal obligation of Health Net in the event of, but not limited to, insolvency of, breach by or billing of Provider by Health Net. [\*See 42 CFR §§422.504(g)(1)(i) and (i)(3)(i); Ch. 11 §100.4 MMCM].

(f) Comply with all applicable Medicare laws, regulations, reporting requirements and CMS instructions. [\*See 42 CFR §422.504(i)(4)(v)]

(g) Perform each service or other activity under this Agreement in a manner consistent and in compliance with Health Net's contractual obligations to CMS. [\*See 42 CFR §422.504(i)(3)(iii)]

(h) Maintain all records relating to this contract for a minimum of ten (10) years from the final date of the Contract Period or the date of the completion of any audit, whichever is later. [\*See Ch. 11. §110.4.3, MMCM]

(i) Health Net oversees and is ultimately responsible to CMS for any functions and responsibilities described in the Medicare Advantage regulations. Provider understands that this accountability provision also applies to this Addendum. [\*See 42 CFR §422.504(i)(4)(iii); Ch 11 §100.4, MMCM].

(j) Comply with Health Net Policies. [\*See Ch. 11. §100.4, MMCM]

(k) For all MA Beneficiaries eligible for both Medicare and Medicaid (includes Medi-Cal), such MA Beneficiaries will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider and Provider subcontractors may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept Health Net payment as payment in full, or (2) bill the appropriate State source. [\*See 42 CFR §§422.504(g)(1)(i) and (iii); 42 C.F.R. §422.504(i)(3)(i)].

## **2. Health Net and Provider agree:**

(a) Health Net is obligated to pay Provider promptly under the terms of the Agreement between Health Net and the Provider, as well as in accordance with Health Net Policies and Section B(5) of this Addendum. [\*See 42 CFR §§422.520(b)(1) and (2); Ch. 11, §100.4, MMCM]

## **3. Provider and its subcontractors further agree to the following:**

(a) To have approved procedures to identify, assess and establish a treatment plan for Beneficiaries with complex or serious medical conditions.

(b) To provide access to benefits in a manner described by CMS.

(c) To protect Beneficiaries who are hospitalized from loss of benefits through the period of time CMS premiums are paid.

(d) To not employ or contract with individuals excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act.

(e) To adhere to Medicare's appeals, expedited appeals and expedited review procedures for Medicare HMO Beneficiaries, including gathering and forwarding information on appeals to Health Net, as necessary.

(f) That Medicare Beneficiaries' health services are being paid for with Federal funds, and as such, payments for such services are subject to laws applicable to individuals or entities receiving Federal funds.

(g) To submit to Health Net all data, including medical records, necessary to characterize the content and purpose of each encounter with Beneficiary.

- (h) To not collect any co-payment or other cost sharing for influenza vaccine and pneumococcal vaccines.
- (i) For purposes of Medicare Beneficiaries, retroactive eligibility changes shall be limited to thirty-six (36) months or as otherwise required by CMS

**D. Delegation**

The parties acknowledge that none of Health Net's MA Program contract obligations to CMS have been delegated by Health Net to Provider.

## **EXHIBIT B-1**

### **MEDICARE ADVANTAGE FEE-FOR-SERVICE RATE EXHIBIT AND PAYMENT CONDITIONS**

#### **I. Payment Rates**

Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Exhibit B-2, Health Net shall pay, and Provider shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered under Medicare Advantage Benefit Programs pursuant to this Addendum, the lesser of: (i) Provider's Medicare DRG or Medicare allowable amounts current on the date Contracted Services are rendered, or (ii) **65% - 100%** of Provider's Allowable Charges.

#### **II. Payment Conditions**

The Payment Conditions applicable to the Medicare Advantage Benefit Programs are set forth in Exhibit B-2 Facility Fee-For-Service Payment Conditions and supplement Health Net Policies.

## EXHIBIT B-2

### MEDICARE ADVANTAGE PAYMENT CONDITIONS

The Payment Conditions set forth in this Addendum as Exhibit B-2 supplement Health Net Policies.

**I. PAYMENT CONDITIONS APPLICABLE TO: (1) PAYMENT RATES, FOR MEDICARE BENEFIT PROGRAMS, NOT BASED ON MEDICARE/CMS ALLOWABLE; AND (2) PAYMENT RATES, FOR MEDICARE BENEFIT PROGRAMS, BASED ON MEDICARE/CMS ALLOWABLE:**

**1.1.** The codes listed in the applicable Rate Exhibit shall be used by the parties for the purpose of defining the services for which payment will be made under this Agreement. Provider shall utilize the specified codes listed in the applicable Rate Exhibit when submitting Complete Claims for Covered Services under this Agreement.

**1.2** The parties acknowledge that applicable coding agencies periodically issue coding modifications. Such modifications may be implemented by Health Net within sixty (60) days of the date Health Net receives the modification from the applicable coding agency or notification from Provider. The parties agree that in the event such coding modifications have the effect of changing a payment amount in this Agreement, the resulting payment amount change shall be effective on a prospective basis. The parties further agree to reasonably and in good faith discuss any contract rate amendment that may be appropriate based on comprehensive and substantive coding changes by the applicable coding agency within ninety (90) days of written notification by either party. Any and all rate modifications that may result from such contract amendment shall be effective on a prospective basis.

**1.3.** Only one per diem or case rate shall be payable a) for each Beneficiary who is admitted prior to midnight and remains past midnight; b) if a Beneficiary is admitted and discharged during the same day, provided that such admission and discharge is not within forty-eight (48) hours of a prior discharge; c) for mother and newborn child (children) when both mother and newborn child (children) are in the facility on the same day, unless the child (children) is in the neonatal intensive care unit. Pre-admission testing completed within three (3) days of admission will be included in the per diem and will not be billed separately by Provider. A per diem is an all-inclusive daily payment, including but not limited to observation services, supplies, implants, prosthetics, durable medical equipment, and pharmaceuticals with the exception of specific carve-outs or exclusions identified on the applicable rate exhibit. Inpatient Professional services billed by the Provider on behalf of the hospital-based physician(s) are included in the per diems or case rates. Admission kits are included in the per diem rate. Any Outpatient Services delivered to a Beneficiary within twenty-four (24) hours prior to an admission for Inpatient Services for the same medical condition at the same facility are included in the inpatient rate.

**1.4.** The rates set forth in this Agreement apply only to inpatient admissions commencing on or after the Effective Date of this Agreement. The applicable rate of payment that is in effect on the date an inpatient admission commences shall apply to the entire length of stay regardless of any rate change that may occur during the length of stay. Notwithstanding the foregoing, inpatient case rates are applicable beginning the first day of admission if a case rate procedure is performed at any time during the inpatient stay.

**1.5.** All inpatient rates shall include any readmission charges if the patient is readmitted within thirty (30) days following discharge for complications related to the prior admission. Should non-standard conditions occur, the second admission within thirty (30) days may be eligible for reimbursement, provided such admission is in accordance with Health Net Policies.

**1.6.** If a Beneficiary is admitted to the hospital from the emergency room and/or observation room, separate reimbursement for the emergency room, observation room and other outpatient charges shall not be paid; however, the applicable inpatient reimbursement shall be reimbursed as all-inclusive reimbursement.

The rate payable for Emergency Services is an all-inclusive case rate, including but not limited to supplies, implants, prosthetics, durable medical equipment, observation charges, diagnostic services, therapeutic services, pharmaceuticals, and other services incidental to the emergency room visit, with the exception of specific exclusions identified on the applicable rate exhibit. (Remove if ER reimb on % of BC without NTE.)

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**1.7** The all-inclusive procedure rate payable for outpatient surgery (including Cardiac Cath/PTCA, etc., when applicable) is an all-inclusive case rate, including but not limited to supplies, implants, prosthetics, durable medical equipment, emergency room charges, observation charges, diagnostic services, therapeutic services, and pharmaceuticals with the exception of specific exclusions identified on the applicable rate exhibit. Only one (1) case rate shall be paid for each Beneficiary per date of service. [NOTE: Include any other significant case rates in this paragraph.]

**1.8.** Other Outpatient case rates are an all-inclusive payment, including but not limited to supplies, diagnostic services, therapeutic services, and pharmaceuticals with the exception of specific exclusions identified on the applicable rate exhibit. Only one (1) case rate shall be paid for each Beneficiary per date of service; provided, however, that if one or more unique case rate procedure is performed on different body parts, each applicable case rate shall be reimbursed.

**1.9.** Provider shall be reimbursed for multiple and bilateral procedures, or when more than one surgical procedure is performed under the same anesthesia during an operative session:

[NOTE TO NEGOTIATOR: Only use Multiple Procedures hierarchy below when not using case rate. If using case rate, delete section below.]

- (i) The procedure in the highest payment category shall be paid at 100% of the applicable contract rate;
- (ii) The second-ranking procedure shall be paid at 50% of the applicable contract rate;
- (iii) All other procedures are paid at 50% of the applicable contract rate.

**1.10.** In the event that a Beneficiary is transported either within Provider's Facility or to another facility for a service that is within Provider's customary scope of practice, but due to malfunction or other cause cannot be delivered, Provider shall be solely financially responsible for claims incurred for such transportation.

**1.11.** For purposes of this Agreement, New Service/Technology is defined as a service, procedure, device, test, or other item that, as of the effective date of this Agreement: (i) is not performed by Provider, or (ii) is not Covered by Health Net under the applicable Benefit Program, or (iii) for which there is no assigned CPT or other relevant code defined. New Service/Technology does not include a new code that is assigned as a change to an existing service, procedure, device, test, or other item. If Provider offers a New Service/Technology after the effective date of this Agreement for which Provider desires reimbursement under this Agreement, Provider agrees to give Health Net sixty (60) days prior written notice that Provider requests that such New Service/Technology be included in Contracted Services, and that Provider receive a different reimbursement rate for the use of such New Service/Technology for Beneficiaries. Health Net agrees to determine whether such New Service/Technology qualifies as a Covered Service and whether Health Net desires to include such New Service/Technology in Contracted Services within thirty (30) days of the date of Provider's notice hereunder. Health Net's determination of whether a New Service/Technology qualifies as a Covered Service shall be made in Health Net's sole discretion and shall be final and binding on Provider with respect to this Agreement. Only if Health Net agrees that such New Service/Technology is a Covered Service and desires to include such New Service/Technology in Contracted Services, the parties shall enter into good faith negotiations to modify Provider's rates to reflect the New Service/Technology. Any rate modification shall be made only prospectively.

**1.12.** The lowest room and board allowable charge rate shall apply to all days billed within the same revenue code level of care.

**1.13.** If any payment rates are based on Provider's Allowable charges, upon Health Net's written request, Provider shall make Provider's current Charge Master available to Health Net within ten (10) days in electronic format. Provider shall notify Health Net in writing via certified letter at least sixty (60) days prior to making any changes to Provider's Charge Master ("Notice"). The rates in Provider's Charge Master before (insert contract effective date), shall be the "Baseline Charge Master". Changes to the Baseline Charge Master shall be measured during the twelve (12) month period immediately preceding the date of the Notice ("Measurement Period"). The Notice shall be signed

by Provider's Chief Financial Officer (or equivalent) and shall include a statement of any and all changes made to the Baseline Charge Master during the Measurement Period together with the effective date of such change. All changes included in the Notice shall be calculated using the methodology set forth herein. Any change to Provider's Charge Master during the term of this Agreement shall result in a proportional change to reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the threshold (if applicable, i.e. stop-loss, implants, pharmaceuticals,) set forth in the applicable addendum and/or exhibit to this Agreement. The terms of this section shall survive termination of this Agreement with respect to Contracted Services rendered during the term of the Agreement. The methodology for calculating Changes to the Charge Master and rates pursuant to this section is as follows:

a) First Year: Provider agrees that any Notice delivered during the first year of this Agreement shall reflect no changes made to the Baseline Charge Master. In the event Provider has made changes to its Baseline Charge Master, any such change shall result in a proportional change to reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the threshold (if applicable i.e. stop-loss implants, pharmaceuticals) set forth in the applicable addendum and/or exhibit to this Agreement, such that there will not be a change to Health Net's reimbursement to Provider during the first year of this Agreement.

In the event Health Net exercises its right to reconcile and adjust payment, Health Net shall give Provider at least thirty (30) days prior written notice, which notice shall be attached to the applicable rate exhibit in this Agreement and any subsequent addendums and/or exhibits. Any such change in rates shall be implemented upon thirty (30) days prior written notice to Provider and shall be applicable to all claims with dates of service on or after the date of the Charge Master increase in excess of the contractual allowance. Health Net shall use the above methodology for calculating changes to the Charge Master and rates pursuant to this section.

b) Subsequent Years: For each subsequent Measurement Period, Provider shall not change Provider's Baseline Charge Master in a manner that results in an increase in reimbursement under this Agreement by more than (insert percentage, in words) percent (xx%) in the aggregate, unless expressly agreed upon in writing by the parties hereto. Upon request, Provider shall promptly provide Health Net with a Notice that completely and accurately sets forth any and all changes during the Measurement Period. Health Net shall have the right to reconcile and reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the threshold (if applicable i.e. stop-loss, implants, pharmaceuticals) set forth in the applicable addendum and/or exhibit to this Agreement. In the event Health Net exercises its right to reconcile and adjust payment, Health Net shall give Provider at least thirty (30) days prior written notice, which notice shall be attached to the applicable rate exhibit in this Agreement and any subsequent addendums and/or exhibits. Any such change in rates shall be implemented upon thirty (30) days prior written notice to Provider and shall be applicable to all claims with dates of service on or after the date of the Charge Master increase in excess of the contractual allowance.

c) Both parties agree that Charge Master changes shall be calculated using Provider's aggregate weighted average charge increase where weights equal volume for specific charges.

Health Net may periodically review Provider's Charge Master filed with the State or Health Net's historical claims data. If Health Net determines as a result of such review that Provider has made changes to the Baseline Charge Master but has failed to give Health Net Notice, the parties agree that such changes shall result in a proportional change to reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the threshold (if applicable, i.e. stop-loss, implants, pharmaceuticals) set forth in the applicable addendum and/or exhibit to this Agreement and any subsequent addendum and/or exhibits. Any such change in rates shall be implemented upon thirty (30) days prior written notice to Provider and shall be applicable to all claims with dates of service on or after the date of the Charge Master, increase in excess of the contractual allowance.

**NOTE TO NEGOTIATOR: IF YOU ARE CONTRACTING FOR TRAUMA CARE, THE FOLLOWING MUST BE INCLUDED:**

**1.14. Trauma Provisions.** Trauma Care is defined as inpatient or outpatient services provided during one uninterrupted inpatient admission or outpatient service initiated in the Hospital Emergency Department of a Beneficiary, who is treated directly by the hospital-based Trauma Team. The Beneficiary's condition must meet the Trauma Triage Criteria as adopted by the American College of Surgeons Committee on Trauma or the Provider's county specific Emergency Medical Services criteria. Additionally, the activation of the Trauma Team must be in response to notification of key hospital personnel by pre-hospital caregivers (e.g., Paramedics, EMTs or transferring hospital) and be in accord with applicable triage guidelines and criteria. Beneficiaries who are Emergency Room walk-ins or who arrive without pre-arrival notification by pre-hospital caregivers or are admitted to the Emergency Department or hospital for chronic conditions cannot be charged for activation of the Trauma Team.

Trauma activation is defined as on-site active participation of members of the Trauma Team, including a trauma surgeon, in the care of the Beneficiary from admission in the Hospital Emergency Department, in accordance with the applicable triage guidelines and criteria and in response to pre-arrival notification. Initial evaluation of the Beneficiary by the Trauma Team must take place within thirty (30) minutes of the patient's arrival at the Emergency Department; this evaluation must also take place within eight (8) hours of the traumatic event, should the Beneficiary have been transferred from another receiving facility. Trauma rates will not be paid if the Beneficiary is accepted in transfer more than eight (8) hours after the traumatic event or if the initial evaluation occurs more than thirty (30) minutes after the Beneficiary arrives at the Emergency Department.

Beneficiaries who die prior to arriving at the hospital, hospital cannot charge for Trauma Team activation, regardless of whether pre-hospital caregiver notification was provided to the receiving hospital. For Beneficiaries who die within 24 hours of arriving at the Emergency Room, and meet Trauma criteria, hospital can charge the Outpatient Trauma Rate. Beneficiaries who meet the Trauma Criteria as defined herein who die within the 24 hours of arriving at the Emergency, and are admitted, hospital can charge the inpatient trauma rate.

Hospitals must be "trauma certified", meaning that the facility has a designation as a Trauma Center by the local or regional Emergency Medical System Agency or is recognized by the American College of Surgeons Committee on Trauma to be reimbursed at the trauma rates. State Department of Health hospital licensing designation of Emergency Department Level of Care (Stand-by, Basic or Comprehensive) may not be used in lieu of a designation as a Trauma Center by the Emergency Medical System Agency or the American College of Surgeons Committee on Trauma designations. For Trauma designated hospitals, failure to maintain the designation will automatically revoke the applicability of rates.

Claims for Trauma Care are subject to detailed claims review and must have supporting documentation available for Health Net review upon request. Health Net reserves the right to base the final claim disposition based on a complete record review. Documents for review include but are not limited to: trauma team activation records, clinical records, Beneficiary admission, pre-hospital admission records, pre-hospital caregiver records, detailed billing records and other relevant documentation, as needed to substantiate applicability of the Trauma Care definition including level of care changes and charges. Provider shall submit the trauma team activation records prior to submitting a claim. Health Net reserves the right to recognize charges for drugs and other like services at rates that consider external information, for example, at an average wholesale price, as determined by Health Net. Trauma clinical records shall be attached to the claim by Provider to substantiate applicability of the Trauma Care definition including level of care changes. The Trauma Inpatient rate is a global rate and separate charges for Emergency Department, Observation or other charges incurred prior to the Beneficiary's admission as an inpatient are included in the Trauma Care Per Diem Reimbursement Rate and other applicable inpatient rates. The Trauma Outpatient rate is a global rate, and it includes all services incurred by the Beneficiary for the date of service. This includes but is not limited to Emergency Department services, ancillary services such as Lab, Radiology or other Diagnostic Tests, and operating room services, recovery room services and observation room services.

## II. PAYMENT CONDITIONS APPLICABLE TO PAYMENT RATES BASED ON MEDICARE/CMS ALLOWABLE

The following payment conditions are in addition to those set forth in Article I above, and apply to payment rates based upon a percentage of Medicare/CMS allowable rates, and methodology. Notwithstanding the foregoing, to the extent any payment condition set forth in this Article II conflicts with a payment condition in Article I, the payment condition set forth in this Article II shall control with respect to payment based upon a percentage of Medicare/CMS allowable rates, and methodology:

**2.1.** Only one DRG/case rate shall be payable (i) for each Beneficiary who is admitted provided that such admission is not within 48 hours of a prior discharge; (ii) for mother and newborn child (children) when both mother and newborn child (children) are in the facility on the same day unless the child (children) is in the neonatal intensive care unit. Any outpatient services delivered to a Beneficiary within 48 hours prior to an admission for Inpatient Services at the same facility are included in the inpatient rate.

### **NOTE TO NEGOTIATOR:**

**Option 1: If you have a commercial Benefit Program with reimbursements that fall under Medicare rules, i.e. a DRG, then Payment Condition 2.1 remains as is.**

**Option 2: If only the Medicare Benefit Program rates are based on Medicare Allowable rules, then section (ii) must be deleted from the condition which will then be set forth as follows:**

**2.1 Only one DRG/case rate shall be payable for each Beneficiary who is admitted provided that such admission is not within 48 hours of a prior discharge. Any outpatient services delivered to a Beneficiary within 48 hours prior to an admission for Inpatient Services at the same facility are included in the inpatient rate.**

**Option 3: If both the Medicare and any other Benefit Programs have reimbursement that falls under Medicare rules, i.e. a DRG, then the condition should be stated as follows:**

**2.1 Only one DRG/case rate shall be payable (i) for each Beneficiary who is admitted, provided that such admission is not within 48 hours of a prior discharge; (ii) For Benefit Program Beneficiaries other than Medicare Beneficiaries, for mother and newborn child (children) when both mother and newborn child (children) are in the facility on the same day, unless the child (children) is in the neonatal intensive care unit. Any outpatient services delivered to a Beneficiary within 48 hours prior to an admission for Inpatient Services at the same facility are included in the inpatient rate.**

**2.2.** Provider shall be reimbursed in accordance with CMS guidelines for all Outpatient Services.

**2.3** Medicare/CMS allowable for Inpatient Services is defined as Medicare DRG including, DME, DSH, Capital (including Capital IME), and other Medicare payments, and including outliers as defined by Medicare/CMS, but excluding Operating IME and pass-throughs.

**2.4** Provider agrees to adhere to CMS/Medicare billing and compensation guidelines for all services.

## ADDENDUM C

### **MEDI-CAL BENEFIT PROGRAM**

Provider understands and agrees that the obligations of Health Net, LLC set forth in this Addendum shall be solely the obligations of Health Net Community Solutions, Inc. and not the obligations of Health Net, LLC or any other Affiliate of Health Net, LLC. Health Net has entered into one or more Medi-Cal prepaid health plan agreements with the California Department of Health Care Services ("DHCS"). For the purposes of this Addendum, Health Net's Medi-Cal agreements with the DHCS and any subcontracts with Medi-Cal prepaid health plans, are hereinafter collectively referred to as the "Medi-Cal Agreement". Health Net has agreed, under the Medi-Cal Agreement, to provide medical services covered under California's Medi-Cal Program, including Provider risk services, to Medi-Cal HMO Beneficiaries enrolled in or otherwise assigned to Health Net, on a prepaid basis. The provisions of the Addendum are required to appear in all subcontracts under the Medi-Cal Agreement by the terms of the Medi-Cal Agreement and by Medi-Cal law and may not be altered. When required under Medi-Cal law, the Agreement shall be effective upon approval by DHCS in writing or operation of law where DHCS has acknowledged receipt of the Agreement and failed to approve or disapprove within sixty (60) calendar days.

**NOTE TO NEGOTIATOR: the following two paragraphs apply only to Providers participating in the CalViva Health program in Fresno, Kings and Madera Counties. The text should be deleted for all other providers.**

Provider understands and agrees that Health Net Community Solutions, Inc. is an Affiliate of Health Net and of Health Net of California, Inc. and has entered into an agreement with the Fresno-Kings-Madera Regional Health Authority (CalViva Health) to provide Covered Services to Medi-Cal beneficiaries in Fresno, Kings and Madera Counties who enroll in CalViva Health. Provider understands and agrees that Health Net of California, Inc. is providing Covered Services as a subcontractor to Health Net Community Solutions, Inc. for the CalViva Health Medi-Cal membership. Provider further understands and agrees that it will provide Covered Services to CalViva Health Medi-Cal members pursuant to the Agreement and that all terms and conditions of the Agreement, including reimbursement, shall apply to the provision of Covered services to the CalViva Health Medi-Cal members.

Health Net has or may enter into contracts with certain Payors, including local initiatives such as Cal Viva Health in Fresno, Kings and Madera Counties, to provide or arrange for Covered Services to Medi-Cal beneficiaries enrolled in the Medi-Cal plans of such Payors. Provider understands and agrees that a Payor may have adopted policies and procedures, including, but not limited to, quality assurance and quality improvement programs. Provider further understands and agrees that Provider and its Participating Providers shall comply with all the policies and procedures adopted by a Payor and shall participate in the Payor's quality assurance and quality improvement programs.

#### **A. COMPENSATION PROVISIONS.**

**1. Medi-Cal Benefit Programs.** Provider shall arrange and provide Contracted Services to Medi-Cal HMO Beneficiaries of Health Net's Benefit Programs covered under this Addendum on a fee-for-service basis except for Hospital Services rendered to Medi-Cal HMO Beneficiaries assigned to a Provider under a Capitation compensation method. As compensation for providing such Contracted Services, Provider shall be paid in accordance with the rates set forth on Exhibit C-1. Such compensation shall be paid within forty-five (45) working days of receipt of a complete and accurate claim for Covered Services rendered to a Medi-Cal HMO Beneficiary who is not assigned to a provider under a capitation compensation method.

Notwithstanding anything to the contrary contained in this Agreement, if Provider is decertified, suspended and/or terminated by the California Department of Health Care Services ("DHCS"), or other governmental agencies ("DHCS Notice"), Provider acknowledges that it will not be eligible to receive reimbursement for Contracted Services following the date of the DHCS Notice and Health Net will have no liability to pay Provider under this Agreement upon receipt of the DHCS Notice.

**2. Billing.** Notwithstanding anything to the contrary to the Agreement, if Provider is compensated on a fee-for-service basis, Provider shall submit to Health Net, via Health Net's electronic claims submission program or

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hardcopy as determined by Health Net, Complete Claims within one hundred eighty (180) days after the month in which the Covered Service is rendered unless Provider demonstrates good cause pursuant to applicable State law. Where Health Net is the secondary payor under Coordination of Benefits, Provider shall submit Complete Claims for Covered Services accompanied by the explanation of benefits (EOB) or explanation of payment (EOP) from the primary payor to Health Net within one hundred eighty (180) days of the date of the EOB/EOP.

If the Provider fails to comply with the timely claims submission/filing requirements set forth above, Health Net shall reimburse the Provider at the following rates: 75% of usual allowance for claims submitted during the seventh through ninth month after the month of service; 50% of usual allowance for claims submitted during the tenth through the twelfth month after the month of service. Health Net shall not be liable for payment to Provider for any Complete Claims received after the twelfth month after the month of service.

## **B. GENERAL PROVISIONS**

1. Provider is certified to participate in Medicaid/Medi-Cal under Title XIX of the Social Security Act or other applicable State law pertaining to Title XIX of the Social Security Act.

2. **Provision of Covered Services.** Provider shall arrange Covered Services for assigned Beneficiaries. For the purposes of this Addendum, "Covered Services" means those health care services, supplies, and items that are specified as being covered under the Medi-Cal Agreement. Provider and its subcontractors shall arrange Covered Services for Beneficiaries, in accordance with the following, each of which is hereby incorporated by reference as if set out in full herein:

- a) The terms and conditions of this Addendum and the Agreement.
- b) The terms and conditions of the Medi-Cal Agreement and the applicable Evidence of Coverage.
- c) Health Net Medi-Cal policies and procedures and physician bulletins.
- d) DHCS Medi-Cal Managed Care Division (MMCD) Policy Letters.
- e) All laws applicable to Provider and Health Net.
- f) Health Net's Utilization Care Management Program and Quality Improvement Program.
- g) Standards requiring services to be provided in the same manner, and with the same availability, as services are rendered to other patients.
- h) No less than the minimum clinical quality of care and performance standards that are professionally recognized and/or adopted, accepted, or established by Health Net.

3. **Preparation and Retention of Records; Access to Records; Audits.** Provider shall prepare and maintain medical and other books and records required by law in a form maintained in accordance with the general standards applicable to such book or record keeping. Provider shall maintain such financial, administrative, and other records as may be necessary for compliance by Health Net with all applicable local, State, and federal laws. Provider shall retain such books and records for a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later; and shall retain all encounter data for a period of at least ten (10) years. Provider shall make Provider's premises, facilities, equipment, books, records, contracts, computer and other electronic systems and encounter data pertaining to the goods and services furnished under the terms of the Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying by Health Net, DHCS, the Centers for Medicare & Medicaid Services (CMS), the United States Department of Health and Human Services (DHHS), the California Department of Managed Health Care (DMHC), Inspector General, the Comptroller General, the United States Department of Justice (DOJ), or their designees and any other regulatory agency having jurisdiction over Health Net. The records shall be available at Provider's place of business, or at such

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other mutually agreeable location in California. When such entities request Provider's records, Provider shall produce copies of the requested records at no charge. Provider shall permit Health Net, and its designated representatives, and designated representatives of local, State, and federal regulatory agencies having jurisdiction over Health Net, to conduct site evaluations and inspections of Provider's offices and service locations. Provider shall comply with all monitoring provisions of the Medi-Cal Agreement and any monitoring requests by DHCS. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. [22 CCR § 53250(e)(1); W & I § 14452(c); Medi-Cal Agreement]. Furthermore, Provider shall timely gather, preserve, and make available to DHCS, CMS, the Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in Provider's possession related to the recovery for litigation, pursuant to the Medi-Cal Agreement.

**4. Subcontracting Under the Agreement.** Provider shall not subcontract for the performance of services under the Agreement without the prior written consent of Health Net. Every such subcontract shall be in writing and provide that it is terminable with respect to Beneficiaries by Provider upon Health Net's request. Provider shall furnish Health Net or DHCS with copies of such subcontracts, and amendments thereto, within ten days of execution or upon request. Each such subcontracting Provider shall meet Health Net's credentialing requirements, prior to the subcontract becoming effective. Provider shall be solely responsible to pay any health care Provider permitted under the subcontract, and shall hold, and ensure that health care Providers hold, Health Net, Beneficiaries and the State harmless from and against any and all claims which may be made by such subcontracting Providers in connection with services rendered to Beneficiaries under the subcontract. Provider shall maintain and make available to Health Net, DHCS, the Centers for Medicare & Medicaid Services (CMS), the United States Department of Health and Human Services (DHHS), the California Department of Managed Health Care (DMHC), Inspector General, the Comptroller General, the United States Department of Justice (DOJ), or their designees and any other regulatory agency having jurisdiction over Health Net, copies of all Provider's subcontracts under the Agreement and to ensure that all such subcontracts are in writing and require that the subcontractor: (1) make premises, facilities, equipment, books, records, contracts, computer and other electronic systems available for the purpose of an audit, inspection, evaluation, examination, or copying by said entities; (2) retain such books and records for a term of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later; (3) maintain such books and records in a form maintained in accordance with the general standards applicable to such book or record keeping. [22 CCR § 53250(e)(3)]

**5. Federal Disclosure Form.** Provider shall submit to Health Net a completed Disclosure Form, attached to this Addendum, for officers and other persons associated with PPG as required by 42 CFR 455.104, 455.105 and 455.106 and California Welfare and Institutions Code § 14452(a).

**6. Medi-Cal HMO Beneficiary Education.** Provider shall make health education materials and programs available to Medi-Cal HMO Beneficiaries on the same basis that it makes such materials and programs available to the general public and shall use its best efforts to encourage Medi-Cal HMO Beneficiaries to participate in such health education programs. [Medi-Cal Agreement].

**7. Medi-Cal HMO Beneficiaries and State Held Harmless.** Provider agrees that in no event, including, but not limited to, non-payment by Health Net, the insolvency of Health Net, or breach of the Agreement, shall Provider or a subcontractor of Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries, the State of California, or persons other than Health Net acting on their behalf for services provided pursuant to the Agreement. Provider agrees: (1) this provision shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Medi-Cal HMO Beneficiaries; and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Medi-Cal HMO Beneficiaries or persons acting on their behalf. Any modification, addition, or deletion of or to the provisions of this clause shall be effective on a date no earlier than fifteen (15) days after the DHCS has received written notice of such proposed change and has approved such change. [22 CCR § 53250(e)(6)].

**8. No Surcharges and No Copayments.** Provider shall not charge a Medi-Cal HMO Beneficiary any fee, surcharge or Copayment for health care services rendered pursuant to the Agreement except when explicitly allowed by the Medi-Cal Benefit Program, for covered services rendered pursuant to the Agreement. In addition,

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Provider shall not collect a sale, use or other applicable tax from Medi-Cal HMO Beneficiaries for the sale or delivery of medical services. If Health Net receives notice of any additional charge, Provider shall fully cooperate with Health Net to investigate such allegations and shall promptly refund any payment deemed improper by Health Net to the party who made the payment. [Knox-Keene Act and Medi-Cal Agreement].

**9. Grievances and Appeals.** Provider agrees to work with Health Net to resolve all grievances and appeals relating to the provision of services to Medi-Cal HMO Beneficiaries in accordance with the Health Net Medi-Cal grievance and appeal procedures.

**10. Provider Patient Relationship.** Provider shall be solely responsible, without interference from Health Net or its agent, for providing Hospital Services to Medi-Cal HMO Beneficiaries, and shall have the right to object to treating any individual who makes onerous the relationship between Provider and Medi-Cal HMO Beneficiary. In the event of a breakdown in such relationship, Health Net shall make reasonable efforts to assign the Medi-Cal HMO Beneficiary to another Participating Provider. If reassignment is unsuccessful, a request may be filed with the DHCS to permit termination of services to such Medi-Cal HMO Beneficiary. Approval from the DHCS must be obtained before Provider terminates services to such Medi-Cal HMO Beneficiary.

**11. Fair Employment Requirements.** During the term of this Agreement, Provider and its subcontractors shall not unlawfully discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military or veteran status. Provider and its subcontractors also shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination. Provider and its subcontractors shall comply with the provisions of the Fair Employment and Housing Act (California Government Code, Section 12990 *et seq.*) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0 *et seq.*). The applicable regulations of the Fair Employment & Housing Council implementing Government Code, Section 12990, set forth in Subchapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider and its subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreements.

**12. Governing Law.** The Agreement shall be governed by and construed and enforced in accordance with all laws and contractual obligations incumbent upon Health Net. Provider shall comply with all applicable local, State, and federal laws, now or hereafter in effect, to the extent that they directly or indirectly affect Provider or Health Net, and bear upon the subject matter of the Agreement. Provider shall comply with the provisions of the Medi-Cal Agreement, and Chapters 3 and 4 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations. In addition, Health Net is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations. Any provision required to be in the Agreement by either of the above laws shall bind the parties whether or not provided in the Agreement. [22 CCR § 53250(c) (2)]; W & I § 14452(a); Knox-Keene Act].

**13. Notice.** Provider shall notify DHCS in the event this Agreement is amended or terminated. Notice to DHCS is considered given when properly addressed and deposited with the United States Postal Service as first class registered mail, postage attached. [Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13, and Title 22, CCR, Sections 53250(e)(4) and 53867.]

**14. Reports:** Provider shall provide Health Net, within the time requested by Health Net, with all such reports and information as Health Net may require to allow it to meet the reporting requirements under the Medi-Cal Agreement or any applicable law or regulatory directive. [Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867]. Furthermore, Provider shall submit to Health Net, complete, accurate, reasonable, and timely provider data requested by Health Net in order for Health Net to meet its provider data reporting requirements to DHCS. [Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.]

**15. Confidentiality of Information.** Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 45, Code of Federal Regulations, Section 205.50 and Section 14100.2 of the California Welfare and Institutions Code and the regulations adopted thereunder. For the purposes of this Agreement, all information, records, data, and data elements collected and maintained for or

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in connection with performance under this Agreement and pertaining to Medi-Cal HMO Beneficiaries shall be protected by Provider from unauthorized disclosure. With respect to any identifiable information concerning a Medi-Cal HMO Beneficiary under this Agreement that is obtained by Providers or its subcontractors, Provider: (1) will not use any such information for any purpose other than carrying out the express terms of this Agreement; (2) will promptly transmit to Health Net all requests for disclosure of such information; (3) will not disclose, except as otherwise specifically permitted by this Agreement, any such information to any party other than Health Net without Health Net's prior written authorization specifying that the information is releasable under applicable law, and (4) will, at the expiration or termination of this Agreement, return all such information to Health Net or maintain such information according to written procedures provided Provider by Health Net for this purpose. Provider shall ensure that its subcontractors comply with the provisions of this paragraph.

**16. Third Party Tort Liability.** Provider shall make no claim for recovery for health care services rendered to a Medi-Cal HMO Beneficiary when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance, including workers' compensation awards and uninsured motorist coverage. Within five (5) days of discovery, Provider shall notify Health Net of cases in which an action by the Medi-Cal HMO Beneficiary involving the tort or workers' compensation liability of a third party could result in a recovery by the Medi-Cal HMO Beneficiary. Provider shall promptly provide: (1) all information requested by Health Net in connection with the provision of health care services to a Medi-Cal HMO Beneficiary who may have an action for recovery from any such third party; (2) copies of all requests by subpoena from attorneys, insurers or Medi-Cal HMO Beneficiaries for copies of bills, invoices or claims for health care services; and (3) copies of all documents released as a result of such requests. Provider shall ensure that its subcontractors comply with the requirements of this provision.

**17. Amendments.** When required under Medi-Cal law, Amendments to the Agreement shall be submitted by Health Net to the DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes, which are neither approved nor disapproved by the Department, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later. Subcontracts between a prepaid health plan and a subcontractor shall be public records on file with the DHCS. [22 CCR §§ 53250(a), (c)(3), & (e)(4); W & I § 14452(a)].

**18. Notice of Change in Availability or Location of Covered Services.** Health Net is obligated to ensure Medi-Cal HMO Beneficiaries are notified in writing of any changes in the availability or location of Covered Services at least thirty (30) days prior to the effective date of such changes, or within fourteen (14) days prior to the change in cases of unforeseeable circumstances. Such notifications must be approved by DHCS prior to the release. In order for Health Net to meet this requirement, Provider is obligated to notify Health Net in writing of any changes in the availability or location of Covered Services at least forty (40) days prior to the effective date of such changes.

**19. Transfer of Care Upon Termination of the Agreement.** Provider shall, pursuant to the requirements of the Medi-Cal Agreement, assist in the orderly transfer of care of all Medi-Cal HMO Beneficiaries under the care of Provider in the event of the termination of the Agreement for any reason.

**20. Assignment and Delegation.** Assignment or delegation of an obligation or responsibility under the Agreement shall be void unless prior written approval is obtained from the DHCS, in the instances where approval by the DHCS is required.

**21. Carve-out of California Children's Services (CCS) Program Services.** The parties acknowledge that health care services to treat CCS-eligible conditions are "carved out" of Health Net's coverage obligations under the Medi-Cal Benefit Programs. Provider shall identify and timely refer Beneficiaries with possible CCS-eligible conditions to the appropriate County CCS Program. Upon referral, Provider shall inform the Beneficiary's parent or guardian and shall notify Health Net of any such referral. The CCS Program requires eligible children to be treated at CCS-certified facilities by CCS-paneled providers. The CCS Program may require transfer to CCS-certified facilities with CCS-paneled providers. The CCS Program is financially responsible for payment of health care costs to treat a CCS-eligible condition. The parties understand and agree that Health Net is not financially responsible for payment of services to treat CCS-eligible conditions. In the event Health Net inadvertently pays a claim for such services, Health Net may recover the amount paid pursuant to Section 4.3 of the Agreement.

**22. Cultural and Linguistic Services.** Provider shall: (1) not require or encourage Beneficiaries to utilize family Beneficiaries or friends as interpreters; (2) record the language needs of Beneficiaries in the medical record; and (3) document Beneficiary requests or refusals of interpreter services in the Beneficiary's medical record. Provider shall arrange interpreter services for Beneficiaries either through telephone language services or face-to-face interpreters. Provider is encouraged to directly make these interpretive services available. However, upon request, Health Net's Member Services Department is available to provide certain interpretive assistance to facilitate communications. Health Net shall: (1) Provide cultural competency/humility, sensitivity, health equity, and diversity training to Health Net's contracted providers. Provider must ensure that cultural competency/humility, sensitivity, health equity, and diversity training is provided for its employees and staff at key points of contact with Beneficiaries per the Medi-Cal Agreement.

**23. Provider Preventable Conditions.** Health Net and Provider shall comply with the Patient Protection and Affordable Care Act (PPACA), as amended, including any reporting requirements and non-payment for Provider Preventable Conditions. Provider shall comply with Health Net's Policies regarding any reporting requirements and non-payment for Provider Preventable Conditions.

**24. Reviews and/or Investigations.** Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and direct Health Net to terminate Provider's Agreement due to fraud.

**25. Prospective Requirements.** Health Net shall inform Provider of prospective requirements added by DHCS to the agreement between Health Net and DHCS, before the effective date of such requirements. Provider agrees to comply with any changes to such requirements within thirty (30) days of the effect of said requirements from DHCS, unless DHCS instructs otherwise and to the extent possible.

**26. Coordination of Care.** To the extent that Provider is responsible for the coordination of care for Members, Health Net shall share with Provider any utilization data that DHCS has provided to Health Net to use for the purpose of Member care coordination.

**27. Emergency Service Providers.** Health Net is responsible for coverage and payment of emergency services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has an agreement with Health Net. Post-stabilization care services following an emergency inpatient admission are covered and paid for in accordance with provisions set forth in 42 CFR 422.113 (c) .

**28. Provider's Performance.** This Agreement is subject to termination, or other actions, fines, and/or penalties, if DHCS or Health Net determine that Provider has not performed satisfactorily.

**29. Suspected Fraud, Waste, or Abuse.** Provider must notify Health Net, and Health Net Subcontractors or Downstream Subcontractors Provider also contracts with, within ten (10) business days of any suspected Fraud, Waste, or Abuse. Health Net shall share such information with DHCS in accordance with the Medi-Cal Agreement.

**30. Emergency Preparedness.** Provider shall i.) annually submit to Health Net evidence of adherence to CMS Emergency Preparedness Final Rule 81 FR 63859; ii.) advise Health Net as part of Provider's Emergency plan; and iii.) notify Health Net within 24 hours of an Emergency if Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency. Emergency for purposes of this section shall include any natural or manmade disaster or public health crisis.

**31. Local Health Department Coordination.** As more fully set out in the Medi-Cal Agreement, Health Net or a contracting Medi-Cal plan has (or will) entered into agreements for specified public health services with certain county health departments. The public health agreements specify the scope and responsibilities of the local health departments and Health Net, billing and reimbursements, reporting responsibilities, and medical record management to ensure coordinated health care services. The public health services specified under the agreements are as follows:

- 31.1 Family planning services;
- 31.2 Sexually transmitted disease ("STD") services diagnosis and treatment of disease episode of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale;
- 31.3 Confidential HIV testing and counseling;
- 31.4 Immunizations;
- 31.5 Child Health and Disability Prevention Program;
- 31.6 California Children Services;
- 31.7 Maternal and Child Health;
- 31.8 Refugee assessments;
- 31.9 Tuberculosis Direct Observed Therapy;
- 31.10 Women, Infants, and Children Supplemental Food Program;
- 31.11 Population based Prevention Programs: collaborate in local health department community based prevention programs.

Provider shall, in accordance with the terms and conditions of the public health agreements with the local health departments and Health Net's related policies and procedures, be responsible for the coordination and arrangement of the public health services for its assigned Beneficiaries. The services specified in Sections 31.1 through 31.5 above require reimbursement to the applicable local health department. The services specified in Sections 31.6 through 31.11 above do not require reimbursement to the applicable local health department. [Medi-Cal Agreement]

**EXHIBIT C-1**

**MEDI-CAL FEE-FOR-SERVICE RATE EXHIBIT**

Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Exhibit C-3, Health Net shall pay, and Provider shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered pursuant to this Addendum C, the lesser of: (i) the rates listed below, or (ii) 100% of Provider’s Allowable Charges.

<b>Category of Service</b>	<b>Compensation</b>
Inpatient Services	100% of APR-DRG based on the current statewide wage-adjusted base rate in effect at the time of service
Inpatient Surgical Implants/Prosthetics/Durable Medical Equipment/Surgical Supplies	Included in case rate or per diem.
<b>Outpatient Services</b>	
Outpatient Services	100% of the current Medi-Cal Fee Schedule, subject to any changes made by the State of California
Outpatient Surgical Implants/Prosthetics/Durable Medical Equipment/Surgical Supplies with a Medi-Cal Value	100% of the current Medi-Cal Fee Schedule, subject to any changes made by the State of California
Pharmaceuticals with an established Medi-Cal Value	100% of the current Medi-Cal Fee Schedule
Pharmaceuticals without an established Medi-Cal Value	Average Wholesale Price (AWP) – 18%
Unlisted Procedures	
Procedures with Medi-Cal Units not Established but with a Medicare Value	80% of the Current Medicare Allowable
Procedures without Medi-Cal Units and without a Medicare Established Value	15% of Provider’s Allowable Charges

\* For services or items reimbursed at “Invoice Cost,” Provider agrees to submit an invoice with the claim.

**EXHIBIT C-2**

**MEDI-CAL BENEFIT PROGRAMS  
DISCLOSURE FORM**

(Required by California Welfare and Institutions Code Section 14452)

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency;

- 1) the identity of all owners with a control interest of five (5) percent or greater,
- 2) certain business transactions as described in 42 CFR 455.105, and
- 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity.

If there are any changes to the information disclosed in this form, an updated form should be completed and submitted to Health Net Community Solutions, Inc. within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity		
Name of Individual, Group Practice, or Disclosing Entity		
DBA Name		
Federal Tax Identification Number	NPI	CAQH Number

Section I

Please list the name, title address, date of birth, and Social Security Number for each individual having an ownership or control interest in this provider of five (5) percent or greater.			
Please list the name, Tax Identification Number, business address or each organization, corporation, or entity having an ownership or control interest of five (5) percent or greater. (42 CFR 455.104) Please attach a separate sheet if necessary.			
Name of individual or entity	DOB	Address	SSN (for individual) or TIN (for entity)

Section II

Are any of the individuals listed in Section one related to each other?

Yes  
 No

If yes, list the individual's name above who are related to each other (spouse, sibling, parent, child). 42 CFR 455.104

Name	Relationship

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of five (5) percent or more?

Yes  
 No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of five (5) percent or more. 42 CFR 455.104

Name of individual or entity	DOB	Address	SSN (for individual) or TIN (for entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program?

Yes  
 No

If yes, list those persons below. 42 CFR 455.106

Name and Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more of than \$25,000 or any significant business transactions with any subcontractors?

Yes  
 No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than \$25,000 during the previous twelve (12) month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past five (5) year period. 42 CFR 455.105

Name of Supplier or Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information) as a Disclosing Entity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth, Address, Social, Security Number, and percent of interest.				
Name and Title	DOB	Address	SSN	% of Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

\_\_\_\_\_  
 Signature Title (indicate if authorized Agent)

\_\_\_\_\_  
 Name (please print) Date

## EXHIBIT C-3

### FACILITY FEE-FOR-SERVICE PAYMENT CONDITIONS

The Payment Conditions set forth in this Exhibit C-3 supplement Health Net Policies and are applicable to the Medical Benefit Program.

1. The codes listed in the applicable Rate Exhibit shall be used by the parties for the purpose of defining the services for which payment will be made under this Agreement. Provider shall utilize the specified codes listed in the applicable Rate Exhibit when submitting Complete Claims for Covered Services under this Agreement.

2. The parties acknowledge that applicable coding agencies periodically issue coding modifications. Such modifications may be implemented by Health Net within sixty (60) days of the date Health Net receives the modification from the applicable coding agency or notification from Provider. The parties agree that in the event such coding modifications have the effect of changing a payment amount in this Agreement, the resulting payment amount change shall be effective on a prospective basis. The parties further agree to reasonably and in good faith discuss any contract rate amendment that may be appropriate based on comprehensive and substantive coding changes by the applicable coding agency within ninety (90) days of written notification by either party. Any and all rate modifications that may result from such contract amendment shall be effective on a prospective basis.

3. Only one per diem or case rate shall be payable a) for each Beneficiary who is admitted prior to midnight and remains past midnight; b) if a Beneficiary is admitted and discharged during the same day, provided that such admission and discharge is not within forty-eight (48) hours of a prior discharge; c) for mother and newborn child (children) when both mother and newborn child (children) are in the facility on the same day, unless the child (children) is in the neonatal intensive care unit. Pre-admission testing completed within three (3) days of admission will be included in the per diem and will not be billed separately by Provider. A per diem is an all-inclusive daily payment, including but not limited to observation services, supplies, implants, prosthetics, durable medical equipment, and pharmaceuticals with the exception of specific carve-outs or exclusions identified on the applicable rate exhibit. Inpatient Professional services billed by the Provider on behalf of the hospital-based physician(s) are included in the per diems or case rates. Admission kits are included in the per diem rate. Any Outpatient Services delivered to a Beneficiary within twenty-four (24) hours prior to an admission for Inpatient Services for the same medical condition at the same facility are included in the inpatient rate.

4. The rates set forth in this Agreement apply only to inpatient admissions commencing on or after the Effective Date of this Agreement. The applicable rate of payment that is in effect on the date an inpatient admission commences shall apply to the entire length of stay regardless of any rate change that may occur during the length of stay. **Notwithstanding the foregoing, inpatient case rates are applicable beginning the first day of admission if a case rate procedure is performed at any time during the inpatient stay.**

**NOTE TO NEGOTIATOR: Please delete the above highlighted sentence and replace with the following language when inpatient case rates are negotiated in addition to per diems. "Notwithstanding the foregoing, inpatient case rates are applicable the day a case rate procedure is performed."**

5. All inpatient rates shall include any readmission charges if the patient is readmitted within thirty (30) days following discharge for complications related to the prior admission. Should non-standard conditions occur, the second admission within thirty (30) days may be eligible for reimbursement, provided such admission is in accordance with Health Net Policies.

6. If a Beneficiary is admitted to the hospital from the emergency room and/or observation room, separate reimbursement for the emergency room, observation room and other outpatient charges shall not be paid; however, the applicable inpatient reimbursement shall be reimbursed as all-inclusive reimbursement.

The rate payable for Emergency Services is an all-inclusive case rate, including but not limited to supplies, implants, prosthetics, durable medical equipment, observation charges, diagnostic services, therapeutic services, pharmaceuticals, and other services incidental to the emergency room visit, with the exception of specific exclusions identified on the applicable rate exhibit. (Remove if ER reimb on % of BC without NTE.)

7 The all-inclusive procedure rate payable for outpatient surgery (including Cardiac Cath/PTCA, etc., when applicable) is an all-inclusive case rate, including but not limited to supplies, implants, prosthetics, durable medical equipment, emergency room charges, observation charges, diagnostic services, therapeutic services, and pharmaceuticals with the exception of specific exclusions identified on the applicable rate exhibit. Only one (1) case rate shall be paid for each Beneficiary per date of service. [NOTE: Include any other significant case rates in this paragraph.]

8. Other Outpatient case rates are an all-inclusive payment, including but not limited to supplies, diagnostic services, therapeutic services, and pharmaceuticals with the exception of specific exclusions identified on the applicable rate exhibit. Only one (1) case rate shall be paid for each Beneficiary per date of service; provided, however, that if one or more unique case rate procedure is performed on different body parts, each applicable case rate shall be reimbursed.

9. Provider shall be reimbursed for multiple and bilateral procedures, or when more than one surgical procedure is performed under the same anesthesia during an operative session:

**[NOTE TO NEGOTIATOR: Only use Multiple Procedures hierarchy below when not using case rate. If using case rate, delete section below.]**

- (i) The procedure in the highest payment category shall be paid at 100% of the applicable contract rate;
- (ii) The second-ranking procedure shall be paid at 50% of the applicable contract rate;
- (iii) All other procedures are paid at 50% of the applicable contract rate.

10. Pharmaceuticals shall include inhaled/infused/injected medications provided by and delivered in a hospital outpatient/ambulatory setting. AWP pricing shall be determined by Health Net utilizing a nationally recognized source for pharmaceutical pricing to be updated at least quarterly. Provider shall bill administered dosage in accordance with applicable HCPCS and NDC codes. Multi-dose vials shall be reimbursed on a per dose basis.

11 In the event that a Beneficiary is transported either within Provider's Facility or to another facility for a service that is within Provider's customary scope of practice, but due to malfunction or other cause cannot be delivered, Provider shall be solely financially responsible for claims incurred for such transportation.

12. For purposes of this Agreement, New Service/Technology is defined as a service, procedure, device, test, or other item that, as of the effective date of this Agreement: (i) is not performed by Provider, or (ii) is not Covered by Health Net under the applicable Benefit Program, or (iii) for which there is no assigned CPT or other relevant code defined. New Service/Technology does not include a new code that is assigned as a change to an existing service, procedure, device, test, or other item. If Provider offers a New Service/Technology after the effective date of this Agreement for which Provider desires reimbursement under this Agreement, Provider agrees to give Health Net sixty (60) days prior written notice that Provider requests that such New Service/Technology be included in Contracted Services, and that Provider receive a different reimbursement rate for the use of such New Service/Technology for Beneficiaries. Health Net agrees to determine whether such New Service/Technology qualifies as a Covered Service and whether Health Net desires to include such New Service/Technology in Contracted Services within thirty (30) days of the date of Provider's notice hereunder. Health Net's determination of whether a New Service/Technology qualifies as a Covered Service shall be made in Health Net's sole discretion and shall be final and binding on Provider with respect to this Agreement. Only if Health Net agrees that such New Service/Technology is a Covered Service and desires to include such New Service/Technology in Contracted Services, the parties shall enter into good faith negotiations to modify Provider's rates to reflect the New Service/Technology. Any rate modification shall be made only prospectively.

13. The lowest room and board allowable charge rate shall apply to all days billed within the same revenue code level of care.

14. If any payment rates are based on Provider's Allowable charges, upon Health Net's written request, Provider shall make Provider's current Charge Master available to Health Net within ten (10) days in electronic format. Provider shall notify Health Net in writing via certified letter at least sixty (60) days prior to making any changes to Provider's Charge Master ("Notice"). The rates in Provider's Charge Master before (insert contract effective date), shall be the "Baseline Charge Master". Changes to the Baseline Charge Master shall be measured during the twelve (12) month period immediately preceding the date of the Notice ("Measurement Period"). The Notice shall be signed by Provider's Chief Financial Officer (or equivalent) and shall include a statement of any and all changes made to the Baseline Charge Master during the Measurement Period together with the effective date of such change. All changes included in the Notice shall be calculated using the methodology set forth herein. Any change to Provider's Charge Master during the term of this Agreement shall result in a proportional change to reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the stop-loss threshold (if applicable) set forth in the applicable addendum and/or exhibit to this Agreement. The terms of this section shall survive termination of this Agreement with respect to Contracted Services rendered during the term of the Agreement. The methodology for calculating Changes to the Charge Master and rates pursuant to this section is as follows:

a) First Year: Provider agrees that any Notice delivered during the first year of this Agreement shall reflect no changes made to the Baseline Charge Master. In the event Provider has made changes to its Baseline Charge Master, any such change shall result in a proportional change to reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the stop-loss threshold (if applicable) set forth in the applicable addendum and/or exhibit to this Agreement, such that there will not be a change to Health Net's reimbursement to Provider during the first year of this Agreement.

In the event Health Net exercises its right to reconcile and adjust payment, Health Net shall give Provider at least thirty (30) days prior written notice, which notice shall be attached to the applicable rate exhibit in this Agreement and any subsequent addendums and/or exhibits. Any such change in rates shall be implemented upon thirty (30) days prior written notice to Provider and shall be applicable to all claims with dates of service on or after the date of the Charge Master increase in excess of the contractual allowance. Health Net shall use the above methodology for calculating changes to the Charge Master and rates pursuant to this section.

b) Subsequent Years: For each subsequent Measurement Period, Provider shall not change Provider's Baseline Charge Master in a manner that results in an increase in reimbursement under this Agreement by more than (insert percentage, in words) percent (xx%) in the aggregate, unless expressly agreed upon in writing by the parties hereto. Upon request, Provider shall promptly provide Health Net with a Notice that completely and accurately sets forth any and all changes during the Measurement Period. Health Net shall have the right to reconcile and reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the stop-loss threshold (if applicable) set forth in the applicable addendum and/or exhibit to this Agreement. In the event Health Net exercises its right to reconcile and adjust payment, Health Net shall give Provider at least thirty (30) days prior written notice, which notice shall be attached to the applicable rate exhibit in this Agreement- and any subsequent addendums and/or exhibits. Any such change in rates shall be implemented upon thirty (30) days prior written notice to Provider and shall be applicable to all claims with dates of service on or after the date of the Charge Master increase in excess of the contractual allowance.

c) Both parties agree that Charge Master changes shall be calculated using Provider's aggregate weighted average charge increase where weights equal volume for specific charges.

Health Net may periodically review Provider's Charge Master filed with the State or Health Net's historical claims data. If Health Net determines as a result of such review that Provider has made changes to the Baseline Charge

Master but has failed to give Health Net Notice, the parties agree that such changes shall result in a proportional change to reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the stop-loss threshold (if applicable) set forth in the applicable addendum and/or exhibit to this Agreement and any subsequent addendum and/or exhibits. Any such change in rates shall be implemented upon thirty (30) days prior written notice to Provider and shall be applicable to all claims with dates of service on or after the date of the Charge Master increase in excess of the contractual allowance.

**PROVIDER PARTICIPATION AGREEMENT**  
**Between**  
**HEALTH NET OF CALIFORNIA, INC.**  
**And**  
**<<PROVIDER>>**

This Provider Participation Agreement (“Agreement”) is made and entered into as of the \_\_\_\_ day of \_\_\_\_\_, 20\_\_ (the “Effective Date”) by and between **[INSERT NAME OF PROVIDER]** (“Provider”), and Health Net of California, Inc. on behalf of itself and its subsidiaries and affiliates (collectively, “Health Net”).

**RECITALS**

- A. Provider has the legal authority to enter into this Agreement, and to deliver or arrange for the delivery of Contracted Services.
- B. Health Net has the legal authority to enter into this Agreement, and to perform the obligations of Health Net hereunder with respect to the Benefit Programs.
- C. The parties desire to enter into this Agreement to arrange for Provider to participate in one or more of Health Net’s networks of Participating Providers that render Contracted Services to Beneficiaries of various Benefit Programs.
- D. Provider’s primary consideration shall be the quality of the health care services rendered to Beneficiaries, pursuant to Title 10 CCR 2240.4

**AGREEMENT**

NOW, THEREFORE, in consideration of the above recitals and the covenants contained herein, the parties hereby agree as follows:

**I. DEFINITIONS**

Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Article I.

**1.1 Allowable Charges.** Defined as Provider’s billed charges for Contracted Services.

**1.2 Beneficiary.** A person who is properly enrolled in and eligible to receive Covered Services under a Benefit Program at the time Covered Services are rendered. The parties acknowledge that the term ‘member’ may be used by Health Net in certain related materials, such as Benefit Program documents covering various products, marketing materials, and Health Net Policies. For reference purposes, the term Beneficiary includes the term ‘member’ wherever used.

**1.3 Benefit Program.** The group agreement, evidence of coverage, certificate of insurance, summary plan description or similar documents in effect at the time Covered Services are rendered for lines of business offered through Health Net. The Benefit Programs in which Provider participates and terms and conditions such as payment rates relating to such Benefit Programs, are set forth in the Addenda to this Agreement.

**1.4 Coinsurance.** That portion of the cost of Covered Services that a Beneficiary is obligated to pay under a particular Benefit Program which is calculated as a percentage of the contracted reimbursement rate for such services. Coinsurance does not include Copayments or Deductibles.

**1.5 Complete Claim.** A Complete Claim means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides reasonably relevant information as defined by applicable State or federal statutes and regulations, and which is submitted to Health Net or a Payor by

Provider for payment of Contracted Services that may be processed by Health Net or a Payor without obtaining additional information from Provider or from a third party.

**1.6 Contracted Services.** Covered Services that are (i) those services which Provider is licensed to provide and which Provider customarily provides to its patients, and (ii) to be provided to a Beneficiary under the terms of the applicable Benefit Program in effect at the time such services are rendered or as required by State or federal law, and (iii) compensated in accordance with this Agreement except as otherwise may be required by State or federal law.

**1.7 Coordination of Benefits.** The allocation of financial responsibility between two or more payors of health care services, each with a legal duty to pay for or provide Covered Services to a Beneficiary at the same time.

**1.8 Copayment.** That portion of the cost of Covered Services that a Beneficiary is obligated to pay under a particular Benefit Program, which is a fixed dollar amount and is paid at the time Covered Services are rendered. Copayments do not include Coinsurance or Deductibles.

**1.9 Covered Services.** The health care services, equipment and supplies that are covered as determined by the Benefit Program and by applicable State and federal law and regulations, including without limitation decisions issued as a result of independent medical review conducted under applicable State or federal law.

**1.10 Deductible.** The amount of money that a Beneficiary must pay before the Benefit Program pays certain benefits for Covered Services. Deductibles do not include Coinsurance or Copayments.

**1.11 Dispute.** The term “Dispute”, as used in this Agreement, including Sections 7.5 and 7.6, shall mean any controversy or disagreement that may arise out of or relate to this Agreement, or the breach thereof, whether involving a claim in tort, contract or other applicable area of law.

**1.12 Emergency.** The term “Emergency” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient’s health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Active labor is considered an Emergency. “Active labor” means labor at the time that either of the following could reasonably occur: (1) There is inadequate time to effect safe transfer to another Hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the Enrollee or unborn child.

Certain Benefit Plans require adherence to the federal and government program standard for defining and Emergency, which defines an Emergency as : a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the patient’s health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

**1.13 Excluded Services.** Those health care services, equipment and supplies that are determined by Health Net or a Payor to be non-Covered Services under the applicable Benefit Program in effect at the time such services are rendered and for which Provider may bill the Beneficiary.

**1.14 Facility(ies).** All service locations owned, operated, leased, or subcontracted by Provider at which Contracted Services are provided under this Agreement. Provider’s service locations as of the date this Agreement is executed by the parties are listed on the signature page of this Agreement.

**1.15 Health Net.** A network of managed health care delivery or indemnity companies, owned, controlled, controlling, under common control with, managed or administered in whole or in part now or hereafter, by Health Net, LLC, its successors and assigns.

**1.16 Health Net Policies.** The policies, procedures and programs established by Health Net and applicable to Participating Providers in effect at the time Covered Services are rendered, including without limitation Health Net's grievance and appeal procedures, provider dispute and/or appeal process, drug formulary or preferred drug list, fraud detection, recovery procedures, eligibility verification, billing and coding guidelines, payment and review policies, anti-discrimination requirements, medical management programs, continuity of care policies, provider manuals and/or operations manuals. The medical management program includes policies regarding topics such as credentialing, utilization management, quality improvement, catastrophic care management, peer review, medical and other record reviews, outcome rate reviews, Prior Authorization, and Referral.

**1.17 Inpatient Services.** An inpatient day is a measure of time during which a Beneficiary receives hospital services and which occurs when a Beneficiary occupies a bed as of twelve o'clock midnight and is admitted to Provider's Facility. Inpatient Services include, but are not limited to: a) bed and board; b) all medical, nursing, surgical, pharmacy and dietary services; c) all diagnostic and therapeutic services required by a Beneficiary when ordered by an attending physician with appropriate medical and clinical staff privileges; d) use of facilities, and medical, mental health, social services, and discharge planning services required for the provision of Contracted Services; e) drugs while an inpatient, implants, supplies, appliances and equipment; f) transportation services subsequent to admission and prior to discharge required in providing Inpatient Services; g) Covered Services delivered by Professional Providers in Provider's Facility where Provider bills for these services on a CMS UB04 or successor form.

**1.18 Medically Necessary.** A Medically Necessary service or supply is one that meets the following criteria: it is an otherwise covered category of service, not specifically excluded and is recommended by the treating physician and determined by Health Net's Medical Director or physician designee to be: (i) for the purpose of treating a medical condition; (ii) the most appropriate supply or level of service, considering potential benefits and harm to the Beneficiary; not furnished primarily for the convenience of the Beneficiary or Provider; not required solely for custodial, comfort or maintenance reasons; consistent with Health Net Policies and furnished in the most appropriate place of service consistent with nationally recognized review criteria and/or guidelines, such as, for example, Milliman or Interqual criteria; and (iii) known to be effective and safe in improving health outcomes. For new treatments, services or supplies, effectiveness is determined by scientific evidence. For existing treatments, services or supplies, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. The fact that a physician or other provider may prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary or make it a Covered Service.

**1.19 Outpatient Services.** Those services customarily provided at a Facility, and/or a Professional Provider's office, to a Beneficiary who is not admitted as an inpatient, including without limitation Emergency Services, observation services, outpatient and short stay surgery, day program, clinic care, urgent care, and related nursing, surgical, pharmaceutical, dietary, diagnostic and ancillary services.

**1.20 Participating Provider.** A facility, physician, physician organization, physician group, independent practice association, health care provider, supplier, or other organization which has met applicable credentialing requirements, if any, and has, or is governed by, an effective written agreement directly with Health Net or indirectly through another entity, such as a PPG, to provide Covered Services.

**1.21 Payer.** Any public or private entity contracted with Health Net which provides, administers, funds, insures or is responsible for paying Participating Providers for Covered Services rendered to Beneficiaries under a Benefit Program, including self-funded health plans.

**1.22 PPG.** A participating physician group that has entered into an agreement with Health Net to deliver or arrange for the delivery of certain Covered Services to Beneficiaries.

**1.23 Primary Care Physician (PCP).** A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who: (i) is duly licensed and qualified under the laws of the relevant jurisdiction to render certain Covered Services; (ii) is a Participating Provider; and (iii) meets the credentialing standards of Health Net for designation as a PCP;

and (iv) is responsible for coordinating the provisions of health care services and providing for continuity of care and twenty-four (24) hours a day, seven (7) days a week availability to Beneficiaries.

**1.24 Prior Authorization.** The written or electronically issued prior approval by Health Net or its designee for the provision of Covered Services which may be required under a Benefit Program or a Health Net Policy.

**1.25 Professional Provider.** The physicians, allied health professionals and other health care providers who contract with Provider, or are employed by Provider, and who have been accepted by Health Net to provide Contracted Services to Beneficiaries under the terms and conditions of this Agreement, and billed through Provider's federal tax identification number and/or national provider identifier.

**1.26 Records.** Books, documents, contracts, subcontracts, and records prepared and/or maintained by a party that relate to this Agreement whether in written or electronic format, including without limitation medical records, Beneficiary billing and payment records, financial records, policies and procedures, and other books and records that may be required by applicable federal and State law.

**1.27 Referral.** The written or electronically issued referral of a Beneficiary by a Participating Provider to another health care provider that may be required under a Benefit Program or a Health Net Policy prior to the rendition of Covered Services, usually for a specified number of visits or type or duration of treatment.

**1.28 State.** The State of California.

**1.29 Surcharge.** An additional fee which is charged to a Beneficiary for a Covered Service, but which is not approved by the applicable State and federal regulatory authority, and is neither disclosed nor provided for in a Benefit Program.

## **II. DUTIES OF PROVIDER**

**2.1 General Obligations.** Provider agrees on behalf of itself, and each of its Facilities and Professional Providers, as applicable, that during the term of this Agreement and any renewal terms, each of them is:

- 2.1.1 licensed without restriction or limitation by the State to provide Contracted Services to the extent required by the State;
- 2.1.2 operating and providing Contracted Services in compliance with applicable local, State, and federal laws, rules, regulations and legal standards of care;
- 2.1.3 either certified to participate or has not been excluded from participation in Medicare under Title XVIII of the Social Security Act, and in Medicaid/Medi-Cal under Title XIX of the Social Security Act or other applicable State law pertaining to Title XIX of the Social Security Act;
- 2.1.4 accredited or certified by the accrediting or certifying organization(s) listed on the signature page of this Agreement, if any;
- 2.1.5 delivering Contracted Services to Beneficiaries in the same manner and with the same availability, as services are delivered to other patients;
- 2.1.6 maintaining such physical plant, equipment, patient service personnel and allied health personnel as may be necessary to provide Contracted Services;
- 2.1.7 available to Beneficiaries twenty four (24) hours per day, seven (7) days per week on an Emergency basis.
- 2.1.8 Provider shall notify Health Net in writing, thirty (30) days in advance, of any changes to federal tax identification numbers and/or national provider identifier numbers.

- 2.1.9 National Committee for Quality Assurance (“NCQA”) Accreditation of Health Plans Standards. Provider agrees to: i) cooperate with Quality Management and Improvement (“QI”) activities; ii) maintain the confidentiality of Member information and records pursuant to this Agreement; and iii) allow Health Net to use Provider’s performance data.
- 2.1.10 Provider agrees to cooperate and implement the California Health and Human Services Data Exchange Framework data sharing that requires the real time exchange of health information for members as outlined in California Assembly Bill 133 and Health Net Policies.

**2.2 Provision of Services.** Provider agrees to render Contracted Services to Beneficiaries of Benefit Programs under the terms and conditions of this Agreement. Notwithstanding the foregoing, Provider understands and agrees that Health Net or a Payor does not have an obligation under this Agreement to assign or refer to Provider any minimum amount of Beneficiaries. Health Net has not represented or guaranteed to Provider that any Beneficiaries shall receive Covered Services from Provider or that Provider shall participate in all networks of Participating Providers offered by or through Health Net.

Provider acknowledges that Health Net or a Payor shall not be liable for, nor will exercise control or direction over, the manner or method by which Provider, Facilities, and/or Professional Providers render any Covered Services to Beneficiaries under this Agreement.

**2.3 Verification of Eligibility.** Except in an Emergency, Provider shall verify the eligibility of Beneficiaries using Health Net’s telephonically or electronically available system before providing Contracted Services, in compliance with the timeframes and procedures set forth in Health Net Policies.

**2.4 Non-Discrimination.** Provider shall not discriminate against any Beneficiary in the provision of Contracted Services hereunder, whether on the basis of the Beneficiary's coverage under a Benefit Program, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, source of payment, utilization of medical or mental health services, equipment, pharmaceuticals or supplies, health status (including without limitation, Beneficiaries who are, were, or may be victims of domestic violence, or have or may have conditions that are caused by domestic violence), genetic information, or other unlawful basis including, without limitation, the filing by such Beneficiary of any complaint, grievance or legal action against Provider, Health Net or Payor. Provider agrees to make reasonable accommodations for Beneficiaries with disabilities or handicaps, including but not limited to, providing such auxiliary aides and services to Beneficiaries as are reasonable, necessary and appropriate for the proper rendering of Contracted Services at the Provider’s expense..

**2.5 Professional Providers and Facilities.** The following provisions apply when Provider utilizes Professional Providers or Facilities to deliver Contracted Services to Beneficiaries:

- 2.5.1 Provider binds its Facilities and Professional Providers, if any, covered by this Agreement, to the terms and conditions of this Agreement, to the extent Contracted Services and/or contractual provisions are performed by, or apply to, such Facilities and Professional Providers;
- 2.5.2 Health Net and Provider agree to meet and confer in the event Provider desires to add a new or satellite facility to this Agreement. No new or satellite facility shall be added to, or allowed to deliver Covered Services under this Agreement until Health Net has approved such Facility. Health Net may deny participation under this Agreement to any new or satellite facility without any obligation to provide a right to appeal except as may be required by applicable State and federal law.
- 2.5.3 In the event Provider acquires, whether through buying, building, or merger, a new facility or facilities, Provider shall notify Health Net in writing of such new facility or facilities as soon as possible, but in no event later than thirty (30) days after the acquisition. Provider acknowledges and agrees that Health Net shall have the right to

determine whether the new facility or facilities are acceptable to participate in Health Net's network. Notwithstanding the foregoing, Provider understands and agrees that the rates set forth in this Agreement shall apply to any new facility or facilities with like services on the date the Provider acquired such facility or facilities, irrespective of whether Health Net was notified or approved participation in the network. In the event the Provider acquires whether through buying, building, or merger, a new facility or facilities, which does not provide the same scope of services, and where there is not a rate established, Provider agrees to negotiate and establish a rate within thirty (30) days after the acquisition.

Provider additionally shall comply with the terms of Section 2.6 hereof with respect to its Facilities and Professional Providers, to the extent Facilities are not owned, and/or Professional Providers are not employed, by Provider.

**2.6 Subcontracting.** The following requirements shall survive termination of this Agreement with respect to Contracted Services rendered during the term of the Agreement and apply when Contracted Services are provided by a subcontractor, such as a reference laboratory:

- 2.6.1 Provider shall furnish Health Net with copies of its subcontracts within ten (10) days of Health Net's written request
- 2.6.2 Every subcontract shall comply with all applicable local, State and federal laws, including privacy/confidentiality and medical record accuracy laws, be consistent with the terms and conditions of this Agreement, and shall not be used by Provider with respect to Beneficiaries, Benefit Programs and/or Contracted Services upon the reasonable request of Health Net.
- 2.6.3 Provider shall not subcontract either directly or indirectly, with any provider that has been excluded from participation in the Medicare Advantage Program under Section 1128 or 1128A [42 U.S.C. 1320a-7] of the Social Security Act or in the State Medi-Cal program.
- 2.6.4 Each such subcontractor shall meet applicable Health Net credentialing requirements, if any, prior to the subcontract becoming effective with respect to Contracted Services.
- 2.6.5 (i) Provider shall be solely responsible to pay the subcontractor and (ii) Provider shall hold Health Net, Payors and Beneficiaries harmless from and against any and all claims which may be made by subcontractors in connection with Covered Services provided to Beneficiaries by the subcontractor; and (iii) Provider shall require that the subcontractor hold Health Net, Payors, and Beneficiaries harmless from and against any and all claims for payment for such services and shall not attempt to collect any sums owed by Provider from Health Net or a Beneficiary.
- 2.6.6 Subcontracts shall not restrict the rights and obligations of a healthcare provider to communicate freely with Beneficiaries regarding their medical condition and treatment alternatives including medication treatment options, regardless of benefit coverage limitations.
- 2.6.7 In the event that any of Provider's subcontracts fail to comply with the requirements set forth herein, Health Net or Payor shall not be required to recognize the existence or validity of the subcontract with respect to Beneficiaries, Benefit Programs and/or Covered Services. Health Net or a Payor shall further have the right, but not the obligation, to directly pay subcontractors submitting claims for Contracted Services, and to recoup any compensation otherwise due by Health Net or a Payor to Provider pursuant to the terms and conditions of this Agreement. Provider shall indemnify and hold harmless Health Net or a Payor for all such payments and related costs.

**2.7 Participating Providers.** Except in an Emergency, as otherwise permitted in the applicable Benefit Program Requirements, or as otherwise required by applicable federal or State law, if Provider refers a Beneficiary for Covered Services, Provider shall refer Beneficiary only to Participating Providers and Provider shall coordinate such referrals with Health Net or its designee to facilitate the utilization of the most appropriate Participating Provider based upon the Medically Necessary level of care required for the Beneficiary. Provider shall use reasonable efforts to assist Health Net or Payor in their efforts to contract with Provider's Facility-based physicians.

Prior to rendering any non-emergency episode of care, Provider shall determine and disclose to EPO and PPO Beneficiaries the out-of-network providers who are likely to be involved in providing care and the estimated cost of that non-participating provider's care (e.g. for a surgery, Provider shall disclose to the Beneficiary prior to the surgery, all non-participating providers, such as anesthesiologists, radiologists, and pathologists, who are anticipated to be involved in the Beneficiary's care, and the estimated cost of such out-of-network services). Provider's disclosure shall be made sufficiently in advance of the scheduled episode of care to afford the Beneficiary a reasonable opportunity to explore alternate arrangements.

**2.8 Health Net Policies.** Provider shall participate in and comply with all Health Net Policies in effect on the effective date of this Agreement and as modified periodically by Health Net in accordance with Section 3.2 of this Agreement. Provider hereby acknowledges that it has had the opportunity to review Health Net Policies regarding quality improvement and utilization management that pertain to Health Net and Provider's rights and obligations under this Agreement at least fifteen (15) business days prior to the date Provider has executed this Agreement.

**2.9 Prior Authorization/Referral.** When either Prior Authorization and/or a Referral is required for the rendition of a health care service, the receipt of the required Prior Authorization and/or the required Referral, each being separate and distinct requirements, is a prerequisite to payment of Complete Claims for Covered Services in addition to confirming eligibility prior to delivering service as required by this Agreement and Health Net Policies. Health Net (or its designee as applicable) may rescind or modify its Prior Authorization, in a manner consistent with Health Net Policies, based on variety of factors, including but not limited to the eligibility of the Beneficiary and whether the rendered service is a Covered Service. However, when Health Net or its designee issues a Prior Authorization for a specific service under a Benefit Program regulated by the California Department of Managed Health Care or the California Department of Insurance, Health Net (or its designee as applicable) shall not rescind or modify its Prior Authorization after Provider has rendered the specified and authorized service in good faith and pursuant to the terms of the Prior Authorization for any reason, including, but not limited to, Health Net's subsequent rescission, cancellation, or modification of the Beneficiary's contract or Health Net's subsequent determination that it did not make an accurate determination of the Beneficiary's eligibility; provided, however that this section shall not be construed to expand or alter benefits available to a Beneficiary under such Benefit Program.

**2.10 Notification.** Provider shall notify Health Net or a Payor and the appropriate PCP or PPG as applicable, as soon as possible, but no later than 24 hours or by the next business day after a Beneficiary is admitted to a Facility.

**2.11 Credentialing Program.** Provider shall submit to Health Net or its designee any applicable Credentials Application, which meets minimum requirements of Health Net. This Agreement will not be executed by Health Net, nor will Provider or any Professional Provider or subcontractor begin performing Provider's obligations under this Agreement, until Provider and/or Professional Provider and/or Facility has satisfied applicable credentialing or re-credentialing requirements, if any.

**2.12 Insurance.** Provider shall maintain insurance in amounts and types as required by Health Net Policies. Provider agrees to provide Health Net with a Certificate of Insurance from Provider's insurance carrier or other mutually agreeable written evidence of such insurance coverage within three (3) days of such request by Health Net. Provider also agrees to notify Health Net in writing at least thirty (30) days prior to any termination, cancellation or material modification of any policy for all or any portion of the coverage required herein.

**2.13 Trade names, Trademarks, Directories.** Provider shall not use or display the trade names, trademarks, or other identifying information of Health Net without Health Net's prior written approval of both form and content, which approval shall not be unreasonably withheld. However, this provision shall not prohibit Provider from posting a reasonable notice on its website or in its Facilities listing by name those insurance carriers that are

accepted by Provider so long as the notice lists each name in substantially similar format. Provider shall supply all printed materials and other information requested by Health Net in connection with the production of provider directories within seven (7) days of Health Net's request. Provider agrees that Health Net may list the name, address, telephone number and other factual information of Provider, each Facility and Professional Provider, and of Provider's subcontractors and their facilities in its provider directories, marketing and informational materials, and electronic media.

**2.14 Non-Solicitation.** Neither Provider nor any employee, agent or subcontractor of Provider shall solicit or attempt to convince or otherwise persuade any Beneficiary to discontinue participation in any Benefit Program or in any other manner interfere with Health Net's contract and/or property rights; provided, however, that this provision does not prohibit Provider from posting a reasonable notice on its website or in its Facilities listing by name those insurance carriers that are accepted by Provider so long as the notice lists each name in substantially similar format. Notwithstanding the foregoing, Health Net in no way restricts Provider from discussing medical treatment options with Beneficiaries regardless of Benefit Program coverage options. Further, Health Net and Provider, and its employees and subcontractors shall portray each other in a positive light to Beneficiaries and the public.

**2.15 Additional Rights and Obligations.** Any additional rights or obligations of Provider or Health Net shall be set forth in the Addenda to this Agreement.

**2.16 Federal Lobbying Restriction.** Health Net is obligated under 31 U.S.C. § 1352 to obtain certain information from subcontractors engaged to fulfill part or all of Health Net's obligations under its health maintenance contracts with state and local governments, the proceeds of which are funded by federal grants or federal appropriations. To that end, Provider certifies and agrees as follows:

Certification: Provider certifies that it has not and will not use any funds received from Health Net under this Agreement to lobby Congress or any employee or member of Congress, or any federal agency or federal government employee or official (hereinafter "the federal government") for the award of any federal contract, grant, appropriation or loan (or the continuation, extension, renewal, amendment, or modification of the same) or for the ability to participate in any federal cooperative agreement.

Required Disclosures: Provider also agrees that if it engages any person to lobby the federal government for the award to Health Net of a federal contract, grant, appropriation, or loan (or the continuation, extension, renewal, amendment, or modification of the same) or for the ability to participate in any federal cooperative agreement involving Health Net, the undersigned will fully and truthfully execute Standard Form LLL as set forth in Health Net Policies, and will provide such executed form to Health Net. Provider understands that Health Net is legally obligated to provide such information to certain federal grant and contract recipients with which it contracts, and further understands that all executed Standard Form LLLs will be supplied to the federal government. Provider agrees to supplement its disclosure under this paragraph promptly if there is a change in any of the information therein.

Subcontracting Obligation: If Provider engages any subcontractor to perform all or part of its obligations under this Agreement, it will require the subcontractor (1) to sign a certification stating that it will not use funds earned under the subcontract to lobby for the award of a federal contract, grant, appropriation or loan (or the continuation, extension, renewal, amendment, or modification of the same) or for the ability to participate in any federal cooperative agreement, and (2) to execute Standard Form LLL, in the event that it engages any person to lobby the federal government for such purposes. Provider will promptly provide to Health Net any Standard Form LLLs executed by its subcontractor(s).

**2.17 Benefit Programs Funded with Federal Funds.** Provider shall, for Benefit Programs funded in whole or in part with federal funds, ensure compliance with all State and/or federal laws, rules, regulations, and other mandates governing payment to providers whose names appear on one or more excluded provider lists maintained by State and/or federal agencies. Such agencies include, but are not limited to, the U.S. Office of the Inspector General (OIG), the CA Department of Healthcare Services (DHCS), and the General Services Administration (GSA). Where any such law, rule, regulation, and/or mandate impose a compliance obligation on a party, and where such compliance depends upon the other party's cooperation, the other party shall not unreasonably withhold such cooperation, sought on reasonable notice.

**2.18 Long Term Services and Supports (“LTSS”) Provider.**

- 2.18.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services (“HCBS”) are a subset of LTSS that functions outside of institutional care to maximize independence in the community.
- 2.18.2 Acknowledgement. Health Net acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.
- 2.18.3 Notification Requirements. Provider or the applicable Professional Provider shall provide the following notifications to Health Net, via written notice or via telephone contact at a number to be provided by Health Net, within the following time frames:
- a) Provider or the applicable Professional Provider shall notify Health Net of a Member’s visit to urgent care or the emergency department of any hospital, or of a Member’s hospitalization, within twenty- four (24) hours of becoming aware of such visit or hospitalization.
  - b) Provider or the applicable Professional Provider shall notify Health Net of any change to the designated/assigned services being provided under a Member’s plan of care and/or service plan, within twenty-four (24) hours of becoming aware of such change.
  - c) Provider or the applicable Professional Provider shall notify Health Net if a Member misses an appointment with Provider, within twenty-four (24) hours of becoming aware of such missed appointment.
  - d) Provider or the applicable Professional Provider shall notify Health Net of any change in a Covered Person’s medical or behavioral health condition, within twenty-four (24) hours of becoming aware of such change. (Examples of changes in condition are set forth in Health Net Policies).
  - e) Provider or the applicable Professional Provider shall notify Health Net of any safety issue identified by Provider or Professional Provider or its agent or subcontractor, within twenty-four (24) hours of the identification of such safety issue. (Examples of safety issues are set forth in Health Net Policies).
  - f) Provider or the applicable Professional Provider shall notify Health Net of any change in Provider’s or Professional Provider’s key personnel, within twenty-four (24) hours of such change.
- 2.18.4 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Health Plan or its designee the Minimum Data Set as defined by CMS and required under federal law and Health Plan policy as it relates to all Covered Persons who are residents in Contracted Provider’s facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by Health Plan.

- 2.19 Person-Centered Planning, Care/Service Plan, and Services.** Provider shall comply with all state and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:
- (a) Members shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.
  - (b) The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by state and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the member.
  - (c) LTSS providers shall be aware of, respect, and adhere to a member's preferences for the delivery of services and supports.
  - (d) LTSS providers shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to members and the person(s) supporting them who have disabilities and/or are limited English proficient.
  - (e) Health Net agrees to complete the care/service plan in a timely manner (within at least 120 days of enrollment or annually, or less if state requirements differ) and provide a copy to all LTSS providers responsible for implementation.

### **III. DUTIES OF HEALTH NET**

**3.1 Payment.** Health Net shall, or Health Net shall require Payor to, make payment to Provider for Contracted Services in accordance with Article IV and the applicable addenda, schedules and exhibits of this Agreement.

**3.2 Health Net Policies.** Health Net Policies are set forth in references and forms available to Provider through the Provider Section of Health Net's website at "<https://providerlibrary.healthnetcalifornia.com>" or by other means which Health Net will communicate to Provider periodically. Health Net Policies in existence as of the effective date of this Agreement are hereby incorporated into this Agreement by reference. Notwithstanding the foregoing and/or any other provision of this Agreement, the parties agree that a formal amendment to this Agreement shall not be required to effectuate modifications to Health Net Policies. Modifications to Health Net Policies may be made periodically as determined by Health Net in accordance with the procedures set forth in applicable State law (including without limitation the California Health Care Providers' Bill of Rights). Such modifications shall be deemed incorporated in this Agreement as of the effective date of such modification unless otherwise mutually agreed by the parties in writing at the time of the modification in accordance with applicable State law (including without limitation the California Health Care Providers' Bill of Rights).

**3.3 Insurance.** Health Net shall maintain appropriate insurance programs or policies including bodily injury and personal injury coverage, which includes persons serving on Health Net committees as insured by definition. In the event that a policy or program is terminated or the coverage of committee persons is materially changed, Health Net shall so notify Provider.

**3.4 Reporting to Regulators.** Health Net and/or Payor shall accept sole responsibility for filing reports, obtaining approvals and complying with applicable laws and regulations of State, federal and other regulatory agencies having jurisdiction over Health Net and/or Payor; provided, however, that Provider agrees to cooperate in providing Health Net and/or Payor with any information and assistance reasonably required in connection therewith, including without limitation, permitting the regulatory agencies to conduct periodic site evaluations of Provider, Facilities, Professional Providers and any of their equipment, operations, and billing and medical records of Beneficiaries. Such records shall be located in the State.

### **3.5 Access To This Agreement.**

3.5.1 Access by Health Net. As of the effective date of this Agreement, the following Health Net subsidiaries and affiliates may at their option access this Agreement: Health Net of California, Inc., Health Net Life Insurance Company, Health Net Community Solutions, Inc., Wellcare of California, Inc., Arizona Complete Plan, Health Net Health Plan of Oregon, Inc., Health Net Insurance Services, Inc., Health Net Federal Services, LLC., and Network Providers LLC. Notwithstanding the foregoing, Provider agrees that any other subsidiary or affiliate of Health Net not listed above may access the rates and terms set forth in this Agreement. This would include members of non-California based health plan affiliates who may be treated by Provider. To the extent Health Net allows a Health Net subsidiary or affiliate to access this Agreement, Health Net binds such subsidiaries and/or affiliates to the terms and conditions of this Agreement.

3.5.2 Access by Payors. To the extent Health Net allows a self-funded Payor to access this Agreement, Health Net has obligated such self-funded Payor to fund a claims payment account in a sufficient and timely manner to pay claims for services provided by health care providers like Provider. In the event a self-funded Payor accessing this Agreement fails to sufficiently and timely fund a claims payment account to the material detriment of Provider, Provider may terminate this Agreement as to such self-funded Payor in accordance with Section 5.3 hereof, and, notwithstanding the provisions of Section 4.6 of this Agreement, take legal action against the self-funded Payor and/or Beneficiary as may be permitted by law. Additional information regarding Payors and conditions for accessing this Agreement is set forth in Addendum A of this Agreement.

**3.6 Language Assistance Program.** Health Net shall maintain an ongoing language assistance program to ensure Limited English Proficient (“LEP”) Beneficiaries have appropriate access to language assistance while accessing Provider services, pursuant to Health and Safety Code §§ 1367(e)(3), 1367.04 and 1367.07 and Insurance Code §§ 10133.8 and 10133.9. Provider shall cooperate and comply with Health Net’s Language Assistance Program.

**IV. FINANCIAL OBLIGATIONS.** The terms of this Article IV shall survive termination of this Agreement with respect to Covered Services rendered during the term of this Agreement:

**4.1 Payment Rates.** Health Net shall pay (or shall require Payor to pay), and Provider shall accept as payment in full for Contracted Services, the rates payable by Health Net or Payor under the terms and conditions of this Agreement (including the payment conditions, chargemaster and other provisions set forth in the applicable addenda, schedules and exhibits to this Agreement), less Copayments, Coinsurance and Deductibles payable by Beneficiaries in accordance with the applicable Benefit Program or as otherwise permitted by the section of this Agreement covering Third Party Lien Recoveries. Any overpayment, inaccurate payment or other payment error made by Health Net or Payor shall not be deemed or construed or otherwise operate to change the payment terms or rates provided for under this Agreement.

### **4.2 Billing and Payment.**

4.2.1 Billing. If Provider is compensated for a Complete Claim for a Covered Service on a fee-for-service basis, Provider shall submit to Health Net/Payor, via Health Net's/Payor’s electronic claims submission program or hardcopy as determined by Health Net/Payor, Complete Claims within one hundred twenty (120) days after Provider renders Contracted Services unless Provider demonstrates good cause pursuant to applicable State law. Where Health Net and/or Payor is the secondary payor under Coordination of Benefits, Provider shall submit Complete Claims for Covered Services accompanied by the explanation of benefits (EOB) or explanation of payment (EOP) from the primary payor to Health Net or a Payor within one hundred twenty (120) days of the date of the EOB/EOP. If Provider fails to comply with the timely claims submission/filing requirements set forth herein, Health Net shall have no obligation to pay for such claims, and Provider shall be prohibited from billing the Beneficiary as set forth in Section 4.6 hereof.

Provider agrees that Health Net or a Payor shall have the right to determine the accuracy of all Complete Claims submitted to it prior to payment, including verification of diagnostic codes, DRG assignment, and whether Provider has delivered the Covered Service in good faith and pursuant to the terms of an applicable Prior Authorization.

4.2.2 **Payment.** Health Net or Payor, as applicable, shall make payment on each of Provider's timely-submitted Complete Claims in accordance with this Agreement and pursuant to the timeframes, procedures and other requirements of applicable State and federal law, including without limitation the calculation and payment of interest on overdue payments. Payment of interest plus the amount of any Complete Claim payment deficiency shall be Provider's sole measure of damages (i.e., claims for consequential or incidental damages do not apply) for failure of Health Net or Payor to make timely and accurate payments. In no event shall Health Net be under any obligation to pay Provider for any claim or expense, which is the responsibility of a self-funded Payor.

4.2.3 **Appeals.** In addition to the dispute resolution and arbitration rights described in Section 7.5 and Section 7.6 herein, Provider may dispute any Health Net action that adjusts, denies, or contests a claim, billing practice, or other contractual provision so long as Provider submits a written dispute to the Health Net Provider Appeals Unit. Unless Provider demonstrates good cause pursuant to applicable State or federal law, Health Net or Payor shall not grant Provider reconsideration or appeal of a claims payment for Covered Services that exceed three hundred sixty five (365) days of Health Net's action or in the case of inaction, within three hundred sixty five (365) days after the time for contesting or denying claims (as defined in applicable State or federal law) has expired. Appeals shall be submitted by Provider in accordance with the procedures and to the address for Health Net's Provider Appeals Unit, listed in Health Net Policies. If Provider fails to comply with the timely appeals submission/filing requirements set forth herein, Health Net shall have no obligation to pay for such claims except as otherwise required by applicable State and federal law, and Provider shall be prohibited from billing the Beneficiary as set forth in Section 4.6 hereof. Provider and Health Net agree to comply with all timeliness and procedural requirements for submitting and responding to disputes submitted to Health Net's Provider Appeals Unit as set forth in Health Net Policies.

#### **4.3 Recoupment of Overpayments; Right of Offset.**

4.3.1 Provider shall inform Health Net of any overpayment made to Provider, and shall return any such overpayment to Health Net within thirty (30) business days from the date Provider first becomes aware of any such overpayment.

4.3.2 In the event Health Net determines that it has overpaid a claim, either in connection with an audit or otherwise, Health Net shall notify Provider in writing through a separate overpayment notice clearly identifying the claim, the name of the Beneficiary, the date of service and explanation of the basis upon which Health Net or Payor believes the amount paid on the claim was in excess of the amount due, including any interest and penalties that may be due on the claim. Such overpayment notice shall be issued within (i) three hundred sixty-five (365) days of the date of payment on the overpaid amount for claims arising from Benefit Programs regulated by the California Department of Managed Health Care or the California Department of Insurance, or within (ii) three (3) years from the date of payment on the overpaid amount for claims arising from other types of Benefit Programs that are not regulated by the California Department of Managed Health Care or the California Department of Insurance, or (iii) at any time, in the event of fraud and/or misrepresentation. Such notice shall be sent to Provider's address of record with Health Net for the receipt of claim related correspondence and payments unless Provider informs Health Net in writing of an alternative address to which such notices are to be sent at least thirty (30) days in advance of the address change.

- 4.3.3 If Provider does not contest Health Net's overpayment notice, Provider shall reimburse Health Net or Payor within thirty (30) business days from the date Provider receives the overpayment notice. If Provider fails to reimburse Health Net or Payor within those thirty (30) business days, then, beginning on the first calendar day after the expiration of this thirty (30) business day time period, Health Net shall commence offsetting, as set forth herein and interest shall accrue on any and all unpaid amounts at the rate of ten percent (10%) per annum.
- 4.3.4 In the event Provider wishes to contest the overpayment notice, it must do so within thirty (30) business days from the date Provider receives the overpayment notice, by sending to Health Net's Provider Appeals Unit (at the address listed in Health Net Policies) a written appeal clearly stating the basis upon which Provider believes that the claim was not overpaid. Health Net shall review and make a decision with respect to Provider's appeal, and shall notify Provider of its decision in writing within forty-five (45) business days from the date Health Net receives Provider's written appeal. In the event Health Net denies Provider's appeal and upholds Health Net's determination that an overpayment has been made, Provider shall reimburse Health Net or Payor for the overpayment within thirty (30) business days from the date it receives the written notice of Health Net's denial of Provider's written appeal. If Provider fails to reimburse Health Net or Payor within those thirty (30) business days, then beginning on the first calendar day after the expiration of this thirty (30) business day time period, Health Net may commence offsetting as set forth herein, and interest shall accrue on any and all unpaid amounts at the rate of ten percent (10%) per annum.
- 4.3.5 If Health Net or Payor exercises offset rights hereunder against Provider's current claims payments, Health Net or Payor shall give Provider a detailed written explanation identifying the specific overpayments that have been offset against the specific current claims payments.
- 4.3.6 If Provider desires to continue to contest the overpayment, it shall do so by following the dispute resolution process set forth in Sections 7.5 and 7.6 of this Agreement.

**4.4 Eligibility.** The parties acknowledge that verification of eligibility by Health Net is based on information available to Health Net from its customers on the date Provider seeks verification. Health Net shall use reasonable efforts to discourage its customers from retroactively canceling or adding Beneficiaries to a Benefit Program and encourage its customers to timely and accurately provide eligibility information. In the event Contracted Services are provided to an individual who is not a Beneficiary, based on an erroneous or delayed enrollment/eligibility list the following shall apply: (i) when the individual is enrolled in a substitute or replacement health care service or insurance plan which is obligated under applicable law to make payment to Provider for services delivered to the individual, Provider shall seek payment from the substitute or replacement carrier; and (ii) when the individual does not have substitute or replacement coverage, Health Net shall pay Provider for Contracted Services delivered to the individual by Provider prior to the time Provider received notice of that individual's ineligibility pursuant to the terms and conditions of this Agreement, provided, however, for those Benefit Programs that are not regulated by the California Department of Managed Health Care or the California Department of Insurance, as an additional prerequisite for payment pursuant to this Section 4.4(ii), Provider shall submit to Health Net evidence that Provider has unsuccessfully sought payment through two billing cycles for all or a portion of such charges from the patient or the person having legal responsibility for the patient, or from the entity having financial responsibility for such payment. In the event Health Net pays Provider pursuant to this Section 4.4, Provider shall have no further right and shall not attempt to collect any additional payment from the individual for said services (except for applicable Copayments, Coinsurance and Deductibles) and Provider hereby assigns and transfers all legal rights of collection and Coordination of Benefits for services to Health Net.

**4.5 Collection of Copayments, Coinsurance and Deductibles.** Provider shall collect all Copayments, Coinsurance and Deductibles due from Beneficiaries, and shall not waive or fail to pursue such collection except when otherwise permitted through Provider's established patient financial assistance program. Provider shall not charge Beneficiary any fees or Surcharges for Contracted Services rendered pursuant to this

Agreement (except for Copayments, Coinsurance and Deductibles). In addition, Provider shall not collect a sales, use or other applicable tax from Beneficiaries for the sale or delivery of Contracted Services unless required by applicable State or federal law. If Health Net or any Payor receives notice of any attempt to collect or the receipt of any inappropriate additional charges, including without limitation Surcharges, Health Net or Payor shall take appropriate action. Provider shall cooperate with Health Net or such Payor to investigate such allegations, and shall promptly refund to the party who made the payment, any payment reasonably determined to be improper by Health Net or a Payor.

**4.6 Beneficiary Held Harmless.** Provider agrees that in no event, including, but not limited to, non-payment by Health Net or a Payor, insolvency of Health Net or a Payor, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries or persons acting on their behalf other than Health Net or a Payor for Contracted Services provided pursuant to this Agreement except for Copayments, Coinsurance, Deductibles, Excluded Services or permitted third party liens under this Agreement and as permitted under Section 3.5.2 hereof. This provision shall not prohibit collection of Copayments, Coinsurance or Deductibles or Excluded Services or permitted third party liens under this Agreement made in accordance with applicable Benefit Program Requirements. Provider agrees that: (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Beneficiaries; and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Beneficiaries or persons acting on their behalf. Provider agrees to (iii) address any and all concerns it has with claims payment through Health Net's provider appeal process pursuant to Health Net Policies and (iv) give the Beneficiary and Health Net confirmation that Provider has rescinded the collection notice and taken any other actions necessary to clear the Beneficiary's credit record of the collection matter.

**4.7 Conditions for Compensation for Excluded Services.** Provider may bill a Beneficiary for Excluded Services rendered by Provider to such Beneficiary only if the Beneficiary is notified in advance that the services to be provided are not Covered Services under the Beneficiary's Benefit Program, and the Beneficiary requests in writing that Provider render the Excluded Services, prior to Provider's rendition of such services.

**4.8 Coordination of Benefits.** Provider agrees to conduct Coordination of Benefits in accordance with federal and State laws and regulations and Health Net Policies ("Coordination of Benefit Rules"), including but not limited to, the prompt notification to Health Net or a Payor of any third party entity who may be responsible for payment and collection of Copayments. Provider shall not bill Beneficiaries for any portion of Contracted Services not paid by the primary carrier when Health Net or a Payor is the secondary carrier, but shall seek payment from Health Net/Payor. When Health Net or a Payor is secondary under the Coordination of Benefits Rules, Health Net or a Payor shall pay Provider an amount up to Beneficiary's primary plan's copayment, coinsurance or deductibles as applicable, where that payment does not exceed Health Net's contracted rate under this Agreement. In the event that Medicare is the primary carrier and Health Net Commercial Benefit Program is secondary, Health Net shall pay Provider only up to Medicare's allowable amount and/or the Beneficiary's Copayment, Coinsurance or Deductibles as applicable. When Health Net Medi-Cal is the secondary Payor, Health Net will not pay more than the Provider would receive if DHCS were paying secondary in accordance with Medi-Cal Coordination of Benefits. Such recoveries shall be performed in accordance with the applicable Benefit Program Requirements and Health Net Policies.

**4.9 Third Party Recoveries.** In the event Provider provides Covered Services to Health Net Beneficiaries for injuries resulting from the acts of third parties, or resulting from work related injuries, Provider shall have the right to recover from any settlement, award, or recovery from any responsible third-party the reasonable and necessary charges for such Contracted Services using the procedures for such recovery provided by the Hospital Lien Act, Civ. Code section 3045.1 et. seq., and shall have all rights and benefits afforded by that statute. Provider shall notify Health Net of any such recovery and shall provide Health Net with an accounting of all such sums recovered. In the event Health Net has compensated Provider for such Contracted Services and Provider has recovered sums from a third party, Provider agrees to pay such recovered sums to Health Net up to the amounts that Health Net paid to Provider, to the extent that Health Net has not recovered such amounts from its own third party recovery efforts. Provider shall pay these amounts to Health Net within sixty (60) days of Health Net's written request, which request shall inform Provider of the amounts Health Net recovered from its own third party recovery efforts, if any. This section 4.9 does not obligate, nor does it prohibit, either Health Net or Provider to undertake such third party recovery efforts.

**4.10 Reciprocity.** Provider agrees that Health Net may allow the payment rates set forth in this Agreement to be used by Participating Providers and PPGs who may periodically be responsible for compensating Provider for Covered Services rendered by Provider to a Beneficiary.

**4.11 Telehealth.** Health Net shall reimburse Provider for the diagnosis, consultation, or treatment of a commercial Beneficiary appropriately delivered through Telehealth services, on the same basis and to the same extent as the reimbursement for the same service through in-person diagnosis, consultation, or treatment. Telehealth shall be defined as applicable in California law and regulations, California Health and Safety Code Sections 1374.14 and 1374.141, California Insurance Code Sections 10123.855 and 10123.856, and California Business and Professions Code Section 2290.5.

## V. TERM AND TERMINATION

**5.1 Term.** The term of this Agreement shall commence on the Effective Date and shall continue for a period of **two (2) years thereafter** (the “Initial Term”). Either party may terminate this Agreement effective as of the end of the Initial Term by providing at least one **hundred eighty (180) days** prior written notice to the other party. This Agreement shall automatically renew for successive one (1) year periods (the “Renewal Terms”).

**5.2 Immediate Termination.** Either party may terminate this Agreement immediately upon notice to the other party, in the event of: (i) a party’s violation of material law, rule or regulation; (ii) a party’s failure to maintain the insurance coverage specified hereunder; or (iii) a felony conviction or a plea of guilty, nolo contendere or no contest related to the medical and/or financial practices of a party. Health Net may terminate this Agreement immediately upon notice to Provider in the event of (iv) action taken by a State or federal regulator that results in a material restriction upon Provider’s ability to operate a Facility or reportable discipline against Provider’s license, accreditation, or certification; (v) Health Net’s determination that the health, safety or welfare of any Beneficiary may be in jeopardy if this Agreement is not terminated; (vi) any material adverse finding as a result of a lawsuit or claim, related to the medical and/or financial practices of Provider.

**5.3 Termination Due to Material Breach.** In the event either party believes the other party has committed a material breach of this Agreement, the non-breaching party shall send the other party a written Notice Of Breach and Demand to Cure (“Notice”). Without limiting either party’s other termination rights under this Article V, in the event that either party fails to cure a material breach of this Agreement within thirty (30) days of receipt of the Notice from the other party (the “Cure Period”), the non-defaulting party may terminate this Agreement by providing the defaulting party thirty (30) days prior written notice of termination. The non-defaulting party may exercise this termination option, if at all; within thirty (30) days of the date the Cure Period expires. If the breach is cured within the Cure Period, or if the breach is one which cannot reasonably be corrected within the Cure Period, and the defaulting party is making substantial and diligent progress toward correction during the Cure Period to the reasonable satisfaction of the non-defaulting party, this Agreement shall remain in full force and effect. The provisions of this Section 5.3 shall not apply to Health Net claims payment timeliness issues which are governed by Article IV of this Agreement, unless and until the parties have completed the dispute resolution process set forth in Sections 7.5 and 7.6 of this Agreement, and the dispute relates to habitual, chronic and material claims payment timeliness issues. In the event a Payor fails in its obligations under the terms of this Agreement to make Complete Claim payments to Provider when due, Provider may terminate the specific delinquent Payor without terminating this Agreement in its entirety, but only after all of the following conditions have been met: (i) Payor has failed to make a payment to Provider within the applicable time frame set forth in this Agreement; (ii) Provider provides written notice to Payor that such payment has not been made; (iii) Payor fails to remit payment to Provider within ten (10) days following Payor’s receipt of Provider’s written notice; (iv) Provider has made a good-faith attempt to meet with Health Net and Payor to resolve the payment issue(s).

**5.4 Termination Upon Notice.** Either party may terminate this Agreement during a Renewal Term for any reason or no reason upon one **hundred eighty (180) days** prior written notice to the other party. In the event either party provides the other party with such notice, and following Health Net’s completion of any regulatory filing requirements, Health Net may, at its option, begin to transition Beneficiaries under this Agreement to another Participating Provider.

**5.5 Information to Beneficiaries.** The parties each agree not to disparage the other in any information supplied by either party to Beneficiaries or other third parties in connection with any expiration, termination or non-renewal of this Agreement. Health Net shall assume sole responsibility for notifying Beneficiaries, and Health Net may commence transferring Beneficiaries to alternate providers, prior to the effective date of any expiration, termination or non-renewal of this Agreement in accordance with State and federal law. If Beneficiaries seek services or Participating Providers order tests or seek services from Provider after the effective date of any expiration, termination or non-renewal, Provider shall inform such Beneficiaries and Participating Providers only that Provider no longer has an agreement with Health Net to render Covered Services and shall direct them to Health Net's customer service department. Provider shall not otherwise initiate communications with Beneficiaries or other third parties, verbally or in writing, concerning the expiration, termination or non-renewal of this Agreement and Provider's participation in Health Net's Participating Provider network, unless the parties have agreed in writing to the content of such communications in the context of a mutually agreed communication plan. Nothing in this provision is intended nor shall it be construed to prohibit or restrict Provider, Professional Provider, or other Participating Providers from (i) disclosing to any Beneficiary information regarding treatment options available, the risks, benefits and alternatives thereto, or (ii) disclosing to any Beneficiary the decision or process of Health Net or a Payor to Prior Authorize or deny benefits under a Benefit Program, or (iii) posting a reasonable notice on Provider's website or in Provider's Facilities listing by name those insurance carriers that are accepted by Provider, provided that the notice lists each name in substantially similar format. The terms of this Section 5.5 shall survive termination of this Agreement.

**5.6 Effect of Termination.** In the event that a Beneficiary is receiving Contracted Services on the date this Agreement expires, non-renews, and/or terminates, upon the request of Beneficiary and Health Net, Provider shall continue to provide Contracted Services to the Beneficiary until the later of: (i) treatment is completed; (ii) the Beneficiary is discharged if Provider is an inpatient facility; (iii) the Beneficiary is assigned to another Participating Provider; or (iv) the anniversary date of the Beneficiary's Benefit Program. Provider's compensation for such Contracted Services shall be at the rates contained in the applicable Addendum hereto. If Provider's services are continued beyond the expiration, non-renewal, and/or termination of this Agreement, Provider shall be subject to the same contractual terms and conditions that were imposed on Provider prior to the expiration/non-renewal/termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.

## VI. RECORDS, AUDITS AND REGULATORY REQUIREMENTS

**6.1 Medical and Other Records.** Provider shall prepare and maintain Records in accordance with the general standards applicable to such Record-keeping and in compliance with all applicable federal and State confidentiality and privacy laws. Provider shall maintain such Records for at least ten (10) years after the rendition of Contracted Services, and Records of a minor child shall be kept for at least three (3) years after the minor has reached the age of eighteen (18), but in no event less than ten (10) years after the rendition of Contracted Services. Additionally, Provider shall maintain such Records as may be necessary and reasonably requested by Health Net to comply with applicable federal and State law, and accrediting agency reporting requirements, rules and regulations. Provider shall comply with and require Professional Providers and Facilities to comply with all confidentiality and Beneficiary records accuracy requirements. Provider's Records shall be and remain the property of Provider.

**6.2 Access to Records and Audits by Regulatory Agencies.** Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit designated representatives of local, State, and federal regulatory agencies having jurisdiction over Health Net or Payor and designated representatives of public and private exchange-based purchasers and accreditation agencies having jurisdiction over Health Net or Payor (collectively referred to as "Regulatory Agencies"), access to Provider's Records, at Provider's place of business in this State during normal business hours, in order to audit, inspect and review and make copies of such Records. Such Regulatory Agencies shall include, but not be limited to, the State Department of Health Care Services, the State Department of Insurance, the State Department of Managed Healthcare, the United States Justice Department, CMS, the United States Department of Health and Human Services, Covered California, the National Committee for Quality Assurance, and any of their representatives. When requested by Regulatory Agencies, Provider shall produce copies of any such Records at no charge. Additionally, Provider agrees to permit Regulatory Agencies or their representatives, to conduct site evaluations, inspections and audits of Provider's Records, offices and service locations at no cost to Health Net, Payor, and/or Regulatory Agencies, and within a reasonable time period, but not more than five (5) days after the request is submitted to Provider.

**6.3 Access to Records and Audits by Health Net.** Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit Health Net or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, in order to audit, inspect, review, perform chart reviews, and duplicate such Records unless Provider agrees to a remote audit of such records. If performed on site, access to Records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least thirty (30) business days prior written notice by Health Net or its designated representative, but not more than sixty (60) days following such written notice. Provider shall attend an exit interview upon completion of the audit for the purpose of obtaining a mutually agreed upon reconciliation of the initial audit findings. Such exit interview shall be conducted at a mutually agreeable time at Provider's place of business in this State during normal business hours upon at least ten (10) days prior written notice by Health Net or its designated representative, but not more than thirty (30) days following such written notice. In the event Provider fails to attend the scheduled exit interview, Provider shall be deemed to have accepted the audit findings. If the audit was performed remotely, such exit interview shall consist of Health Net or its designated representative sharing its audit findings with Provider via written or electronic communications as determined by Health Net. Provider shall be allowed ten (10) days to contest the audit results. If not contested within ten (10) days then Provider shall be deemed to have accepted the audit findings. Except when Health Net or its designated representative requests Provider Records that are related to care management or claims, Provider may require reasonable fees associated with the retrieval of Provider's Records and or duplication and preparation of requested Provider Records. Such fees shall not be more than those provided in California Health and Safety Code Section 123110. Actions taken as a result of audit findings shall include adjustment for late charges, overcharges. Any such adjustment shall be the net amounts as reflected in the audit findings. Any payments owed by one party to the other as the result of an audit shall be paid within thirty (30) days of the exit interview for such audit.

**6.4 Continuing Obligation.** The obligations of Provider under this Article VI shall not be terminated upon termination of this Agreement, whether by rescission, non-renewal or otherwise. After such termination of this Agreement, Health Net, Payors and Regulatory Agencies shall continue to have access to Provider's Records as necessary to fulfill the requirements of this Agreement and to comply with all applicable laws, rules and regulations.

**6.5 Regulatory Compliance.** Each party agrees to comply with all applicable local, State, and federal laws, rules and regulations, now or hereafter in effect, regarding the performance of the party's obligations hereunder, including without limitation, laws or regulations governing Beneficiary confidentiality, privacy, appeal and dispute resolution procedures to the extent that they directly or indirectly affect Provider, Provider's Facility(ies), Provider's Professional Providers, a Beneficiary, Health Net, or Payor, and bear upon the subject matter of this Agreement. If Health Net is sanctioned by any Regulatory Agency for non-compliance that is caused by Provider, Provider shall compensate Health Net for amounts tied to this sanction incurred by Health Net including Health Net's costs of defense and fees.

## **VII. GENERAL PROVISIONS**

**7.1 Amendments.** This Agreement may be amended by mutual written agreement of the parties. Notwithstanding the foregoing, amendments required to comply with State or federal laws or regulations, requirements of Regulatory Agencies, or requirements of Accreditation Agencies, shall not require the consent of Provider or Health Net and shall be effective immediately on the effective date of the requirement. The parties acknowledge that changes to Health Net Policies that may affect a party's rights or obligations under this Agreement are addressed in Section 3.2 hereof.

**7.2 Separate Obligations.** The rights and obligations of Health Net under this Agreement shall apply to each Health Net subsidiary or affiliate and/or Payor accessing this Agreement only to the extent such Health Net subsidiary or affiliate and/or Payor has accessed this Agreement with respect to the Benefit Programs of such Health Net subsidiary or affiliate or Payor. Health Net or Payor shall not be responsible for the obligations of any other Health Net subsidiary or affiliate or Payor under this Agreement with respect to the other's Benefit Programs. The terms of this Section 7.2 shall survive termination of this Agreement.

**7.3 Assignment.** Provider shall not assign this Agreement in whole or in part without Health Net's prior written consent, which consent shall not be unreasonably withheld, conditioned or delayed. Any change in control of Provider resulting from a merger, consolidation, stock transfer or asset sale shall be deemed an

assignment or transfer for purposes of this Agreement that requires Health Net's prior written consent. Health Net expressly reserves the right to assign, delegate or transfer any or all of its rights, obligations or privileges under this Agreement to an entity controlling, controlled by, or under common control with Health Net, LLC.

**7.4 Confidentiality.** The Parties each agree that, unless disclosure is required by state or federal law, they shall hold Beneficiary health information and all confidential or proprietary information or trade secrets of each other, in trust and confidence. The Parties each agree that, unless disclosure is required by state or federal law, they shall keep strictly confidential all customized, non-template terms and rates set forth in this Agreement (including without limitation all addenda, exhibits, and any past or future amendments to this Agreement). The Parties further agree that in the event a disclosure is required by state or federal law, they shall disclose only the specific information mandated by such law in order to comply with the applicable legal requirements. Notwithstanding the foregoing, the Parties acknowledge and agree that this provision does not preclude disclosure by Health Net to Beneficiaries, customers, Regulatory Agencies and exchanges of certain financial terms of this Agreement, including without limitation detailed information contained in the Explanation of Benefits, Records under the conditions set forth in Article VI of this Agreement, and/or information regarding the method of compensation used by Health Net with respect to Health Net's Participating Provider networks, e.g., fee-for-service, capitation, shared risk pool, DRG or per diem. Health Net, Payors and Provider agree that such information shall be used only for the purposes contemplated herein, and not for any other purpose. Health Net, Payors and Provider agree that nothing in this Agreement shall be construed as a limitation of (i) Provider's rights or obligations to discuss with the Beneficiaries matters pertaining to the Beneficiaries' health regardless of Benefit Program coverage options or (ii) Health Net's rights or obligations with respect to subcontractors, including without limitation delegated providers, or (iii) disclosures to counsel or a consultant of a party for the purpose of monitoring regulatory compliance or rendering legal advice pertaining only to this Agreement or disclosures to internal or independent auditors of a party for audit purposes pertaining to this Agreement, provided that in either case the counsel or consultant agrees in writing to comply with the provisions of this Section 7.4 and agrees that the terms of this Agreement may not be disclosed to any other person or entity or used in any manner whatsoever in connection with any other agreement involving Health Net. The terms of this Section 7.4 shall survive termination of this Agreement.

Nothing in this provision or this Agreement shall be construed to prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to an enrollee, Member or subscriber of Health Net, to a qualified entity, as defined in Section 1395kk(e)(2) of Title 42 of the United States Code. All disclosures of data made under this provision shall comply with all applicable state and federal laws for the protection of the privacy and security of the data, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the federal Health Information Technology for Economic and Clinical Health Act, Title XIII of the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and implementing regulations.

**7.5 Provider Dispute Resolution Procedure.** The parties agree to use the dispute resolution process set forth in this Section 7.5, and binding arbitration as described in Section 7.6, as the final steps in resolving any Dispute. The parties each understand and agree that any and all Health Net internal appeals processes (including without limitation as set forth in Section 4.2.3 hereof) must be properly pursued and exhausted before engaging in the dispute resolution process set forth in this Section 7.5.

(i) Meet and Confer Process:

Initiation: If the parties are unable to resolve any Dispute through applicable Health Net internal appeal processes, if any, the parties agree to meet and confer within thirty (30) days of a written request by either party in a good faith effort to informally settle any Dispute. The parties each agree and understand that the meet and confer requirements set forth herein may be satisfied only by meeting each of the following requirements: (a) an actual meeting must occur between executive level employees of the parties who have authority to resolve the Dispute and are each prepared to discuss in good faith the Dispute and proposed resolution(s) to the Dispute, and (b) such meeting may take place either in person or on the telephone at a mutually agreeable time, and (c) unless otherwise mutually agreed by the parties, neither party is allowed to have legal counsel present at the meeting or to substitute legal counsel for the executive level employee, and (d) such meeting and all related discussions between the parties shall be treated in the same

manner as confidential protected settlement discussions under the State Rules of Civil Procedure.

Confidentiality: All documents created for the purpose of, and exchanged during, the meet and confer process and all meet and confer discussions, negotiations and proceedings shall be treated as compromise and settlement negotiations subject to applicable State law. To the extent the parties produce or exchange any documents, the parties agree that such production or exchange shall not waive the protected nature of those documents and shall not otherwise affect their inadmissibility as evidence in any subsequent proceedings.

(ii) Voluntary Mediation:

If the parties are unable to resolve any Dispute through the meet and confer process set forth above, and desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, a joint request for such services may be made to the American Arbitration Association ("AAA"), or the Judicial Arbitration and Mediation Services ("JAMS") prior to submitting a Dispute to arbitration, or the parties may initiate such other procedures as they may mutually agree upon.

**7.6 Binding Arbitration.** If the parties are unable to resolve a Dispute through the dispute resolution process set forth in Section 7.5, the parties agree that such Dispute shall be settled by final and binding arbitration, upon the motion of either party, under the appropriate rules of the AAA or JAMS, as agreed by the parties. Any Arbitrator must be either a judge, or an attorney licensed to practice law in the State of California, who is in good standing with the State Bar, and has at least ten (10) years of experience with health care matters and the arbitration of managed care disputes. The parties each understand and agree that the exhaustion of any Health Net internal appeals processes and the Meet and Confer Process set forth in Section 7.5 (i) hereof are conditions precedent to binding arbitration under this Section 7.6. Notwithstanding the foregoing, nothing contained herein is intended to require binding arbitration of disputes alleging medical malpractice between a Beneficiary and Provider or to Disputes between the parties alleging breaches of confidentiality of Beneficiary information, trade secret or intellectual property obligations. The arbitration shall be conducted in San Francisco, California or Los Angeles, California. The written demand shall contain a detailed statement of the matter and facts and include copies of all material documents supporting the demand. Arbitration must be initiated within one year after the date the Dispute arose by submitting a written notice to the other party.

The parties expressly agree that the deadlines to file arbitration set forth above shall not be subject to waiver, tolling, alteration or modification of any kind or for any reason except for fraud. The failure to initiate arbitration before such deadlines shall mean the complaining party shall be barred forever from initiating such proceedings.

All such arbitration proceedings shall be administered by the AAA or JAMS, as agreed by the parties; however, the arbitrator shall be bound by applicable State and federal law, and shall issue a written opinion setting forth findings of fact and conclusions of law. The parties agree that the decision of the arbitrator shall be final and binding as to each of them. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. The arbitrator shall have no authority to make material errors of law or to award punitive damages or to add to, modify, or refuse to enforce any agreements between the parties. The arbitrator shall make findings of fact and conclusions of law and shall have no authority to make any award, which could not have been made by a court of law. The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of the entry of judgment on the award. The parties waive their right to a jury or court trial.

The parties recognize and agree that theirs is an ongoing business relationship, which may lead to sensitive issues with respect to the exchange of information related to any Dispute. The parties agree, therefore, to enter into such protective orders (including without limitation creating a category of discovery documents "for attorney's eyes only" to the extent feasible given the nature of the evidence and the Dispute). All discovery information shall be used solely and exclusively for arbitration of the Dispute between the parties and may not be used for any other purpose. After the arbitration award becomes final, each party shall return or destroy all documents obtained from the other party during the course of the arbitration that are subject to a protective order, and within thirty (30) days

of such date shall provide to the other party an officer's certificate signed under penalty of perjury indicating that all such information has been returned or destroyed.

In all cases submitted to arbitration, the parties agree to share equally the administrative fee as well as the arbitrator's fee, if any, unless otherwise assessed by the arbitrator. The administrative fees shall be advanced by the initiating party subject to final apportionment by the arbitrator in this award. The parties agree that the content and decision of any arbitration proceeding shall be confidential unless disclosure is required by applicable State or federal statutes or regulations. The terms of Section 7.5 and Section 7.6 shall survive termination of this Agreement.

**7.7 Entire Agreement.** This Agreement represents the entire agreement between the parties hereto with respect to the subject matter hereof and supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding.

**7.8 Governing Law.** This Agreement shall be governed by and construed and enforced in accordance with the laws of the State, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern. Health Net is subject to the requirements of various local, State, and federal laws, rules and regulations including, but not limited to, the requirements of Chapter 2.2 of Division 2 of the California Health & Safety Code (the Knox-Keene Health Care Service Plan Act), and of Chapters 1 and 2 of Division 1 of Title 28 of the California Code of Regulations ("C.C.R.") and Title 10 of the C.C.R. Any provision required to be in this Agreement by any of the above shall bind Provider and Health Net whether or not expressly set forth herein.

**7.9 Indemnification.**

7.9.1 Responsibility for Own Acts. Each party shall be responsible for its own acts or omissions and for any and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that party or its employees or representatives in the performance or omission of any act or responsibility of that party under this Agreement.

7.9.2 Provider agrees to indemnify, defend, and hold harmless Health Net, its agents, officers, and employees from and against any and all liability expense including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from Provider's performance or failure to perform its obligations hereunder.

7.9.3 Health Net agrees to indemnify, defend, and hold harmless Provider, its agents, officers, and employees from and against any and all liability expense, including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from Health Net's performance or failure to perform its obligations hereunder.

**7.10 Non-Exclusive Contract.** This Agreement is non-exclusive and shall not prohibit Provider or Health Net or Payor from entering into agreements with other health care providers or purchasers of health care services.

**7.11 No Third Party Beneficiary.** Nothing in this Agreement is intended to, or shall be deemed or construed to, create any rights or remedies in any third party, including a Beneficiary. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to increase the rights of any such Beneficiary or the duties or responsibilities of Provider or Health Net or Payor with respect to such Beneficiaries.

**7.12 Notice.** Notices regarding the breach, term, termination or renewal of this Agreement shall be given in writing in accordance with this Section 7.12 and shall be deemed given five (5) days following deposit in the U.S. mail, postage prepaid. If sent by hand delivery, overnight courier, or facsimile, notices shall be deemed given upon documentation of delivery. All notices shall be addressed as follows:

Health Net:

Health Net of California, Inc.  
Attn: Provider Contracts Administration - Ancillary  
21281 Burbank Blvd.  
Woodland Hills, CA 91367

Electronic copy to: [AncillaryContractNotices@healthnet.com](mailto:AncillaryContractNotices@healthnet.com)

Provider:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Facsimile number: \_\_\_\_\_

Email: \_\_\_\_\_

The addresses to which notices are to be sent may be changed by written notice given in accordance with this Section. Notwithstanding the previous paragraph, Health Net may provide all other notices by electronic mail, through its provider newsletter, or on its provider website.

**7.13 Severability.** If any provision of this Agreement is rendered invalid or unenforceable by any local, State, or federal law, rule or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.

**7.14 Status as Independent Entities.** None of the provisions of this Agreement is intended to create, nor shall be deemed or construed to create any relationship between Provider and Health Net or a Payor other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither Provider nor Health Net/Payor, nor any of their respective agents, employees or representatives shall be construed to be the agent, employee or representative of the other.

**7.15 Addenda.** Each Addendum to this Agreement is made a part of this Agreement as though set forth fully herein. Any provision of an Addendum that is in conflict with any provision of this Agreement shall take precedence and supersede the conflicting provision of this Agreement with respect to the subject matter of the Addendum.

**7.16 Calculation of Time.** The parties agree that for purposes of calculating time under this Agreement, any time period of less than ten (10) days shall be deemed to refer to business days and any time period of ten (10) days or more shall be deemed to refer to calendar days unless the term “business” precedes the term “days”.

**7.17 Waiver of Breach.** The waiver of any breach of this Agreement by either party shall not constitute a continuing waiver of any subsequent breach of either the same or any other provision(s) of this Agreement. Further, any such waiver shall not be construed to be a waiver on the part of such party to enforce strict compliance in the future and to exercise any right or remedy related thereto.

**THIS CONTRACT CONTAINS A BINDING ARBITRATION CLAUSE, WHICH MAY BE ENFORCED BY THE PARTIES.**

IN WITNESS WHEREOF, the parties have executed this Agreement.

Note to Negotiator—Insert full Legal Name of Provider as set forth in First Paragraph of Agreement and remove word "Provider"

**PROVIDER**

**HEALTH NET OF CALIFORNIA, INC.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Valentina T. Shabanian  
Print Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Regional Health Plan Officer  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Federal Tax Identification Number

\_\_\_\_\_  
Name of Tax Identification Number Owner

\_\_\_\_\_  
Ancillary  
Provider Type

\_\_\_\_\_  
NPI#

The information below is mandatory. Please complete all applicable fields.

**(Applicable to all Facility (Hospital, SNF, Dialysis, ASC, Lab, Radiology) templates.)**

**Provider must submit all National Provider Identifiers and a populated billing form (e.g. UB 04 or successor form) for each as directed by Health Net. In addition, the corresponding Tax Identification Number, with a completed W-9 for each TIN, shall be attached. The billing information on the billing form must be consistent with the W-9 form.**

Provider/Facility Name, Address, Telephone and Facsimile Phone	State License Number	Federal Tax Identification Number	Medicare Provider Number	Medi-Cal Provider Number	National Provider Identifier	Accreditation
<i>Additional Location(s):</i>						
<i>Billing/Remit Address:</i>						

**This section is for SNFs only**

Bariatric (Max Wt)	Wound Care	Hospice	Trachs	Vents	SNFist (M.D)

**Special Programs**

Mental Health	Alzheimer's	Dementia	Homeless Assistance	Locked Ward

X-Ray Vendor:	Laboratory Vendor:	Durable Medical Equipment Vendor:	Pharmacy Vendor:

**This section is for Home Health only**

Please mark a "Y" for Yes and a "N" for No to indicate whether or not the listed services are offered.

Counties Served	Wound Care	Pediatric Cases	Physical Therapy	Occupational Therapy	Speech Therapy	PICC Line	Other Services (Hospice etc.)

## ADDENDUM A

### COMMERCIAL BENEFIT PROGRAMS

- I. **Applicability.** This Addendum A and accompanying exhibits apply to Covered Services delivered to Beneficiaries covered by commercial Benefit Programs that include but are not limited, to HMO, PPO, EPO, POS, Salud Con Health Net (state-wide network), and any leased networks. All Covered Services delivered to a Beneficiary covered by a commercial Benefit Program shall be paid in accordance with this Addendum A regardless of product specific name unless otherwise specifically agreed by the parties and set forth in a separate rate exhibit.
- II. **Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Point of Service (POS), Leased PPO Benefit Programs, and Payor Disclosures.** Provider understands and agrees that Health Net may sell, lease, transfer or convey a list, including Provider, to Payors.

Payors shall actively encourage subscribers to use the list of contracted providers when obtaining medical care. Active encouragement includes offering subscribers direct financial incentives to use the list of contracted providers when obtaining medical care (such as reduced Copayments, Coinsurance and Deductibles), or providing or causing the provision of information to subscribers advising such subscribers of the existence of a list of contracted providers through a variety of advertising or marketing approaches that supply the names, addresses and telephone numbers of contracted providers to subscribers in advance of their selection of a health care provider. Nothing in this Addendum A shall be construed to require a Payor to actively encourage such Payor's subscribers to use the list of contracted providers, including Provider, when obtaining medical care in the event of an Emergency.

Health Net shall not permit Payors to access this Agreement and pay Provider's contracted rate for the Benefit Programs covered by this Addendum unless Payor, or Health Net on Payor's behalf, has actively encouraged Payor's subscribers to use the list of contracted providers in obtaining medical care.

Provider agrees that the following commercial Benefit Program Payors are eligible to pay Provider's contracted rate under this Addendum A as of the effective date of this Agreement:

#### **NO PAYORS**

Health Net may modify the above list periodically. Provider may request in writing, and Health Net shall have thirty (30) days from the date of such request, to provide Provider with an updated listing of Payors.

Provider understands and agrees that any Health Net subsidiary or affiliate, including, but not limited to, Health Net Life Insurance Company, are not Payors under this Addendum A but shall access this Agreement as Health Net.

- III. **Payment.** As compensation for rendering Contracted Services to Beneficiaries covered by commercial HMO, PPO, EPO, POS and Leased PPO Benefit Programs under this Addendum A, Health Net shall pay and Provider shall accept as payment in full the rates set forth in Exhibit A-1, subject to the Payment Conditions set forth in Exhibit A-2, the terms of this Agreement and applicable State and federal law. Notwithstanding any other provision in this Agreement, the parties acknowledge that each Payor is solely responsible for paying Provider for Covered Services rendered to those individuals for whom Payor provides health care coverage. For self-insured Payors, Health Net shall not be obligated to pay all or any portion of any Provider claim on a Payor's behalf unless and until Health Net has received sufficient funds from the applicable Payor to cover such claim. In the event such Payor fails to provide funds to Health Net, Provider may seek payment from Member up to the rates specified in this Exhibit, unless prohibited by applicable law.

**EXHIBIT A-1**

**ANCILLARY FEE-FOR-SERVICE RATE EXHIBIT**

**NOTE TO NEGOTIATOR: INSERT APPROPRIATE ANCILLARY RATE EXHIBITS AND PAYMENT CONDITIONS APPLICABLE TO COMMERCIAL BENEFIT PROGRAMS. SEE CONTRACTS ADMIN DRIVE.**

**EXHIBIT A-2**

**COMMERCIAL FEE-FOR-SERVICE PAYMENT CONDITIONS**

**NOTE TO NEGOTIATOR: INSERT APPROPRIATE ANCILLARY RATE EXHIBITS AND PAYMENT CONDITIONS APPLICABLE TO COMMERCIAL BENEFIT PROGRAMS. SEE CONTRACTS ADMIN DRIVE.**

## **ADDENDUM B**

### **MEDICARE ADVANTAGE PROVISIONS**

- I. **Applicability.** Provider and Health Net agree that this Addendum B shall apply only to Contracted Services delivered to Beneficiaries covered by the Medicare Advantage (MA) Program, and this Addendum B may be accessed by those Health Net entities holding a valid Medicare Advantage agreement with CMS at the time Contracted Services are delivered.
- II. **Payment.** Subject to the terms of this Agreement, including without limitation the Payment Conditions set forth in Exhibit B-2, Health Net shall pay and Provider shall accept as payment in full for non-capitated Medically Necessary Covered Services delivered under Health Net's MA Program pursuant to this Addendum B and accompanying Exhibit B-1.
- III. **Obligations.**

A. **Definitions**

For purposes of this Addendum, the definitions included herein shall have the meaning required by law governing the Medicare Advantage (MA) Program.

1. **Medicare Advantage (MA).** The statutory name applicable to the federal program of prepaid health care services for Medicare beneficiaries established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
2. **Medicare (MA) Member or Beneficiary.** A Medicare Beneficiary who has elected to enroll in and receive coverage through a Health Net MA or MAPD Benefit Program, under the terms and conditions of the Benefit Program's MA or MAPD Evidence of Coverage, and whose enrollment has been confirmed by the Centers for Medicare and Medicaid Services ("CMS"), an agency of the U.S. Department of Health and Human Services ("HHS") that administers the Medicare Advantage program.
3. **Contract Period.** The term of the contract between Health Net and CMS.
4. **Delegation.** Delegation to Provider of a certain contractual obligation of Health Net under Health Net's contract with CMS.
5. **MA Benefit Program.** A Health Net Medicare Advantage Benefit Program that provides coverage for certain health care services.
6. **MAPD Benefit Program.** An MA Benefit Program that includes Medicare Part D prescription drug coverage.
7. **MA/MAPD Evidence of Coverage.** A legally binding statement of coverage, revised annually, between a Medicare Member and Health Net under which a Medicare Member is entitled to receive coverage for certain hospital, medical and other associated health care services.

B. **Medicare Advantage Program Obligations.**

1. **Provider Obligations.** Provider agrees to render Contracted Services to MA Members, in accordance with the terms and conditions of Health Net's MA Programs. Health Net shall provide Provider with the Benefit Program Requirements of such Benefit Programs not set forth in this Addendum. Such Benefit Program Requirements include the provisions of the applicable MA or MAPD Evidence of Coverage, and Health Net policies and procedures. Provider acknowledges that the determination of Covered Services shall be governed by coverage guidelines established by Health Net and the MA Program, with Health Net being solely responsible for final coverage determinations, subject to applicable appeal procedures.

2. **Member Services.** Provider shall cooperate fully with Health Net in the investigation and resolution of complaints by MA Members regarding Provider, or the services Provider provides or arranges, in compliance with CMS and state regulatory requirements.
3. **Reports and Administration.** Health Net shall have sole responsibility for filing reports, obtaining approval from, and complying with the applicable laws and regulations of federal, state and local governmental agencies having jurisdiction over Health Net. Provider shall cooperate in providing Health Net with such information and assistance regarding MA Members and Provider's performance under this Agreement and Addendum as Health Net may reasonably require in filing such reports and complying with applicable laws and regulations.
4. **Health Net Policies and Procedures.** Health Net shall promptly communicate any material change in Health Net's policies and procedures affecting Provider in accordance with Section 3.2 of this Agreement.
5. **Prompt Payment.** Health Net and Provider agree to: (i) Process contracted Provider claims received at Health Net within 60 calendar days of receipt, and (ii) Process non-contracted provider clean claims received by Provider within 30 calendar days and 60 calendar days for all other claims.

C. **Regulatory Obligations**

1. Health Net and Provider agree and Provider will require its subcontractors to agree to:
  - (a) HHS, CMS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems, including medical records and documentation of Provider and any Provider subcontractor, involving transactions related to CMS' contract with Health Net through ten (10) years from the final date of the final Contract Period of the contract entered into between CMS and Health Net or from the date of completion of any audit, whichever is later. This right can be exercised directly with any first tier, downstream or related entity. For records subject to review under this provision, except in exceptional circumstances, CMS will provide notification to Health Net that a direct request for information has been initiated. [\*See 42 CFR §§422.504(i)(2)(i-iv); Ch. 11. §100.4, Medicare Managed Care Manual "MMCM"]
  - (b) Cooperate in assist in, and provide information as requested for audits, evaluations and inspections performed under Section C.1(a) above. [\*See Ch. 11. §100.4, MMCM]
  - (c) Safeguard each MA Beneficiary's privacy and comply with the confidentiality and MA Beneficiary record accuracy requirements, including: 1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records , or other health and enrollment information, 2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by MA Beneficiaries to the records and information that pertain to them. [\*See 42 CFR §422.504(a)(13); 42 CFR §422.118; Ch. 11. §100.4, MMCM].
  - (d) Contracts or other written agreements between Provider and Provider subcontractors must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. [\*See 42 CFR §422.520(b)(1); Ch. 11, §100.4, MMCM].
  - (e) Hold each MA Beneficiary harmless for payment of any fees that are the legal obligation of Health Net in the event of, but not limited to, insolvency of, breach by or billing of Provider by Health Net. [\*See 42 CFR §§422.504(g)(1)(i) and (i)(3)(i); Ch. 11 §100.4 MMCM].
  - (f) Comply with all applicable Medicare laws, regulations, reporting requirements and CMS instructions. [\*See 42 CFR §422.504(i)(4)(v)]

- (g) Perform each service or other activity under this Agreement in a manner consistent and in compliance with Health Net’s contractual obligations to CMS. [\*See 42 CFR §422.504(i)(3)(iii)]
- (h) Maintain all records relating to this contract for a minimum of ten (10) years from the final date of the Contract Period or the date of the completion date of any audit, whichever is later. [\*See Ch. 11. §110.4.3, MMCM]
- (i) Health Net oversees and is ultimately responsible to CMS for any functions and responsibilities described in the Medicare Advantage regulations. Provider understands that this accountability provision also applies to this Addendum. [\*See 42 CFR §422.504 (i)(4)(iii); Ch. 11 §100.4, MMCM]
- (j) Comply with Health Net Policies. [\*See Ch. 11. §100.4, MMCM]
- (k) For all MA Beneficiaries eligible for both Medicare and Medicaid (includes Medi-Cal), such MA Beneficiaries will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider and Provider subcontractors may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept Health Net payment as payment in full, or (2) bill the appropriate State source. [\*See 42 CFR §§422.504(g)(1)(i) and (iii); 42 C.F.R. §422.504(i)(3)(i)]

**2. Provider and Health Net agree:**

- (a) Health Net is obligated to pay Provider promptly under the terms of the Agreement between Health Net and the Provider, as well as in accordance with Health Net Policies and Section B(5) of this Addendum. [\*See 42 CFR §§422.520(b)(1) and (2); Ch. 11. §100.4, MMCM]

**3. Provider and its subcontractors further agree to the following:**

- (a) To have approved procedures to identify, assess and establish a treatment plan for Beneficiaries with complex or serious medical conditions.
- (b) To provide access to benefits in a manner described by CMS.
- (c) To protect Beneficiaries who are hospitalized from loss of benefits through the period of time CMS premiums are paid.
- (d) To not employ or contract with individuals excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act.
- (e) To adhere to Medicare’s appeals, expedited appeals and expedited review procedures for Medicare HMO Beneficiaries, including gathering and forwarding information on appeals to Health Net, as necessary.
- (f) That Medicare Beneficiaries’ health services are being paid for with Federal funds, and as such, payments for such services are subject to laws applicable to individuals or entities receiving Federal funds.
- (g) To submit to Health Net all data, including medical records, necessary to characterize the content and purpose of each encounter with Beneficiary.
- (h) To not collect any co-payment or other cost sharing for influenza vaccine and pneumococcal vaccines.
- (i) For purposes of Medicare Beneficiaries, retroactive eligibility changes shall be limited to thirty six (36) months or as otherwise required by CMS

**D. Delegation**

**NOTE TO NEGOTIATOR: Choose option 1 if no delegated activities are assigned to Provider and delete option 2. Choose option 2 if delegated activities are assigned to Provider and delete option 1.**

**Option One**

1. The parties acknowledge that none of Health Net's MA Program contract obligations to CMS have been delegated by Health Net to Provider.

**Option Two**

1. If any of Health Net's activities or responsibilities under its contract with CMS have been Delegated in the underlying agreement, Health Net and Provider must enter into a written Delegation instrument that shall adhere to the following Delegation requirements: The Delegation instrument must (a) specify the Delegated activities, (b) specify Provider's reporting requirements, (c) either provide for revocation by CMS and/or Health net of the Delegated activities and reporting requirements, or specify other remedies if CMS and/or Health Net determines that the Provider has not performed satisfactorily, and (d) specify that Health Net monitors the Provider's performance on an ongoing basis. [\*See 42 CFR §422.504(i)(4); Ch. 11, §§100.4 and 110.2, MMCM]

2. In the event Health Net Delegates credentialing to Provider, the parties agree that Health Net will review and approve the credentialing process, and shall audit the credentialing process on an ongoing basis. If Health Net delegates the selection of providers, contractors or subcontractors, the Health Net retains the right to approve, suspend, or terminate any such arrangement. [\*See 42 CFR § 422.504(i)(4)(iv)]

**EXHIBIT B-1**

**MEDICARE ADVANTAGE FEE-FOR-SERVICE RATES**

**NOTE TO NEGOTIATOR: INSERT APPROPRIATE ANCILLARY RATE EXHIBITS AND PAYMENT  
CONDITIONS APPLICABLE TO MEDICARE BENEFIT PROGRAMS. SEE CONTRACTS ADMIN  
DRIVE.**

**EXHIBIT B-2**

**MEDICARE ADVANTAGE FEE-FOR-SERVICE  
PAYMENT CONDITIONS**

**NOTE TO NEGOTIATOR: INSERT APPROPRIATE ANCILLARY RATE EXHIBITS AND PAYMENT  
CONDITIONS APPLICABLE TO MEDICARE BENEFIT PROGRAMS. SEE CONTRACTS ADMIN  
DRIVE.**

## ADDENDUM C

### **MEDI-CAL BENEFIT PROGRAM**

Provider understands and agrees that the obligations of Health Net, set forth in this Addendum, shall be solely the obligations of Health Net Community Solutions, Inc. and not the obligations of Health Net or any other affiliate of Health Net and Health Net of California, Inc. Health Net has entered into one or more Medi-Cal prepaid health plan agreements with the California Department of Health Care Services ("DHCS"). For the purposes of this Addendum, Health Net's Medi-Cal agreements with the DHCS and any subcontracts with Medi-Cal prepaid health plans, are hereinafter collectively referred to as the "Medi-Cal Agreement". Health Net has agreed, under the Medi-Cal Agreement, to provide medical services covered under California's Medi-Cal Program, including Provider risk services, to Medi-Cal HMO Beneficiaries enrolled in or otherwise assigned to Health Net, on a prepaid basis. The provisions of the Addendum are required to appear in all subcontracts under the Medi-Cal Agreement by the terms of the Medi-Cal Agreement and by Medi-Cal law and may not be altered. When required under Medi-Cal law, the Agreement shall be effective upon approval by DHCS in writing or operation of law where DHCS has acknowledged receipt of the Agreement and failed to approve or disapprove within sixty (60) calendar days.

**NOTE TO NEGOTIATOR: the following two paragraphs apply only to Providers participating in the CalViva Health program in Fresno, Kings and Madera Counties. The text should be deleted for all other providers.**

Provider understands and agrees that Health Net Community Solutions, Inc. is an affiliate of Health Net and of Health Net of California, Inc. and has entered into an agreement with the Fresno-Kings-Madera Regional Health Authority (CalViva Health) to provide Covered Services to Medi-Cal beneficiaries in Fresno, Kings and Madera Counties who enroll in CalViva Health. Provider understands and agrees that Health Net of California, Inc. is providing Covered Services as a subcontractor to Health Net Community Solutions, Inc. for the CalViva Health Medi-Cal membership. Provider further understands and agrees that it will provide Covered Services to CalViva Health Medi-Cal members pursuant to the Agreement and that all terms and conditions of the Agreement, including reimbursement, shall apply to the provision of Covered services to the CalViva Health Medi-Cal members.

Health Net has or may enter into contracts with certain Payors, including local initiatives such as CalViva Health in Fresno, Kings and Madera Counties, to provide or arrange for Covered Services to Medi-Cal beneficiaries enrolled in the Medi-Cal plans of such Payors. Provider understands and agrees that a Payor may have adopted policies and procedures, including, but not limited to, quality assurance and quality improvement programs. Provider further understands and agrees that Provider and its Participating Providers shall comply with all the policies and procedures adopted by a Payor and shall participate in the Payor's quality assurance and quality improvement programs.

#### **A. COMPENSATION PROVISIONS.**

**1. Medi-Cal Benefit Programs.** Provider shall arrange and provide Contracted Services to Medi-Cal HMO Beneficiaries of Health Net's Benefit Programs covered under this Addendum on a fee-for-service basis except for Hospital Services rendered to Medi-Cal HMO Beneficiaries assigned to a Provider under a Capitation compensation method. As compensation for providing such Contracted Services, Provider shall be paid in accordance with the rates set forth on Exhibit C-1. Such compensation shall be paid within forty-five (45) working days of receipt of a complete and accurate claim for Covered Services rendered to a Medi-Cal HMO Beneficiary who is not assigned to a provider under a capitation compensation method.

Notwithstanding anything to the contrary contained in this Agreement, if Provider is decertified, suspended and/or terminated by the California Department of Health Care Services ("DHCS"), or other governmental agencies ("DHCS Notice"), Provider acknowledges that it will not be eligible to receive reimbursement for Contracted Services following the date of the DHCS Notice and Health Net will have no liability to pay Provider under this Agreement upon receipt of the DHCS Notice.

**2. Billing.** Notwithstanding anything to the contrary to the Agreement, if Provider is compensated on a fee-for-service basis, Provider shall submit to Health Net, via Health Net's electronic claims submission program or hardcopy as determined by Health Net, Complete Claims within one hundred eighty (180) days

after the month in which the Covered Service is rendered unless Provider demonstrates good cause pursuant to applicable State law. Where Health Net is the secondary payor under Coordination of Benefits, Provider shall submit Complete Claims for Covered Services accompanied by the explanation of benefits (EOB) or explanation of payment (EOP) from the primary payor to Health Net within one hundred eighty (180) days of the date of the EOB/EOP.

If the Provider fails to comply with the timely claims submission/filing requirements set forth above, Health Net shall reimburse the Provider at the following rates: 75% of usual allowance for claims submitted during the seventh through ninth month after the month of service; 50% of usual allowance for claims submitted during the tenth through the twelfth month after the month of service. Health Net shall not be liable for payment to Provider for any Complete Claims received after the twelfth month after the month of service.

## **B. GENERAL PROVISIONS**

1. Provider is certified to participate in Medicaid/Medi-Cal under Title XIX of the Social Security Act or other applicable State law pertaining to Title XIX of the Social Security Act.

2. **Provision of Covered Services.** Provider shall arrange Covered Services for assigned Beneficiaries. For the purposes of this Addendum, "Covered Services" means those health care services, supplies and items that are specified as being covered under the Medi-Cal Agreement. Provider and its subcontractors shall arrange Covered Services for Beneficiaries, in accordance with the following, each of which is hereby incorporated by reference as if set out in full herein:

- (a) The terms and conditions of this Addendum and the Agreement.
- (b) The terms and conditions of the Medi-Cal Agreement and the applicable Evidence of Coverage.
- (c) Health Net Medi-Cal policies and procedures and physician bulletins.
- (d) DHCS Medi-Cal Managed Care Division (MMCD) Policy Letters.
- (e) All laws applicable to Provider and Health Net.
- (f) Health Net's Utilization Care Management Program and Quality Improvement Program.
- (g) Standards requiring services to be provided in the same manner, and with the same availability, as services are rendered to other patients.
- (h) No less than the minimum clinical quality of care and performance standards that are professionally recognized and/or adopted, accepted or established by Health Net.

3. **Preparation and Retention of Records; Access to Records; Audits.** Provider shall prepare and maintain medical and other books and records required by law in a form maintained in accordance with the general standards applicable to such book or record keeping. Provider shall maintain such financial, administrative and other records as may be necessary for compliance by Health Net with all applicable local, State and federal laws. Provider shall retain such books and records for a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later; and, shall retain all encounter data for a period of at least ten (10) years. Provider shall make Provider's premises, facilities, equipment, books, records, contracts, computer and other electronic systems and encounter data pertaining to the goods and services furnished under the terms of the Agreement available for the purpose of an audit, inspection, evaluation, examination or copying by Health Net, DHCS, the Centers for Medicare & Medicaid Services (CMS), the United States Department of Health and Human Services (DHHS), the California Department of Managed Health Care (DMHC), Inspector General, the Comptroller General, the United States Department of Justice (DOJ), or their designees and any other regulatory agency having jurisdiction over Health Net. The records shall be available at Provider's place of business, or at such other mutually agreeable location in California. When such entities request Provider's records, Provider shall produce copies of the requested records at no charge. Provider shall permit Health

Net, and its designated representatives, and designated representatives of local, State, and federal regulatory agencies having jurisdiction over Health Net, to conduct site evaluations and inspections of Provider's offices and service locations. Provider shall comply with all monitoring provisions of the Medi-Cal Agreement and any monitoring requests by DHCS. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. [22 CCR § 53250(e)(1); W & I § 14452(c); Medi-Cal Agreement] Furthermore, Provider shall timely gather, preserve and make available to DHCS, CMS, the Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in Provider's possession related to the recovery for litigation, pursuant to the Medi-Cal Agreement.

**4. Subcontracting Under the Agreement.** Provider shall not subcontract for the performance of services under the Agreement without the prior written consent of Health Net. Every such subcontract shall be in writing and provide that it is terminable with respect to Beneficiaries by Provider upon Health Net's request. Provider shall furnish Health Net or DHCS with copies of such subcontracts, and amendments thereto, within ten days of execution or upon request. Each such subcontracting Provider shall meet Health Net's credentialing requirements, prior to the subcontract becoming effective. Provider shall be solely responsible to pay any health care Provider permitted under the subcontract, and shall hold, and ensure that health care Providers hold, Health Net, Beneficiaries and the State harmless from and against any and all claims which may be made by such subcontracting Providers in connection with services rendered to Beneficiaries under the subcontract. Provider shall maintain and make available to Health Net, DHCS, the Centers for Medicare & Medicaid Services (CMS), the United States Department of Health and Human Services (DHHS), the California Department of Managed Health Care (DMHC), Inspector General, the Comptroller General, the United States Department of Justice (DOJ), or their designees and any other regulatory agency having jurisdiction over Health Net, copies of all Provider's subcontracts under the Agreement and to ensure that all such subcontracts are in writing and require that the subcontractor: (1) make premises, facilities, equipment, books, records, contracts, computer and other electronic systems available for the purpose of an audit, inspection, evaluation, examination, or copying by said entities; (2) retain such books and records for a term of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later; (3) maintain such books and records in a form maintained in accordance with the general standards applicable to such book or record keeping. [22 CCR § 53250(e)(3)]

**5. Federal Disclosure Form.** Provider shall submit to Health Net a completed Disclosure Form, attached to this Addendum for officers and other persons associated with Provider as required by 42 CFR 455.104, 455.105 and 455.106 and California Welfare and Institutions Code §14452(a).

**6. Medi-Cal HMO Beneficiary Education.** Provider shall make health education materials and programs available to Medi-Cal HMO Beneficiaries on the same basis that it makes such materials and programs available to the general public, and shall use its best efforts to encourage Medi-Cal HMO Beneficiaries to participate in such health education programs. [Medi-Cal Agreement].

**7. Medi-Cal HMO Beneficiaries and State Held Harmless.** Provider agrees that in no event, including, but not limited to, non-payment by Health Net, the insolvency of Health Net, or breach of the Agreement, shall Provider or a subcontractor of Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries, the State of California, or persons other than Health Net acting on their behalf for services provided pursuant to the Agreement. Provider agrees: (1) this provision shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Medi-Cal HMO Beneficiaries; and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Medi-Cal HMO Beneficiaries or persons acting on their behalf. Any modification, addition, or deletion of or to the provisions of this clause shall be effective on a date no earlier than fifteen (15) days after the DHCS has received written notice of such proposed change and has approved such change. [22 CCR § 53250(e)(6)].

**8. No Surcharges and No Copayments.** Provider shall not charge a Beneficiary any fee, surcharge or Copayment for health care services rendered pursuant to the Agreement. In addition, Provider shall not collect a sales, use or other applicable tax from Beneficiaries for the sale or delivery of medical services. If Health Net receives notice of any additional charge, Provider shall fully cooperate with Health Net to investigate such allegations, and shall promptly refund any payment deemed improper by Health Net to the party who made the payment. [Knox-Keene Act and Medi-Cal Agreement].

**9. Grievances.** Provider agrees to work with Health Net to resolve all grievances relating to the provision of services to Medi-Cal HMO Beneficiaries in accordance with the Health Net Medi-Cal grievance procedures.

**10. Provider Patient Relationship.** Provider shall be solely responsible, without interference from Health Net or its agent, for providing Hospital Services to Medi-Cal HMO Beneficiaries, and shall have the right to object to treating any individual who makes onerous the relationship between Provider and Medi-Cal HMO Beneficiary. In the event of a breakdown in such relationship, Health Net shall make reasonable efforts to assign the Medi-Cal HMO Beneficiary to another Participating Provider. If reassignment is unsuccessful, a request may be filed with the DHCS to permit termination of services to such Medi-Cal HMO Beneficiary. Approval from the DHCS must be obtained before Provider terminates services to such Medi-Cal HMO Beneficiary.

**11. Fair Employment Requirements.** During the term of this Agreement, Provider and its subcontractors shall not unlawfully discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military or veteran status. Provider and its subcontractors also shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination. Provider and its subcontractors shall comply with the provisions of the Fair Employment and Housing Act (California Government Code, Section 12990 *et seq.*) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0 *et seq.*). The applicable regulations of the Fair Employment & Housing Council implementing Government Code, Section 12990, set forth in Subchapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider and its subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreements.

**12. Governing Law.** The Agreement shall be governed by and construed and enforced in accordance with all laws and contractual obligations incumbent upon Health Net. Provider shall comply with all applicable local, State, and federal laws, now or hereafter in effect, to the extent that they directly or indirectly affect Provider or Health Net, and bear upon the subject matter of the Agreement. Provider shall comply with the provisions of the Medi-Cal Agreement, and Chapters 3 and 4 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations. In addition, Health Net is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations. Any provision required to be in the Agreement by either of the above laws shall bind the parties whether or not provided in the Agreement. [22 CCR § 53250(c)(2)]; W & I § 14452(a); Knox-Keene Act].

**13. Notice.** Provider shall notify DHCS in the event this Agreement is amended or terminated. Notice to DHCS is considered given when properly addressed and deposited with the United States Postal Service as first class registered mail, postage attached. [Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13, and Title 22, CCR, Sections 53250(e)(4) and 53867.]

**14. Reports:** Provider shall provide Health Net, within the time requested by Health Net, with all such reports and information as Health Net may require to allow it to meet the reporting requirements under the Medi-Cal Agreement or any applicable law or regulatory directive. [Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867]. Furthermore, Provider shall submit to Health Net, complete, accurate, reasonable, and timely provider data requested by Health Net in order for Health Net to meet its provider data reporting requirements to DHCS. [Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.]

**15. Confidentiality of Information.** Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 45, Code of Federal Regulations, Section 205.50 and Section 14100.2 of the California Welfare and Institutions Code and the regulations adopted thereunder. For the purposes of this Agreement, all information, records, data, and data elements collected and maintained for or in connection with performance under this Agreement and pertaining to Medi-Cal HMO Beneficiaries shall be protected by Provider from unauthorized disclosure. With respect to any identifiable information concerning a Medi-Cal HMO Beneficiary under this Agreement that is obtained by Providers or its subcontractors, Provider: (1) will not use any such information for any purpose other than carrying out the express terms of this Agreement; (2) will promptly transmit to Health Net all requests for disclosure of such information; (3) will not disclose, except as otherwise specifically permitted by this Agreement, any such information to any party other than Health Net without Health Net's prior written authorization specifying that the information is releasable under applicable law, and (4) will, at the expiration or termination of this Agreement, return all such information to Health Net or maintain such information according to written procedures provided Provider by Health Net for this purpose. Provider shall ensure that its subcontractors comply with the provisions of this paragraph.

**16. Third Party Tort Liability.** Provider shall make no claim for recovery for health care services rendered to a Medi-Cal HMO Beneficiary when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance, including workers' compensation awards and uninsured motorist coverage. Within five (5) days of discovery, Provider shall notify Health Net of cases in which an action by the Medi-Cal HMO Beneficiary involving the tort or workers' compensation liability of a third party could result in a recovery by the Medi-Cal HMO Beneficiary. Provider shall promptly provide: (1) all information requested by Health Net in connection with the provision of health care services to a Medi-Cal HMO Beneficiary who may have an action for recovery from any such third party; (2) copies of all requests by subpoena from attorneys, insurers or Medi-Cal HMO Beneficiaries for copies of bills, invoices or claims for health care services; and (3) copies of all documents released as a result of such requests. Provider shall ensure that its subcontractors comply with the requirements of this provision.

**17. Amendments.** When required under Medi-Cal law, Amendments to the Agreement shall be submitted by Health Net to the DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes, which are neither approved nor disapproved by the Department, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later. Subcontracts between a prepaid health plan and a subcontractor shall be public records on file with the DHCS. [22 CCR §§ 53250(a), (c)(3), & (e)(4); W & I § 14452(a)].

**18. Notice of Change in Availability or Location of Covered Services.** Health Net is obligated to ensure Medi-Cal HMO Beneficiaries are notified in writing of any changes in the availability or location of Covered Services at least thirty (30) days prior to the effective date of such changes, or within fourteen (14) days prior to the change in cases of unforeseeable circumstances. Such notifications must be approved by DHCS prior to the release. In order for Health Net to meet this requirement, Provider is obligated to notify Health Net in writing of any changes in the availability or location of Covered Services at least forty (40) days prior to the effective date of such changes.

**19. Transfer of Care Upon Termination of the Agreement.** Provider shall, pursuant to the requirements of the Medi-Cal Agreement, assist in the orderly transfer of care of all Medi-Cal HMO Beneficiaries under the care of Provider in the event of the termination of the Agreement for any reason.

**20. Assignment and Delegation.** Assignment or delegation of an obligation or responsibility under the Agreement shall be void unless prior written approval is obtained from the DHCS, in the instances where approval by the DHCS is required.

**21. Carve-out of California Children's Services (CCS) Program Services.** The parties acknowledge that health care services to treat CCS-eligible conditions are "carved out" of Health Net's coverage obligations under the Medi-Cal Benefit Programs. Provider shall identify and timely refer

Beneficiaries with possible CCS-eligible conditions to the appropriate County CCS Program. Upon referral, Provider shall inform the Beneficiary's parent or guardian and shall notify Health Net of any such referral. The CCS Program requires eligible children to be treated at CCS-certified facilities by CCS-paneled providers. The CCS Program may require transfer to CCS-certified facilities with CCS-paneled providers. The CCS Program is financially responsible for payment of health care costs to treat a CCS-eligible condition. The parties understand and agree that Health Net is not financially responsible for payment of services to treat CCS-eligible conditions. In the event Health Net inadvertently pays a claim for such services, Health Net may recover the amount paid pursuant to Section 4.3 of the Agreement.

**22. Cultural and Linguistic Services.** Provider shall: (1) not require or encourage Beneficiaries to utilize family Beneficiaries or friends as interpreters; (2) record the language needs of Beneficiaries in the medical record; and (3) document Beneficiary requests or refusals of interpreter services in the Beneficiary's medical record. Provider shall arrange interpreter services for Beneficiaries either through telephone language services or face-to-face interpreters. Provider is encouraged to directly make these interpretive services available. However, upon request, Health Net's Member Services Department is available to provide certain interpretive assistance to facilitate communications. Health Net shall: (1) Provide cultural competency/humility, sensitivity, health equity, and diversity training to Health Net's contracted providers. Provider must ensure that cultural competency/humility, sensitivity, health equity, and diversity training is provided for its employees and staff at key points of contact with Beneficiaries per the Medi-Cal Agreement.

**23. Provider Preventable Conditions.** Health Net and Provider shall comply with the Patient Protection and Affordable Care Act (PPACA), as amended, including any reporting requirements and non-payment for Provider Preventable Conditions. Provider shall comply with Health Net's Policies regarding any reporting requirements and non-payment for Provider Preventable Conditions.

**24. Prospective Requirements.** Health Net shall inform Provider of prospective requirements added by DHCS to the agreement between Health Net and DHCS, before the effective date of such requirements. Provider agrees to comply with any changes to such requirements within thirty (30) days of the effect of said requirements from DHCS, unless DHCS instructs otherwise and to the extent possible.

**25. Provider Network Requirements.** Provider acknowledges that, in the event Provider does not have, within its network, sufficient coverage, or is unable to meet service requirements of Health Net's Beneficiaries, Provider agrees to authorize, permit and/or refer Beneficiaries to any provider outside Provider's network regardless of affiliation to Provider. Provider shall not use any Administrative subcontractors, including, but not limited to, any Administrative Services Organizations, ("ASO") to restrict an assigned Health Net Beneficiary's right to obtain services outside the Provider's network, when Provider's network is inadequate to meet the service requirements of such Health Net Beneficiaries. Furthermore, in the event Provider's network is determined, by Health Net, to be inadequate or that Provider is unable to provide the services that Provider is required to and/or contracted to render to Health Net Beneficiaries, Health Net shall impose any of the following:

- a) require Provider to meet and comply with a Corrective Action Plan, ("CAP");
- b) impose sanctions, including monetary penalties or reductions in payments
- c) as required by DHCS, submit a report of such Provider network inadequacy, to the DHCS.

**26. Immunization Services.** Provider shall ensure that all Participating Providers and/or Professional Providers, who render any Immunization services, of any kind, are registered with, and submit applicable information to a CA immunization registry and shall provide evidence of such, upon request or audit, by Health Net or any designee.

**27. Emergency Service Providers.** Health Net is responsible for coverage and payment of emergency services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has an agreement with Health Net. Post-stabilization care services following an emergency inpatient admission are covered and paid for in accordance with provisions set forth in 42 CFR 422.113 (c)

**28. Provider's Performance.** This Agreement is subject to termination, or other remedies, if DHCS or Health Net determine that Provider has not performed satisfactorily.

**29. Suspected Fraud, Waste, or Abuse.** Provider must notify Health Net, and Health Net Subcontractors or Downstream Subcontractors Provider also contracts with, within ten Working Days of any suspected Fraud, Waste, or Abuse. Health Net shall share such information with DHCS in accordance with the Medi-Cal Agreement.

**30. Emergency Preparedness.** Provider shall i.) annually submit to Health Net evidence of adherence to CMS Emergency Preparedness Final Rule 81 FR 63859; ii.) advise Health Net as part of Provider's Emergency plan; and iii.) notify Health Net within 24 hours of an Emergency if Provider closes down, is unable to meet the demands of a medical surge or is otherwise affected by an Emergency. Emergency for purposes of this section shall include any natural or manmade disaster or public health crisis.

## EXHIBIT C-1

### MEDI-CAL FEE-FOR-SERVICE RATE EXHIBIT

**NOTE TO NEGOTIATOR: INSERT APPROPRIATE ANCILLARY RATE EXHIBITS AND PAYMENT CONDITIONS APPLICABLE TO MEDI-CAL BENEFIT PROGRAMS. SEE CONTRACTS ADMIN DRIVE.**

Subject to the terms of this Agreement, including without limitation, the Payment Conditions set forth in Exhibit C-2 of this Agreement, when Contracted Services rendered by Provider are paid on a fee-for-service basis, Health Net shall pay and Provider shall accept the lesser of: i) the rates set forth in this Exhibit C-1, or ii) 100% of Provider's Allowable Charges.

Category of Service	Compensation
Outpatient Services	<p>100% of the current Medi-Cal Fee Schedule, subject to any changes made by the State of California</p> <p>Maximum rate is 100%; rates greater than 100% of State Medi-Cal fee schedule or any rates based on other reimbursement methodology require approval from State Health Programs Director</p>
Outpatient Surgical Implants/Prosthetics/Durable Medical Equipment/Surgical Supplies	<p>Included in case rate or per diem.</p> <p>Note to Negotiator: If services are excluded from case rate or per diem, Provider shall be reimbursed at 15% of Provider's Allowable Charges if total billed amount is less than or equal to \$500 per item.</p> <p>*If total billed amount is greater than \$500 per item, provider shall be reimbursed at Invoice cost. Claim denied for invoice. Invoice to be manufacturer or supplier's invoice received by the facility when item was stocked and must be specific to this member's use and date of service.</p>
Pharmaceuticals without an established Medi-Cal Value	Average Wholesale Price (AWP) – 18%
Unlisted Procedures	
Procedures with Medi-Cal Units not Established but with a Medicare Value	80% of the Current Medicare Allowable
Procedures without Medi-Cal Units and without a Medicare Established Value	15% of Provider's Allowable Charges.

**\* For services or items reimbursed at "Invoice Cost," Provider agrees to submit an invoice with the claim.**

## EXHIBIT C-2

### MEDI-CAL FEE-FOR-SERVICE PAYMENT CONDITIONS

**NOTE TO NEGOTIATOR: INSERT APPROPRIATE ANCILLARY RATE EXHIBITS AND PAYMENT CONDITIONS APPLICABLE TO MEDI-CAL BENEFIT PROGRAMS. SEE CONTRACTS ADMIN DRIVE.**

The Payment Conditions set forth in this Addendum supplement Health Net Policies, and are applicable to the Medi-Cal Benefit Program.

1. The codes listed in the applicable Rate Exhibit shall be used by the parties for the purpose of defining the services for which payment will be made under this Agreement. Provider shall utilize the specified codes listed in the applicable Rate Exhibit when submitting Complete Claims for Covered Services under this Agreement.
2. The parties acknowledge that applicable coding agencies periodically issue coding modifications. Such modifications may be implemented by Health Net within sixty (60) days of the date Health Net receives the modification from the applicable coding agency or notification from Provider. The parties agree that in the event such coding modifications have the effect of changing a payment amount in this Agreement, the resulting payment amount change shall be effective on a prospective basis. The parties further agree to reasonably and in good faith discuss any contract rate amendment that may be appropriate based on comprehensive and substantive coding changes by the applicable coding agency within ninety (90) days of written notification by either party. Any and all rate modifications that may result from such contract amendment shall be effective on a prospective basis.
3. Only one per diem or case rate shall be payable a) for each Beneficiary who is admitted prior to midnight and remains past midnight; b) if a Beneficiary is admitted and discharged during the same day, provided that such admission and discharge is not within 24 hours of a prior discharge; c) for mother and newborn child (children) when both mother and newborn child (children) are in the facility on the same day, unless the child (children) is in the neonatal intensive care unit. Pre-admission testing completed within **3 (1 – 3) days** of admission will be included in the per diem and will not be billed separately by Provider. A per diem is an all-inclusive daily payment, including but not limited to observation services, supplies, implants, prosthetics, durable medical equipment, and pharmaceuticals with the exception of specific carve-outs or exclusions identified on the applicable rate exhibit. Inpatient Professional services billed by the Provider on behalf of the hospital-based physician(s) are included in the per diems or case rates. . Admission kits are included in the per diem rate. Any Outpatient Services delivered to a Beneficiary within 24 hours prior to an admission for Inpatient Services for the same medical condition at the same facility are included in the inpatient rate.
4. The rates set forth in this Agreement apply only to inpatient admissions commencing on or after the Effective Date of this Agreement. The applicable rate of payment that is in effect on the date an inpatient admission commences shall apply to the entire length of stay regardless of any rate change that may occur during the length of stay. **Notwithstanding the foregoing, inpatient case rates are applicable beginning the first day of admission if a case rate procedure is performed at any time during the inpatient stay.**

**NOTE TO NEGOTIATOR: Please delete the above highlighted sentence and replace with the following language when inpatient case rates are negotiated in addition to per diems. “Notwithstanding the foregoing, inpatient case rates are applicable the day a case rate procedure is performed.”**

5. All inpatient case rates shall include any readmission charges if the patient is readmitted within forty-eight (48) hours following discharge for complications related to the prior admission. Should non-standard conditions occur, the second admission within forty-eight (48) hours may be eligible for reimbursement, provided such admission is in accordance with Health Net Policies.

6. If a Beneficiary is admitted to the hospital from the emergency room and/or observation room, separate reimbursement for the emergency room, observation room and other outpatient charges shall not be paid; however, the applicable inpatient reimbursement shall be reimbursed as all-inclusive reimbursement.

The rate payable for Emergency Services is an all-inclusive case rate, including but not limited to supplies, implants, prosthetics, durable medical equipment, observation charges, diagnostic services, therapeutic services, pharmaceuticals, and other services incidental to the emergency room visit, with the exception of specific exclusions identified on the applicable rate exhibit. (Remove if ER reimb on % of BC without NTE.)

7. The all-inclusive procedure rate payable for outpatient surgery (including Cardiac Cath/PTCA, etc., when applicable) is an all-inclusive case rate, including but not limited to supplies, implants, prosthetics, durable medical equipment, emergency room charges, observation charges, diagnostic services, therapeutic services and pharmaceuticals with the exception of specific exclusions identified on the applicable rate exhibit. Only one (1) case rate shall be paid for each Beneficiary per date of service. [NOTE: Include any other significant case rates in this paragraph.]

8. Other Outpatient case rates are an all-inclusive payment, including but not limited to supplies, diagnostic services, therapeutic services and pharmaceuticals with the exception of specific exclusions identified on the applicable rate exhibit. Only one (1) case rate shall be paid for each Beneficiary per date of service; provided, however, that if one or more unique case rate procedure is performed on different body parts, each applicable case rate shall be reimbursed.

9. Provider shall be reimbursed for multiple and bilateral procedures, or when more than one surgical procedure is performed under the same anesthesia during an operative session:

[NOTE TO NEGOTIATOR: Only use Multiple Procedures hierarchy below when not using case rate. If using case rate, delete section below.]

- (i) The procedure in the highest payment category shall be paid at 100% of the applicable contract rate;
  - (ii) The second-ranking procedure shall be paid at 50% of the applicable contract rate;
  - (iii) All other procedures are paid at 50% of the applicable contract rate.
10. Pharmaceuticals shall include inhaled/infused/injected medications provided by, and delivered in a hospital outpatient/ambulatory setting. AWP pricing shall be determined by Health Net utilizing a nationally recognized source for pharmaceutical pricing to be updated at least quarterly. Provider shall bill administered dosage in accordance with applicable HCPCS and NDC codes. Multi-dose vials shall be reimbursed on a per dose basis.
11. In the event that a Beneficiary is transported either within Provider's Facility or to another facility for a service that is within Provider's customary scope of practice, but due to malfunction or other cause cannot be delivered, Provider shall be solely financially responsible for claims incurred for such transportation.
12. For purposes of this Agreement, New Service/Technology is defined as a service, procedure, device, test, or other item that, as of the effective date of this Agreement: (i) is not performed by Provider, or (ii) is not Covered by Health Net under the applicable Benefit Program, or (iii) for which there is no assigned CPT or other relevant code defined. New Service/Technology does not include a new code that is assigned as a change to an existing service, procedure, device, test, or other item. If Provider offers a New Service/Technology after the effective date of this Agreement for which Provider desires reimbursement under this Agreement, Provider agrees to give Health Net sixty (60) days prior written notice that Provider requests that such New Service/Technology be included in Contracted Services, and that Provider receive a different reimbursement rate for the use of such New Service/Technology for Beneficiaries. Health Net agrees to determine whether such New Service/Technology qualifies as a Covered Service and whether Health Net desires to include such New Service/Technology in Contracted Services within thirty (30) days of the date of Provider's notice hereunder. Health Net's determination of whether a New

Service/Technology qualifies as a Covered Service shall be made in Health Net's sole discretion, and shall be final and binding on Provider with respect to this Agreement. Only if Health Net agrees that such New Service/Technology is a Covered Service and desires to include such New Service/Technology in Contracted Services, the parties shall enter into good faith negotiations to modify Provider's rates to reflect the New Service/Technology. Any rate modification shall be made only prospectively.

13. The lowest room and board billed charge rate shall apply to all days billed within the same revenue code level of care.
14. If any payment rates are based on Provider's Allowable charges, upon Health Net's written request, Provider shall send Health Net an electronic copy of Provider's current Charge Master. Provider shall notify Health Net in writing via certified letter at least sixty (60) days prior to making any changes to Provider's Charge Master ("Notice"). The rates in Provider's Charge Master before [XX insert date, for example the date Provider's most recent fiscal year began], shall be the "Baseline Charge Master." Changes to the Baseline Charge Master shall be measured during the twelve (12) month period immediately preceding the date of the Notice (the "Measurement Period"). The Notice shall be signed by Provider's Chief Financial Officer (or equivalent) and shall include a statement of any and all changes made to the Baseline Charge Master during the Measurement Period together with the effective date of such change. All changes included in the Notice shall be calculated using the methodology set forth herein. Any change to Provider's Charge Master during the term of this Agreement shall result in a proportional change to reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the stop-loss threshold (if applicable) set forth in the applicable addendum and/or exhibit to this Agreement. The terms of this section shall survive termination of this Agreement with respect to Contracted Services rendered during the term of the Agreement. The methodology for calculating Changes to the Charge Master and rates pursuant to this section is as follows:

- (a) First Year: Provider agrees that any Notice delivered during the first year of this Agreement shall reflect no changes made to the Baseline Charge Master. In the event Provider has made changes to its Baseline Charge Master, any such change shall result in a proportional change to reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the stop-loss threshold (if applicable) set forth in the applicable addendum and/or exhibit to this Agreement, such that there will not be a change to Health Net's reimbursement to Provider during the first year of this Agreement.
- (b) Subsequent Years: For each subsequent Measurement Period, Provider shall not change Provider's Baseline Charge Master in a manner that results in an increase in reimbursement under this Agreement by more than percent ( %) in the aggregate, unless expressly agreed upon in writing by the parties hereto. Upon request, Provider shall promptly provide Health Net with a Notice that completely and accurately sets forth any and all changes during the Measurement Period. Health Net shall have the right to reconcile and reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the stop-loss threshold (if applicable) set forth in the applicable addendum and/or exhibit to this Agreement. In the event Health Net exercises its right to reconcile and adjust payment, Health Net shall give Provider at least thirty (30) days prior written notice, which notice shall be attached to the applicable rate exhibit in this Agreement. Any resulting change in payment rates shall be effective upon thirty (30) days prior written notice to Provider and shall be applicable to all claims adjudicated after the thirty (30) day notice period has expired regardless of the dates of service for such claims.
- (c) Both parties agree that Charge Master changes shall be calculated using Provider's aggregate weighted average charge increase where weights equal volume for specific charges.

Health Net may periodically review Provider's Charge Master filed with the State or Health Net's historical claims data. If Health Net determines as a result of such review that Provider has made changes to the Baseline Charge Master but has failed to give Health Net Notice, the parties agree that such changes shall result in a proportional change to reduce the percentage for those categories of service reimbursed on a discount off of charges basis and increase the stop-loss threshold (if applicable) set forth in the applicable addendum and/or exhibit to this Agreement. Any such change in rates shall be effective upon thirty (30) days prior written notice to Provider and shall be applicable to all claims adjudicated after the thirty (30) day notice period has expired

regardless of the dates of service for such claims. Health Net shall use the above methodology for calculating changes to the Charge Master and rates pursuant to this section.

**EXHIBIT C-3**

**FEDERAL DISCLOSURE FORM**

(Required by California Welfare and Institutions Code Section 14452)

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency;

- 1) the identity of all owners with a control interest of five (5) percent or greater,
- 2) certain business transactions as described in 42 CFR 455.105, and
- 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity.

If there are any changes to the information disclosed in this form, an updated form should be completed and submitted to Health Net Community Solutions, Inc. within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity		
Name of Individual, Group Practice, or Disclosing Entity		
DBA Name		
Federal Tax Identification Number	NPI	CAQH Number

Section I

Please list the name, title address, date of birth, and Social Security Number for each individual having an ownership or control interest in this provider of five (5) percent or greater.			
Please list the name, Tax Identification Number, business address or each organization, corporation, or entity having an ownership or control interest of five (5) percent or greater. (42 CFR 455.104) Please attach a separate sheet if necessary.			
Name of individual or entity	DOB	Address	SSN (for individual) or TIN (for entity)

Section II

Are any of the individuals listed in Section one related to each other? <input type="checkbox"/> Yes <input type="checkbox"/> No
--

If yes, list the individual's name above who are related to each other (spouse, sibling, parent, child). 42 CFR 455.104

Name	Relationship

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of five (5) percent or more?

- Yes
- No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of five (5) percent or more. 42 CFR 455.104

Name of individual or entity	DOB	Address	SSN (for individual) or TIN (for entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program?

- Yes
- No

If yes, list those persons below. 42 CFR 455.106

Name and Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than \$25,000 or any significant business transactions with any subcontractors?

- Yes
- No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than \$25,000 during the previous twelve (12) month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past five (5) year period. 42 CFR 455.105

Name of Supplier or Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information) as a Disclosing Entity?

- Yes
- No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date or birth, Address, Social, Security Number, and percent of interest.

Name and Title	DOB	Address	SSN	% of Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

\_\_\_\_\_

Signature

Title (indicate if authorized Agent)

\_\_\_\_\_

Name (please print)

Date





*To Apply: email resume to [lha@localhealthauthority.org](mailto:lha@localhealthauthority.org)*

**Reports to: Chief Executive Officer**

**Job Description: Chief Medical Officer**

The Chief Medical Officer (CMO) reports directly to the Imperial County Local Health Authority, dba Community Health Plan of Imperial Valley (LHA) on medically related matters and to the Chief Executive Officer on all other matters. The CMO is primarily responsible for medical related functions of the LHA by performing duties personally, through the management of subordinate staff, or oversight and leadership of the LHA's Subcontractor for delegated responsibilities (Delegate). The CMO will provide leadership on medical issues affecting the organization. The work is varied and highly complex requiring a high degree of discretion and independent judgment. The CMO position is an at-will classification unless otherwise provided for in an employment contract.

***Essential Duties & Responsibilities:***

- Ensures that medical care rendered by providers meets with applicable professional standards for acceptable medical care and quality that equals or exceeds the standards for medical practice developed by the LHA and approved by the State Department of Health Care Services.
- Develops and implements medical policies for the LHA as well as collaborating with the Delegate.
- Monitors the availability and accessibility of services.
- Ensures that medical decisions by the LHA, and the Delegate, are rendered by qualified medical personnel, unhindered by fiscal or administrative management.
- Coordinates professional interactions among participating providers and lends guidance and assistance toward correcting any deviation from medical standards.
- Monitors and resolves medical-related grievances/appeals that flow through the Member Grievance Process at the LHA or Delegate.
- Serves as chairperson of the Quality Improvement/Utilization Management Committee and the Peer Review/Credentialing Sub Committee. Periodically attends and participates in Delegate Quality and Utilization Committee meetings for the purpose of oversight and guidance, with ultimate responsibility under the LHA.
- Provides medical direction and supervision of all compliance audits, reviews, and assessment of delegated administrative services.
- Maintains a formal Quality Improvement Program for the LHA, its administrative services provider, and participating health care providers.
- Serves as a liaison between the LHA and direct contracting providers and providers contracting through the LHA's administrative services provider.
- Resolves provider claims grievances involving medical matters.
- Ensures the privacy and security of PHI (Protected Health Information) as outlined in RHA's policies and procedures relating to HIPAA compliance.
- Required to travel within US at the direction of the Commission.
- Other duties as required.



***Minimum Qualifications:***

***Education:***

- Medical Degree from an accredited medical school
- Satisfactory completion of an accredited residency program, Board Certification
- License to practice medicine in California

***Knowledge, Skills & Abilities:***

- Administrative practices and procedures (including but not limited to quality assessment and improvement, utilization review, peer review, credentialing, health plan member grievances, and risk management.
- Rules, regulations, policies, and standards related to managed care.
- Principles of effective supervision and organization
- Methods, techniques, practices, principles, and literature in the broad field of medical sciences
- Overview of the highly specialized techniques, procedures, and equipment used in the medical or surgical specialties
- Strong skills in identifying, planning, leading, and executing appropriate and successful health care business strategies to meet changing organizational and community needs and regulatory requirements
- Able to work in a matrix organization with both the LHA and Delegate relationships.

***Physical Requirements:***

- Constant and close visual work at desk or on a computer
- Extensive typing
- Constant sitting and working at desk
- Frequent verbal and written communication with staff and other business associates by telephone, correspondence, or in person
- Frequent walking and standing
- Frequent lifting of folders, files, binders, and other objects weighing up to 30 lbs.
- Must have reliable transportation

*NOTE: The details in this job description highlight the broad type and degree of work that people in this classification are expected to accomplish. It is not intended to be read as an exhaustive list of all the obligations, duties, and skills needed by workers assigned to this position*

## **JOB DESCRIPTIONS-**

### **Miscellaneous**

#### **Vice President, Medical Director 211157**

- Job Profile Name  
Vice President, Medical Director
- Job Code  
211157
- Job Profile Summary  
Position Purpose: Provide strategic and operational direction for utilization management, quality, and administrative or clinical policies, procedures and programs. Implement and monitor regional and line of business performance and medical/clinical management programs throughout state. Provide overall mentorship, development and supervision to a team of experienced Medical Directors and physician consultants, as well as partnership with key operational and Line of Business leaders.

Education/Experience: Doctor of Medical (MD) or Doctor of Osteopathic Medicine (DO) required. 5+ years of managed care clinical experience required. Experience working with health analysts and Information Technology in developing process and utilization-based reports. Demonstrated ability to adjust to changing priorities while remaining focused on overall strategic goals and project deliverables. Demonstrated ability to manage multiple projects and/or multiple teams, either directly or through influence, to achieve desired outcomes (including quality, medical management, and growth, etc.). A demonstrated record of Managed Care Medical and Quality Management leadership experience.

License/Certification: MD licensed in Current State required. Current board certification in trained specialty

#### **Regional Medical Director 211136**

- Job Profile Name  
Regional Medical Director
- Job Code  
211136
- Job Profile Summary  
Position Purpose: Build creditable and trusting relationships with stakeholders regarding performance metrics. Serve as liaison for the health plan to ensure that all the opportunities are highlighted through detailed reporting to the leadership at the groups. Individually own and lead HBR initiatives that ties to cost savings to the AOP for department. Serve as the clinical lead with large employer groups in the bid process.

Education/Experience: Graduate of an accredited medical school, plus board certification by the ABMS in a primary care specialty. MBA, MPH, or epidemiologist degree preferred. 5+ years of managed care experience; experienced with commercial, Medicare and Medicaid lines of business, experience leading teams and projects which include physicians, case/care managers. utilization review and quality of care. Minimum of 3+ years of supervisory/management experience.

License/Certification: Current state's MD license and specialty board certifications

### **Chief Medical Officer 700634**

- Job Profile Name  
Chief Medical Officer
- Job Code  
700634
- Job Profile Summary  
Position Purpose: Provide medical oversight, expertise and leadership to ensure the delivery of cost effective, quality healthcare services to health plan members.

Education/Experience: Medical Doctor or Doctor of Osteopathy. 7+ years of clinical experience in the practice of medicine. Management experience preferred. Utilization Management experience and knowledge of quality accreditation standards preferred. Actively practices medicine. Course work in the areas of Health Administration, Health Financing, Insurance, and/or Personnel Management is advantageous. Experience treating or managing care for a culturally diverse population preferred.

License/Certification: Board certification in a medical specialty recognized by the American Board of Medical Specialists or the American Osteopathic Association's Department of Certifying Board Services. (Certification in Psychiatry specialty Is required.) Current state license as a MD or DO without restrictions, limitations, or sanctions from government programs.

Responsibilities:

- Provide leadership and expertise in the development, implementation and interpretation of medical review and quality related policies and guidelines.
- Provide oversight and direction for staff and provider training and education.
- Promote positive relations with the local medical community, including periodic consultation with providers or prescribers.
- Review case management data, identifies trends and gaps in care and recommends corrective actions.
- Review all quality of care issues and oversees the development and implementation of processes for improvement.
- Monitor performance indicators to ensure the delivery of cost-effective care within quality standards.
- Monitor member and provider satisfaction and recommends and implements changes to improve satisfaction levels.
- Work collaboratively to develop corporate clinical care standards and medical practice policies.
- Provide medical guidance to the Medical Management department.

### **Senior Medical Director 210153**

- Job Profile Name  
Senior Medical Director
- Job Code  
210153
- Job Profile Summary

Position Purpose: Assist the Vice President of Medical Affairs to direct and coordinate the medical affairs functions for the business unit. Oversee the denials and appeals department. May manage other medical directors. Assume VPMA responsibility in absence of VPMA.

Education/Experience: Medical Doctor or Doctor of Osteopathy. 7+ years of clinical experience in the practice of medicine. Management experience preferred. Utilization Management experience and knowledge of quality accreditation standards preferred. Actively practices medicine. Course work in the areas of Health Administration, Health Financing, Insurance, and/or Personnel Management is advantageous. Experience treating or managing care for a culturally diverse population preferred.

License/Certification: Board certification in a medical specialty recognized by the American Board of Medical Specialists or the American Osteopathic Association's Department of Certifying Board Services. (Certification in Psychiatry specialty Is required.) Current state license as a MD or DO without restrictions, limitations, or sanctions from government programs.

Responsibilities:

- Provide medical leadership for all utilization management, pharmacy, case management, disease management, cost containment, and medical quality improvement activities. Perform medical review activities pertaining to utilization review, quality assurance, and medical review of complex, controversial, or experimental medical services. Support the effective implementation of performance improvement initiatives for capitated providers.
- Assist VPMA in planning and establishing goals and policies to improve quality and cost-effectiveness of care and service for members. Provide medical expertise in the operation of approved quality improvement and utilization management programs in accordance with regulatory, state, corporate, and accreditation requirements.
- Assist the VPMA in the functioning of the physician committees including committee structure, processes, and membership. Oversee the activities of physician advisors and other medical directors. Utilize the services of medical and pharmacy consultants for reviewing complex cases and medical necessity appeals. Participate in provider network development and new market expansion as appropriate. Participate in provider profiling initiatives. Assist in the development and implementation of physician education with respect to clinical issues and policies.
- Identify utilization review studies and evaluates adverse trends in utilization of medical services, unusual provider practice patterns, and adequacy of benefit/payment components. Identify clinical quality improvement studies to assist in reducing unwarranted variation in clinical practice by profiling providers in order to improve the quality and cost of care. Interface with physicians and other providers in order to facilitate implementation of recommendations to providers that would improve utilization and health care quality. Review claims involving complex, controversial, or unusual or new services in order to determine medical necessity and appropriate payment.
- May develop alliances with the provider community through the development and implementation of the medical management programs. As needed, may represent the business unit before various publics both locally and nationally on medical philosophy, policies, and related issues. Represent the business unit at appropriate state committees and other ad hoc committees.
- May oversee all aspects of the Appeals and Denials department including implementing budgetary, policy, and personnel decisions for the department.

# **Q1 CHPIV Quality Improvement Health Health Equity Committee Presentation**

# Q1 CHPIV QIHEC Agenda

## Topics

- Call Center Metrics
- Utilization Management
- Appeals & Grievances
- Healthcare Effectiveness Data & Information Set (HEDIS)
- Care Management KPI Report
- Enhanced Care Management/Community Supports
- Long Term Support Services (LTSS)
- Pharmacy
- Behavioral Health

# Q1 CHPIV QIHEC Agenda

## Topics

- Quality Improvement Projects
- Population Health Management (PHM) Quarterly Report
- Health Equity
- Peer Review Credentialing
- Language Assistance Program Evaluation
- 2024 Q1/Q2 Member Experience Evaluation
- 2025 Q1 Community Advisory Committee

# Call Center Metrics

# Call Center Metrics

KPI	Target	October 2024	November 2024	December 2024	Q4	Q3	Q2	Q1
<i>Member Services</i>								
Calls Offered		2,806	2,237	2,021	7,064	8,800	10,369	21,197
Calls Handled		2,791	2,216	2,007	7,014	8,747	10,288	20,473
% Calls Abandoned	<5%	0.53%	0.94%	0.69%	0.72%	0.60%	0.79%	4.46%
% SVL (all abn calls)	>80% w/in 30 seconds	98.39%	96.95%	98.46%	97.93%	98.07%	98.13%	87.49%
Average Speed Answer	<= 30	0:00:04	0:00:08	0:00:05	0:00:05	0:00:05	0:00:05	0:00:25

# Call Center Metrics

KPI	Target	October 2024	November 2024	December 2024	Q4	O3	Q2	Q1
Calls Offered		1,221	1,034	1,025	3,280	4,108	4,488	5,301
Calls Handled		1,213	1,028	1,018	3,259	4,094	4,447	5,233
% Calls Abandoned	<5%	0.66%	0.59%	0.68%	0.64%	0.33%	0.92%	1.28%
% SVL (all abn calls)	>60% w/in 45 seconds	99.75%	98.82%	99.80%	99.45%	99.35%	98.21%	89.27%
Average Speed Answer	<= 45	0:00:05	0:00:07	0:00:05	0:00:06	0:00:07	0:00:09	0:00:14

# Call Center Metrics

## Q4 Top Member Call Types

- Benefits & Eligibility
- PCP Update
- Update Demographics

## Q4 Top Provider Call Types

- Benefits & Provider Eligibility
- Authorization Inquiries
- Provider Search Inquiry

## Q1-Q3 Top Provider Call Types

- Provider Eligibility, Claims
- Claims Adjustments
- PCP Transfer

# Behavioral Health Call Center Metrics

KPI	Target	Aug	Sep	Oct	Nov	Dec	Q4
Calls Offered	N/A	59	57	52	32	33	117
Calls Handled	N/A	59	57	52	32	33	117
Abandonment	≤5%	0%	0%	0%	0%	0%	0%
Average Speed of Answer	≤30 sec	17 sec	7 sec	16 sec	9 sec	5 sec	11 sec
Service Level	≥80%	94.92%	94.74%	92.31%	90.63%	100%	94.02%

# Utilization Management

# Utilization Management Key Metrics

	2024-Q1	2024-Q2	2024-Q3	2024-Q4	“Benchmark”
	Combined	Combined	Combined	Combined	
Admissions per Thousand	54	52	50	52	76
Bed Days per Thousand	1517	613	400	377	653
Average Length of Stay	28	12	8	7	9
Percent 30-Day Readmission	7.6%	7.7%	7.8%	6.0%	12.7
ER per Thousand	473	463	304	297	451
Outpatient Surgery per Thousand	146	162	113	104	77

# Utilization Management Key Metrics

## UM Prior Authorization TAT

CHPIV Metric	CA Prior Auth App/Den/Mod TAT	Oct	Nov	Dec	Q4 - Overall Quarterly Score
CHPIV-101	CHPIV PA Routine Authorizations TAT	96.67%	100.00%	100.00%	98.89%
CHPIV-103	CHPIV PA Urgent Authorizations TAT	100.00%	100.00%	100.00%	100.00%
CHPIV-106	CHPIV Concurrent Authorization TAT	100.00%	100.00%	100.00%	100.00%

# Utilization Management Key Metrics

UM Activities	Jan-2024	Feb-2024	Mar-2024	Q1	Apr-2024	May-2024	Jun-2024	Q2	Jul-2024	Aug-2024	Sep-2024	Q3	Oct-2024	Nov-2024	Dec-2024	Q4
Appeals (Provider)	NA	NA	NA	NA	NA	NA	NA	0	12	25	18	55	17	13	23	53
Approvals	555	905	2348	NA	2298	2930	2262	7490	2675	1951	1494	6120	2050	1392	1486	4928
Denials	34	36	45	115	40	45	21	106	39	78	63	180	157	64	67	288
Deferrals	19	14	15	48	18	18	19	55	15	15	28	58	12	7	13	32
Modifications (Partially Approved)	45	27	26	98	33	36	49	118	34	69	29	132	52	20	41	113



## Comments

- Denials – increased since 8-2024
  - Re-training program instituted
- Approvals – decreased since 8-2024
  - Many procedure codes removed from auth review queue (ARQ)

# Appeals & Grievances

# Appeals & Grievances

## Appeals and Grievances – Rolling Year Totals

2024 Appeals	Q1	Q2	Q3	Q4	YTD
CHPIV	7	15	16	13	51

2024 Grievances	Q1	Q2	Q3	Q4	YTD
CHPIV - QOS	91	136	72	72	371
CHPIV - QOC	5	9	15	6	35
CHPIV - ATC	23	29	23	39	114

# Appeals & Grievances

## Q4 – Top 5 Appeals

Description	Volume	PTMPY	OT
Not Medically Necessary - Diagnostic - MRI	4	0.12	4/4
Not Medically Necessary - DME - Other	2	0.06	0/2
Not a Covered benefit – Outpatient Procedure	2	0.03	1/2
Not Medically Necessary – DME- Infusion Supplies	1	0.03	1/1
Not Medically Necessary – Inpatient-Admission	1	0.03	0/1

# Appeals & Grievances

## Q4 – Top 5 QOS Grievances

Description	Volume	PTMPY
Balance Billing Issues	14	0.44
Transportation – General Complaint Vendor	10	0.31
Administrative Issues- Member Materials	5	0.16
Transportation- Member Reimbursement	4	0.12
Administrative Issues – Claim Not Received	4	0.12

# Appeals & Grievances

## Q4 – Top 5 QOC Grievances

Description	Volume	PTMPY
Quality of Care - PCP – Delay in Referral by PCP	4	0.12
Quality of Care - PCP – Appropriateness of Treatment	2	0.06

1. 6 QOC Grievances filed in Q4
2. All cases referred to Health Net Clinical Department for assignment of severity level
  1. 3 cases – level 0
  2. 1 cases – level 1
  3. 2 cases – level 2
3. All cases will be reviewed by Dr. Arakawa

# Appeals & Grievances

## Q4 – Top 5 Access to Care Grievances

Description	Volume	PTMPY
Access to Care - Prior Authorization delay	14	0.44
Access to Care – Network Availability	4	0.12
Access to Care – Transportation Missed Appointment	4	0.12
Access to Care – DME Delivery Issue	3	0.09
Access to Care – Availability of Appt W/PCP	3	0.09

1. 14 Q4 PA Delay grievances are the second highest total in 2024 (21 in Q2)

# Appeals & Grievances

## PQIs

- For Q4, there was 1 Case identified
- For 2024, there were 2 Total Cases identified

# HEDIS Measures RY2025

Measure	Goal Rate	YTD Rate	Rate Change	Rate Status 2024	Rate Status 2023	Denominator	Gap to Goal	
IM Adolescent	34.3%	42.3%	+3.3%	75 <sup>th</sup> %	50 <sup>th</sup> %	1607	0	←
Lead Screen	63.8%	76.2%	+0.5%	75 <sup>th</sup> %	75 <sup>th</sup> %	1286	0	
WCV 15-30	69.4%	76.4%	+2.1%	75 <sup>th</sup> %	50 <sup>th</sup> %	1265	0	←
Asth Med Ratio	66.2%	92.1%	+34.3%	75 <sup>th</sup> %	<25 <sup>th</sup> %	784	0	←
Breast CA Sc	52.7%	57.4%	+0.7%	50 <sup>th</sup> %	75 <sup>th</sup> %	3574	0	
IM Child	27.5%	32.1%	+2.2%	50 <sup>th</sup> %	25 <sup>th</sup> %	1275	0	←
ED Sub Abuse	36.2%	45.6%	+13.2%	75 <sup>th</sup> %	50 <sup>th</sup> %	353	0	←
Cervical CA Sc	57.2%	52.2%	-2.7%	25 <sup>th</sup> %	25 <sup>th</sup> %	18565	958	
Chlamydia Sc	56.0%	54.8%	+1.1%	25 <sup>th</sup> %	25 <sup>th</sup> %	2273	27	←
Blood Pressure	64.5%	54.9%	+2.1%	<25 <sup>th</sup> %	<25 <sup>th</sup> %	5347	514	
ED MH	53.8%	53.2%	+27.9%	25 <sup>th</sup> %	<25 <sup>th</sup> %	139	1	←
HbA1c Control	33.3%	59.9%	-2.5%	<25 <sup>th</sup> %	<25 <sup>th</sup> %	5657	1503	
Post Part Care	80.2%	75.8%	+8.7%	25 <sup>th</sup> %	<25 <sup>th</sup> %	1084	48	←
Prenatal Care	84.6%	76.1%	+3.9%	<25 <sup>th</sup> %	<25 <sup>th</sup> %	1084	92	←
WCV 0-15	60.4%	55.6%	+2.1%	25 <sup>th</sup> %	25 <sup>th</sup> %	666	33	←
WCV C & A	51.8%	50.1%	+4.5%	25 <sup>th</sup> %	50 <sup>th</sup> %	31699	529	
Dev Screen	35.7%	53.4%	+6.8%	50 <sup>th</sup> %	50 <sup>th</sup> %	3238	0	
Top Fluoride	19.%	10.5%	+5.7%	25 <sup>th</sup> %	<25 <sup>th</sup> %	33802	2880	←

# Care Management

# Care Management

## Physical Health

Metric	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Outreached (UTR,refuse,accept)	222	224	85	104
Engaged	98	102	38	32
Engagement Rate	44.1%	45.5%	44.7%	30.8%
Total Screened and Refused/Declined	38	27	11	15
Unable to Reach (UTR)	86	95	36	57
Total Cases Closed	73	80	76	51
Total Cases Managed	140	169	132	88
Complex Case Management	17	23	18	9
Non-Complex Case Management	123	146	114	79

# Care Management

## Behavioral Health

Metric	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Outreached (UTR,refuse,accept)	34	35	97	45
Engaged	22	32	22	21
Engagement Rate	64.7%	91.4%	22.7%	46.7%
Total Screened and Refused/Declined	2	1	4	3
Unable to Reach (UTR)	10	2	71	21
Total Cases Closed	10	26	24	13
Total Cases Managed	25	47	43	31
Complex Case Management	3	3	5	2
Non-Complex Case Management	22	44	38	29

# Care Management

## Maternity

Metric	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Outreached (UTR,refuse,accept)	228	100	160	278
Engaged	160	37	79	105
Engagement Rate	70.2%	37.0%	49.4%	37.8%
Total Screened and Refused/Declined	11	2	9	18
Unable to Reach (UTR)	57	61	72	155
Total Cases Closed	241	59	46	47
Total Cases Managed	323	117	138	188
Complex Case Management	12	8	8	4
Non-Complex Case Management	311	109	130	184

# Care Management

## Transitional Care Services

Metric	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Outreached (UTR,refuse,accept)	255	283	330	342
Engaged	152	177	196	188
Engagement Rate	59.6%	62.5%	59.4%	55.0%
Total Screened and Refused/Declined	22	12	12	17
Unable to Reach (UTR)	81	94	122	137
Total Cases Closed	88	177	154	183
Total Cases Managed	152	241	263	280
Complex Case Management	0	0	0	0
Non-Complex Case Management	152	241	263	280

# Care Management

## First Year of Life

Metric	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Outreached (UTR,refuse,accept)	142	35	12	11
Engaged	142	35	12	10
Engagement Rate	100%	100%	100%	90.9%
Total Screened and Refused/Declined	0	0	0	0
Unable to Reach (UTR)	0	0	0	1
Total Cases Closed	78	32	11	37
Total Cases Managed	206	161	142	141
Complex Case Management	0	0	0	0
Non-Complex Case Management	206	161	142	141

# Care Management

## Top Diagnoses

PH CASE MANAGEMENT	
Diagnosis/Case Type	Referrals
Diabetes	118
Chronic renal condition	73
Nutritional deficiency/Dehydration	39
Joint degeneration - back	31
Infectious disease	28
Cirrhosis	28
Other dermatology	26
Rx: Antineoplastic treatment	22
Rx: Immunologics/immunosuppressives	21

BH CASE MANAGEMENT	
Diagnosis/Case Type	Referrals
Depression	30
Mental Disorder NOS	28
Alcohol / Substance Abuse	24
Food Insecurity	16
Anxiety Disorder	15
Autistic Disorder	14
Bipolar Disorder	11
Schizophrenia	8
Diagnoses with 2 or less referrals	75

OB CASE MANAGEMENT	
Diagnosis/Case Type	Referrals
Supervision Normal Pregnancy	743
Supervision Of High Risk Pregnancy	76
Gestational Diabetes	8
Hypertension	5
Supervision of Twin Pregnancy	4
Anemia	4
Supervision Of Elderly Multigravida	3
Nausea and Vomiting	3
Diagnoses with one referral	8

# Care Management

## CHPIV Outcomes Report

### Readmissions

Measure for Case Management	Members	90 days prior to CM enrollment*			90 days following CM enrollment*			Difference
		Admissions	Readmissions	Readmit Rate	Admissions	Readmissions	Readmit Rate	
Readmission Rate, within 30 days, all cause, based on claims data	280	119	38	31.9%	62	15	24.2%	-7.7%

### ED Visits

Measure for Case Management	Members	90 days prior to CM enrollment*		90 days following CM enrollment*		Difference	
		ED Claims	ED/1,000/Yr.	ED Claims	ED/1,000/Yr.	ED Claims	ED/1,000/Yr.
Emergency Department (ED) Claims, per 1,000 members per year	280	136	3,886	85	2,428	-51	-729

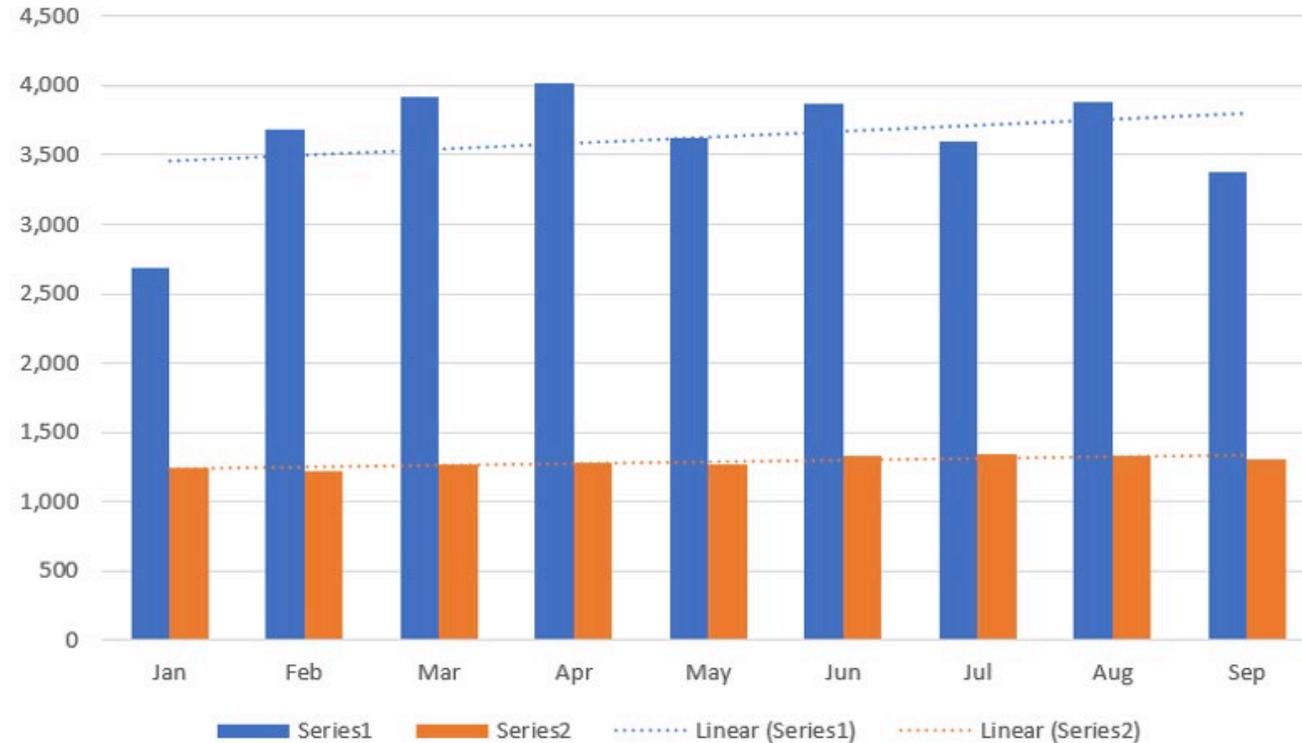
### Maternity Outcomes

Measure for Maternity Program	Members <u>not</u> enrolled in Maternity Program		Members enrolled in Maternity Program		Difference
	Members	Rate	Members	Rate	
First prenatal visit within the first trimester	759	74.4%	103	88.3%	13.9%
Pre-term deliveries by high risk members	67	9.0%	19	5.3%	-3.7%
Postpartum visit between 7 and 84 days after delivery	759	73.1%	103	76.7%	3.6%

# Enhanced Care Management (ECM) & Community Supports (CS)

# Enhanced Care Management (ECM) & Community Supports (CS)

## ECM Enrollment



Assigned/Enrolled Percentages Last 3 Months & Annual Total									
County	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024
Imperial	46.4%	33.0%	32.3%	31.9%	35.2%	34.3%	37.2%	34.4%	38.6%

# Enhanced Care Management (ECM) & Community Supports (CS)

## ECM Information

- Average assignment to enrollment remains steady 38.4%
- Highest number of Claims from Serene Health (76%), MedZed (16%) and ECRMC (2%)
- 58 Members graduated from ECM through Q3

# Enhanced Care Management (ECM) & Community Supports (CS)

## CS Authorizations/Claims Trends



# Enhanced Care Management (ECM) & Community Supports (CS)

## CS Authorizations/Claims Trends

**CS Authorization and Claims Summary**

County	CS Service	Auth Count	Claims Count	Claims Unit
<b>Imperial</b>	Housing Deposits	5	8	8
	Housing Tenancy and Sustaining Services	5	7	6
	Housing Transition/Navigation Services	60	166	166
	Medically Tailored Meals	19,422	173,795	199,032
	Personal Care Services	11	256	1,664
	Recuperative Care	2	9	8
	Respite Services	2		
	<b>TOTAL</b>	<b>19,507</b>	<b>174,241</b>	<b>200,884</b>

**CS Claims Paid Amount by County**

County	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Total
<b>Imperial</b>	\$1,000,857	\$579,062	\$1,340,402	\$2,170,997	\$1,769,593	\$1,653,772	\$1,981,959	\$1,677,712	\$1,975,889	<b>\$14,150,242</b>

# Enhanced Care Management (ECM) & Community Supports (CS)

## CS Information

- 86 CS referrals were made through FindHelp to 11 Providers – Top 3: Mom’s Meals (23%), Roots Food Group (19%), and St. Vincent Preventative Family Care (13%).
- Over 19,500 authorizations for CS were submitted with a 175,000 claims count through Sept., 2024.
- 99% of paid CS claims were for Medically-Tailored Meals/Medically Supported Foods.

# Enhanced Care Management (ECM) & Community Supports (CS)

## Barriers to ECM & CS

- Lack of accurate or available member contact info
- Difficult to find members for referral into program
- Lack of awareness by members and providers about the program
- Training and technical assistance needs by providers for claims and billing, portal access and other operational functions
- Lack of capacity of providers to conduct in-person outreach

# Long Term Support Services (LTSS)

# Long Term Support Services (LTSS)

## LTC (Long Term Care)

Q4

Unique Utilizing LTC Members	Oct 2024	Nov 2024	Dec 2024
El Centro Post Acute	85	88	85
Imperial Manor	31	28	29
Pioneer Memorial D/P	63	69	70
Out of County	30	18	23
Out of State	0	0	0

Q3

Unique Utilizing LTC Members	Jul 2024	Aug 2024	Sep 2024
El Centro Post Acute	87	94	91
Imperial Manor	26	30	29
Pioneer Memorial D/P	73	83	92
Out of County	132	120	137
Out of State	25	26	24

Q2

Unique Utilizing LTC Members	Apr 2024	May 2024	Jun 2024
El Centro Post Acute	77	86	97
Imperial Manor	18	24	26
Pioneer Memorial D/P	57	58	61
Out of County	171	115	55
Out of State	2	0	0

Q1

Unique Utilizing LTC Members	Jan 2024	Feb 2024	Mar 2024
El Centro Post Acute	58	66	64
Imperial Manor	10	14	18
Pioneer Memorial D/P	36	40	42
Out of County	19	24	43
Out of State	0	0	0

# Long Term Support Services (LTSS)

## ICF (Intermediate Care Facilities)

Q4

### ICF/DD (Intermediate Care Facility)

Unique Utilizing LTC Members	Oct 2024	Nov 2024	Dec 2024
ARC #1, #2, #3	16	16	15

Q3

### ICF/DD (Intermediate Care Facility)

Unique Utilizing LTC Members	Jul 2024	Aug 2024	Sep 2024
ARC #1, #2, #3	16	15	16

Q2

### ICF/DD (Intermediate Care Facility)

Unique Utilizing LTC Members	Apr 2024	May 2024	Jun 2024
ARC #1, #2, #3	16	15	16

Q1

### ICF/DD (Intermediate Care Facility)

Unique Utilizing LTC Members	Jan 2024	Feb 2024	Mar 2024
ARC #1, #2, #3	15	16	16

# Long Term Support Services (LTSS)

## CBAS (Community Based Adult Services)

Q4

	Oct 2024	Nov 2024	Dec 2024
Unique Utilizing CBAS Mbrs	249	243	249
Average Days per Week	2.1	1.8	1.6
Members utilizing CBAS six months ago, now in LTC	5	0	0

Q3

	Jul 2024	Aug 2024	Sep 2024
Unique Utilizing CBAS Mbrs	257	251	258
Average Days per Week	2.0	1.9	1.8
Members utilizing CBAS six months ago, now in LTC	1	0	0

Q2

	Apr 2024	May 2024	Jun 2024
Unique Utilizing CBAS Mbrs	267	261	255
Average Days per Week	1.9	2.1	1.8
Members utilizing CBAS six months ago, now in LTC	0	0	1

Q1

	Jan 2024	Feb 2024	Mar 2024
Unique Utilizing CBAS Mbrs	254	254	258
Average Days per Week	1.9	1.9	1.7
Members utilizing CBAS six months ago, now in LTC	0	0	0

# Pharmacy

# Pharmacy

## Data/Results: PA Metrics

	Goal	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
<b>Total CHPIV</b>													
<b>Total # PA's</b>	N/A	76	66	47	50	60	36	63	60	41	50	41	56
<b># Approved %</b>	N/A	57%	71%	55%	60%	55%	64%	51%	50%	61%	62%	54%	50%
<b># Denied %</b>	N/A	43%	29%	45%	40%	45%	36%	49%	50%	39%	38%	46%	50%
<b>PA per 1,000M</b>	N/A	0.79	0.68	0.48	0.51	0.62	0.37	0.65	0.63	0.43	0.52	0.43	0.58
<b>% PA requests meet goal*</b>	100%	76.3%	98.5%	86.8%	88%	96.7%	97.2%	96.8%	98.3%	100%	100%	82.9%	87.5%

# Pharmacy

## Top 5 Pharmacy PA Requests

January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024
filgrastim	filgrastim	pegfilgrastim	filgrastim	pegfilgrastim	filgrastim	pegfilgrastim	pegfilgrastim	pegfilgrastim	pegfilgrastim	pegfilgrastim	pegfilgrastim
pegfilgrastim	pegfilgrastim	filgrastim	pegfilgrastim	viscosupplement	pegfilgrastim	IV iron	IV iron	IV iron	botulinum toxin	IV iron	pembrolizumab
IV Iron	botulinum toxin	IV Iron	botulinum toxin	filgrastim	IV iron	filgrastim	filgrastim	botulinum toxin	denosumab	botulinum toxin	botulinum toxin
botulinum toxin	denosumab	pembrolizumab	denosumab	pembrolizumab	fulvestrant	viscosupplement	atezolizumab	pembrolizumab	filgrastim	denosumab	rituximab
denosumab	pembrolizumab	denosumab	IV iron	IV iron	pembrolizumab	denosumab	botulinum toxin	trastuzumab	IV iron	pembrolizumab	nivolumab

# Pharmacy

## Top 5 Denials in Q4 based on Percentage and Total Number

Drug Name	% Denied	Drug Name	# Denied
epoetin beta	100.00%	pegfilgrastim	26
viscosupplement	100.00%	IV iron	8
IV iron	80.00%	botulinum toxin	5
omalizumab	66.67%	epoetin beta	3
unclassified drugs	60.00%	unclassified drugs	3

# Pharmacy

## Quality Assurance/Reliability Results for Q4

### Analysis/Findings/Outcomes:

- **90%** threshold met. **95%** goal not met; overall score was **92.50%**
- **1** case missed TAT.
- **3** cases were noted that criteria used was not applied or documented appropriately after plan review
- **4** cases had letter language that could have been clearer to the member and/or MD after plan review.
- **1** case were determined to have a questionable denial or approval after plan review.

### Barrier Analysis:

In Q4 2024, Clear and appropriate language was noted as an area of concern, however it did meet the target goal of 90%. All other areas met and exceeded target of 95% A more detailed review and QA on cases in Q4 2024 has been performed and results have been shared with PA management to address concerns.

# Behavioral Health

# Behavioral Health/SUD

Members served by month (unduplicated)

Q3	County	Jul 2024	Aug 2024
	<b>Imperial +</b>	1,538	1,626

Q2	County	Apr 2024	May 2024	Jun 2024
	<b>Imperial +</b>	1,339	1,288	694

Q1	County	Jan 2024	Feb 2024	Mar 2024
	<b>Imperial +</b>	1,058	1,088	1,205

Q4 (2023)	County	Oct 2023	Nov 2023	Dec 2023
	<b>Imperial +</b>	1,041	911	819

# Behavioral Health/SUD

## Referrals

### Q4 BH Medi-Cal Referrals – CHPIV

<b>5</b>	members were referred to HN BH by County SMHP
<b>3</b>	members were referred by HN BH to County SMHS
<b>39</b>	members were referred to HN BH providers

### Q4 Care Coordination Referrals

<b>CHPIV</b>	
members referred for health plan case management	<b>3</b>

### Q3 BH Medi-Cal Referrals – CHPIV

<b>7</b>	members were referred to HN BH by County SMHP
<b>5</b>	members were referred by HN BH to County SMHS
<b>7</b>	members were referred to HN BH providers

# Behavioral Health/SUD

## Applied Behavioral Analysis (ABA) Services – Q4

<b>Community Health Plan of Imperial Valley</b>	
Members authorized for ABA (assessment & treatment):	41
Newly established members*:	<i>Data unavailable*</i>
Total ABA authorizations:	151
ABA full clinical denials:	0
ABA partial clinical denials:	0
Average number of direct treatment (Individual & Group):	~11 hrs/week
Age range:	2 y/o – 19 y/o

# Quality Improvement Update

# Performance Improvement Projects - 2024

## CHPIV Performance Improvement Projects (PIP)

### Non-Clinical Behavioral Health PIP Topic of Focus:

- During the measurement period, Community Health Plan of Imperial Valley (CHPIV) will carry out targeted interventions that will result in improvement in the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of an emergency department visit in Imperial County.
- Participating County: Imperial
- Quarter 4 Update:
  - Submitted PIP Design Steps 1-6 to HSAG on September 11, 2024. The PIP has passed HSAG's validation, and interventions continue to be implemented.

### Clinical PIP Measure Focus:

- W30-6+ visits for Hispanic members
- Participating Counties: Imperial
- Quarter 3 Update:
  - Submitted Steps 1-6 to HSAG on September 11, 2024. The PIP has passed HSAG's validation, and interventions continue to be implemented.
  - Clinical PIP Intervention: Will be focused on opportunities for Dr. Kapoor to improve office processes and member engagement to increase the W30 6+ care gap closure rate.

## Community Health Plan of Imperial Valley QITS Overview

82 Projects

7% Health Equity  
Focus Projects

QITS Data Source: YearEnd 2024 Report\_QITS

## Scheduled Quality Trainings-Coordinated by the HN Training POD

January 2025

Diabetes Prevention Program (HN and Diabetes Care Partners)

January 2025

Measure of Focus (Chronic Conditions Measures)  
PE Office Hours

January 2025

Measure of Focus (Behavioral Health Measures)  
PE Office Hours

# Child Health Equity Sprint

## FOCUS: TO IMPROVE THE COMPLETION OF WELL-CHILD VISITS (WCV)

Duration: 12 Months (April 2024 to March 2025)

### Pilot Sites:

- AltaMed General Pediatrics at Children's Hospital of Los Angeles (Health Net Community Solutions)
- Dr. Vishwa Kapoor (Community Health Plan of Imperial Valley)

### Interventions of Focus (5):

- Focused topic every 1 to 3 months, presented by IHI and DHCS during the CHEC bi-weekly All Learner Calls.
- MCPs implement and test IHI suggested/designed interventions with their pilot sites, to improve Well-Child Visit (WCV) rates and monitor progress in relation to the process measures.
- MCPs collate and report project outcomes to IHI, as a storyboard presentation and post-intervention report.
- Completed Intervention 4 and submitted all 2024 deliverables (storyboard presentations and post-intervention reports). Intervention 5 begins early February (2/6) and ends late March (3/27).

# Child Health Equity Sprint

## Interventions of Focus

1. Equity and Transparent, Stratified, and Actionable Data
2. Understand Provider and Patient/Caregiver Experiences
3. Reliable and Equitable Scheduling Processes
4. Asset Mapping and Community Partnerships
5. Partnering for Effective Education and Communication

# Child Health Equity Sprint

## Study Goals/Aims

### Community Health Plan of Imperial Valley (CHPIV) x Dr. Kapoor:

By the end of March 2025, the CHPIV and pilot site workgroup will implement the IHI suggested/designed interventions to improve Well-Child Visit (WCV) rates among Spanish-speaking, Hispanic members aged 15 to 18 years old at Dr. Kapoor's office in Imperial County, from 27.85% to 40.85%.

# Initial Health Assessments

## Medical Record Review YTD 2024

	Total Records	% Compliant
PED IHA	46	30%
Adult IHA	176	60%

## Claims/Encounter Review

IHA Completion Rates Enrollment From July - Sept 2024	%
IHA Completed within 120 days	39.96↑
Member Outreach Compliance (3 attempts completed)	0.09↓
Overall Compliant (outreach or IHA compliant)	40.06↓

# Quality EDGE Request Summary CHPIV

Current as of 10/23/2024

## Funding Request Type

Row Labels	Community Event	Equipment/Supply	Marketing/Materials	Member Incentive	Mobile Mammography	Multiple/Other	One-Stop	Staff	Technology Support	Grand Total
CHPIV				15				2		17
Approved				15				1		16
Denied										
Need more Info										
Event Cancelled								1		1

## Funding Amount

Row Labels	Community Event	Equipment/Supply	Marketing/Materials	Member Incentive	Mobile Mammography	Multiple/Other	One-Stop	Staff	Technology Support	Grand Total
CHPIV				121,450.00				29,000.00		150,450.00

# Population Health Management

# Population Health Management

## Campaign At-A-Glance: Chronic Disease Management Domain (Imperial)

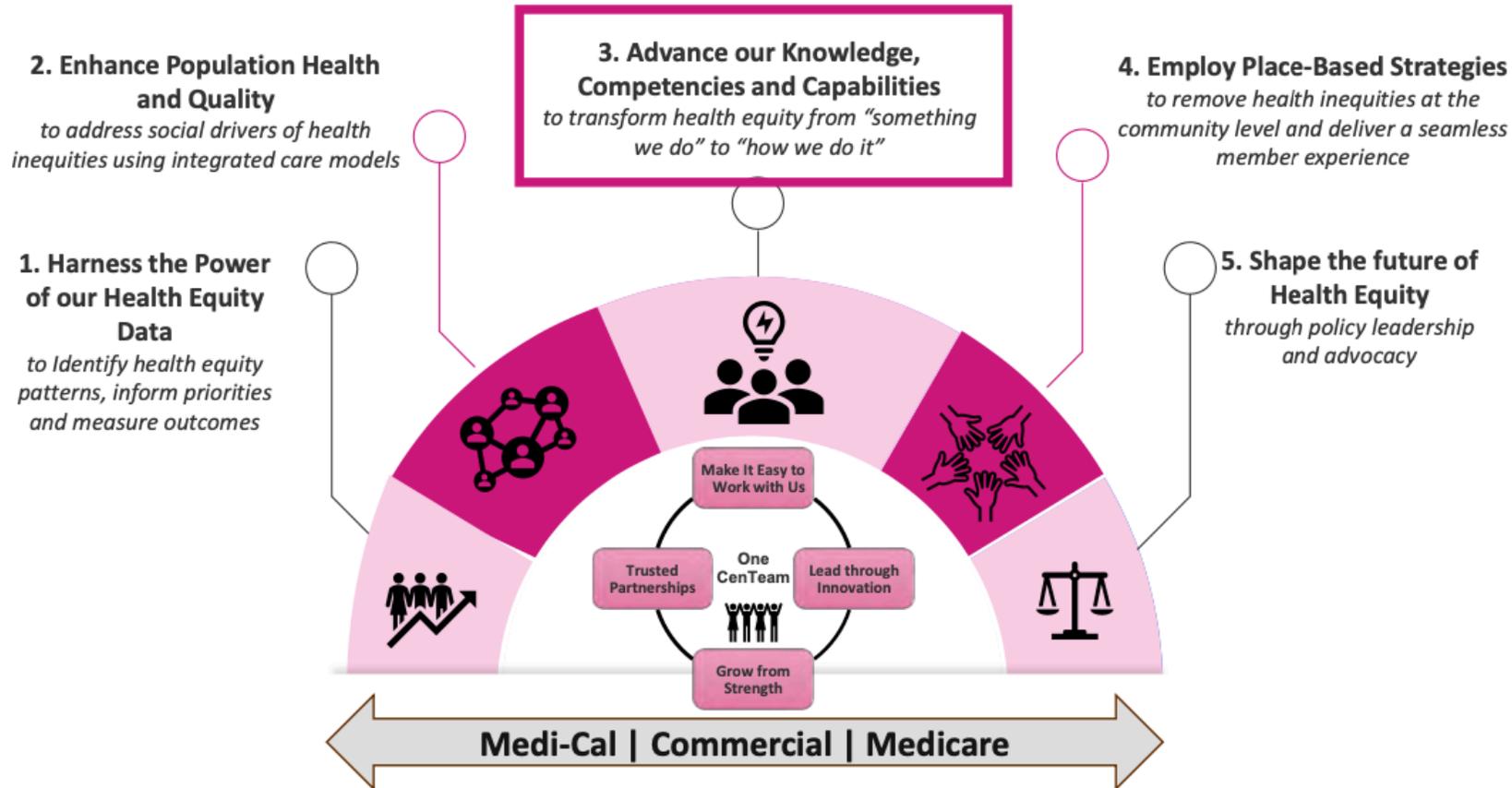
<b>Campaign</b>	Chronic Disease Management Domain (CBP/HBD/AMR)		<b>Campaign Start and End Date</b>		5/8/24- 6/24/24		
<b>Campaign Manager</b>	Tarjani		<b>Business Owner</b>		Dipa	<b>Executive Sponsor</b>	Pooja
<b>LOB Impact</b> (see highlighted areas)	Commercial	Medicare	Medi-Cal HNCS	Medi-Cal CHPIV	Medi-Cal CalViva	Marketplace	Other
<b>Campaign Type</b> (see highlighted areas)	Direct Mail	Email	In-Person	Phone	Text	Other	
<b>Executive Overview of Campaign</b>	Health Net will outreach to and engage priority members and their providers in Imperial County to improve CBP, HBD, and AMR HEDIS Measures by helping to schedule and complete their PCP and lab appointments and perform medication reviews to provide clinical recommendations for therapy optimization to providers. Through this work, CBP, HBD, and AMR related Care Gaps will be addressed and closed.						
<b>WHO is being targeted</b>	Medi-Cal members in Imperial with Care Gaps related to AMR, CBP and HBD HEDIS Measures						
<b>WHAT</b> is the key takeaway/call to action?	<b>Member:</b> Schedule PCP visit for blood pressure monitoring and schedule lab appt for A1c. Check SMBG and BP at home. Ensure medication compliance.		<b>Provider:</b> Identify members who have not received annual PCP visit and/or labs and outreach to members to schedule appointments + reminders.		<b>Community:</b> Connect members to resources for chronic condition management/Community Supports, and spread awareness at local places (grocery, worship), health/county fairs, and member-centric community-based events. Assist with connection to PCP.		
<b>WHERE</b> will the campaign run	Imperial						
<b>WHY</b> is this campaign important?	<ul style="list-style-type: none"> <li>Improves HEDIS rates for AMR, CBP and HBD HEDIS Measures in the measurement year</li> <li>Connects members to their PCPs/lab appointments and providing clinical recommendations for therapy optimization will in turn lead to Care Gap closure related to the CBP and HBD measures</li> </ul>						
<b>Key Areas of Focus</b>	<ul style="list-style-type: none"> <li>CBP (Controlling High Blood Pressure)</li> <li>HBD (Hemoglobin A1c Control in Patients with Diabetes)</li> <li>AMR (Asthma Medication Ratio)</li> </ul>	<b>Areas of Focus - Quality Outcomes</b> (see highlighted areas)	<ul style="list-style-type: none"> <li>Immunizations</li> <li>PCP visits</li> <li>Screenings</li> </ul>	<b>Areas of Focus – CalAIM Programs</b> (see highlighted areas)	<ul style="list-style-type: none"> <li>Community Supports</li> <li>ECM</li> <li>Connection to non-traditional provider</li> </ul>		
<b>Targeted Members</b>	431	<b>Members Called to Date</b> (updated 6/24/24)	431	<b>Members Reached through end of campaign</b>		136	

# Health Equity

# Health Equity Strategy

## Health Equity Mission:

*Help the people and communities we serve achieve the highest level of health by advancing equity in health and healthcare*



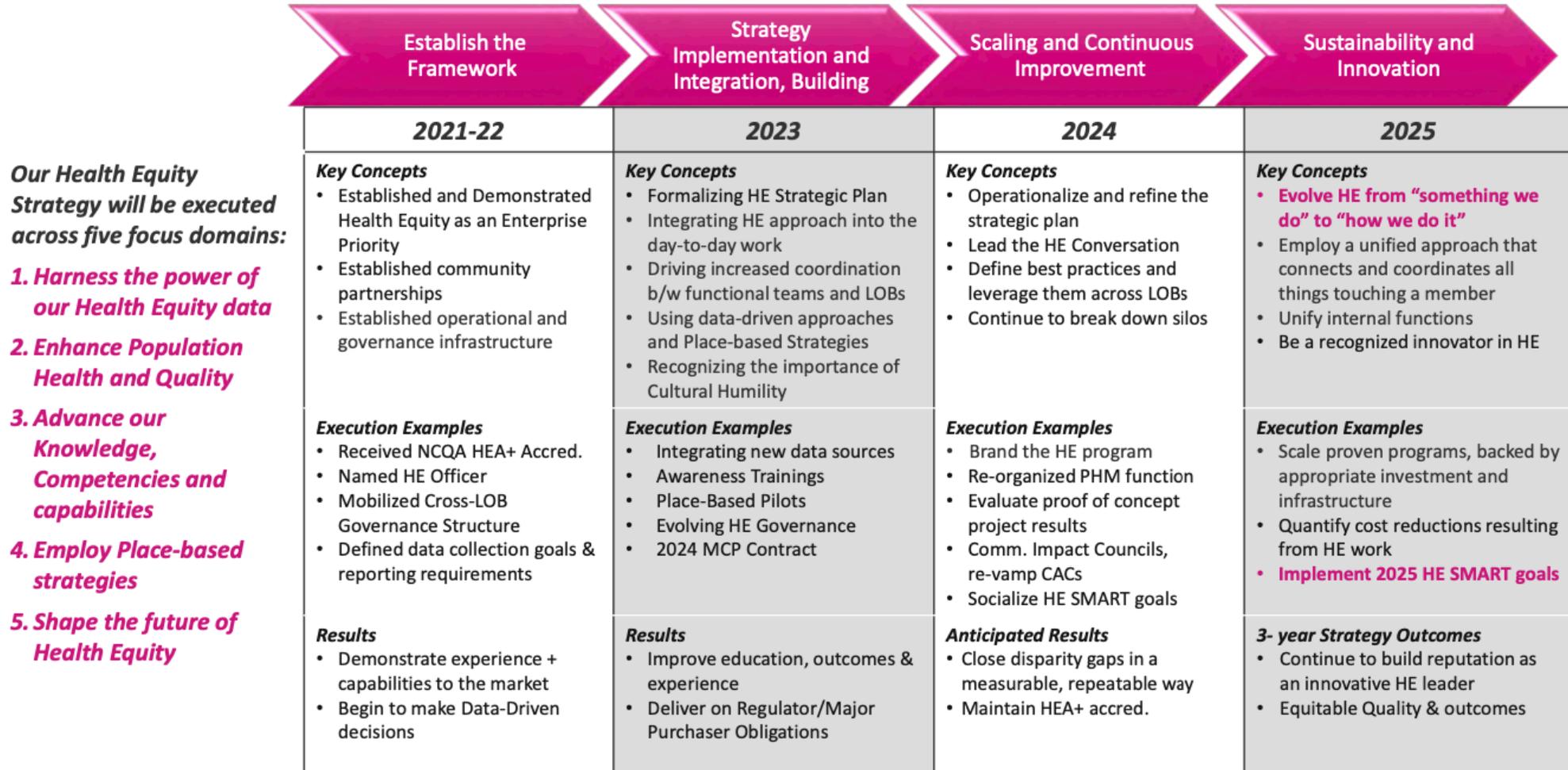
**Strategic Objectives:** Close care gaps, remove health inequities and set the standard with regulators, purchasers and accreditation bodies

**Health Equity Vision:** Become the partner of choice and the innovative industry leader in Health Equity

# Health Equity Strategy

## Health Equity Multi-Year Maturity Model

We will intentionally evolve our approach and programs each year as we proceed towards our vision



# Peer Review Credentialing

# Peer Review Credentialing and Access Reports

## Investigations

For Q4

1. 0 Investigative Cases brought before Peer Review Committee
2. 0 incidences of Appointment Availability Resulting in Substantial Harm
3. 0 incidences of Adverse Injury Occurred During a Procedure by a Contracted Practitioner

# Peer Review Credentialing and Access Reports

## Credentialing/Recredentialing – Q4

### Initial Credentialing

#### Physical Health

First Name	Last Name	Professional Degree	Specialty	PCP/SCP/Non-Physician	License #	Board Certification (Y/N)	Specialty.	Board Certification Date	Approval Date
MEHBOOB	GHULAM	DO	Internal Medicine	PCP	000000012164	N	N/A	N/A	10/3/2024
CHRISTINA	GALINDO	FNP	FAMILY NURSE PRACTITIONER	Non-Physician	000095015163	N/A	N/A	N/A	10/31/2024
RENATO	REYES	MD	Internal Medicine	SPC	000000052496	Yes	Internal Medicine	4/1/2025	12/19/2024

#### Behavioral Health

First Name	Last Name	Professional Degree	Specialty	PCP/SCP/Non-Physician	License #	Board Certification (Y/N)	Specialty.	Board Certification Date	Approval Date
ASHLEY	CODDING	LMF	Marriage/Family Counseling	Non-Physician	000000117315	N/A	N/A	N/A	12/5/2024
AMY	BULLOCK	MSW	Social Worker	Non-Physician	000000061927	N/A	N/A	N/A	12/19/2024

# Peer Review Credentialing and Access Reports

## Credentialing/Recredentialing – Q3

### Re-Credentialing

First Name	Last Name	Professional Degree	Specialty	PCP/SCP/Non-Physician	License #	Board Certification (Y/N)	Specialty.	Board Certification Date	Approval Date
MARIO	CEJA	MD	Family Practice	PCP	000000079700	Yes	Family Practice	2/15/2025	12/19/2024
ARACELY	MARTINEZ	NP	Nurse Practitioner	Non-Physician	000009501908	N/A	N/A	N/A	12/19/2024

# Peer Review Credentialing and Access Reports

## Certification/Recertification – Q4

### Initial Certification

# Peer Review Credentialing and Access Reports

## Certification/Recertification – Q4

### Recertification

Name of Organizational	Type	Approval Date
LEGACY MD MEDICAL GROUP INC	RADIOLOGY	10/31/2024

# 2024 Language Assistance Program Report

# 2024 Language Assistance Program

## LAP Service Requests

Quarter	Face- to- Face Requests	Telephonic Interpreter Requests	Grand Total
1	1	1086	1087
2	2	137	138
3	1	12	3
4	0	6	7
<b>Total</b>	<b>4</b>	<b>1,241</b>	<b>1,245</b>

# 2024 Language Assistance Program

## LAP Grievances

2024 CHPIV Grievance Categories Q1-Q2	
<b>Cultural</b>	
<b>Felt Discriminated due to Gender</b>	<b>1</b>
<b>Felt Discriminated due to Gender Identity</b>	<b>1</b>
<b>Felt Discriminated due to Race</b>	<b>1</b>
<b>Linguistic</b>	
<b>Interpreter Needed</b>	<b>1</b>
<b>Grand Total</b>	<b>4</b>

2024 CHPIV Grievance Categories Q3-Q4	
<b>Cultural</b>	
<b>Felt Discriminated due to Gender Identity</b>	<b>1</b>
<b>Felt Discriminated due to Race</b>	<b>1</b>
<b>Linguistic</b>	
<b>Grand Total</b>	<b>2</b>

# Member Experience

# 2024 Q1/Q2 Member Understanding Report

## Member Understanding Barrier Analysis

Root Cause/Barrier	Opportunities for Improvement	Actions Taken (2024)
<p><b>B &amp; E</b> Members experience confusion in understanding how to obtain Routine Dental benefits.</p>	<ul style="list-style-type: none"> <li>Educate members on how to obtain their Routine Dental benefits.</li> </ul>	<ul style="list-style-type: none"> <li>CSAs proactively educated the members that CHPIV does not offer routine dental benefits, but they may contact the State’s Denti-Cal program for information.</li> </ul>
<p><b>Authorizations:</b> Members experience a perceived delay in accessing care due to confusion as to who is responsible to authorize services between the plan and the provider.</p>	<ul style="list-style-type: none"> <li>Educate the Member and clarify who authorizes services and contact information for support.</li> <li>Recommend that Marketing add language or a supplemental guide in the Welcome Kit to clarify who is responsible for authorizing services and contact information for support.</li> </ul>	<ul style="list-style-type: none"> <li>CSAs proactively educated Members on who is responsible for prior authorization approval, Community Health Plan of Imperial Valley or the Medical Group.</li> <li>The Marketing Team added language to the 2025 Welcome Kit to direct members to review the Member Handbook for details regarding authorizing services and how to contact Member Services for support.</li> <li>In Q3 2024, CHPIV updated the member website (<a href="https://chpiv.org/member-resources/">https://chpiv.org/member-resources/</a>) with information on referrals and prior authorizations. It also directed members to the Member Handbook for more information.</li> </ul>

<p><b>Claims:</b> Members experience confusion in understanding why they are receiving a bill from a provider for a covered service.</p>	<ul style="list-style-type: none"> <li>Educate members on the cost share for covered services.</li> <li>Recommend that Marketing add language or a supplemental guide in the Welcome Kit regarding member cost share per Medi-Cal</li> </ul>	<ul style="list-style-type: none"> <li>CSAs proactively educated members that they do not have a member cost share for covered services as indicated in the Member Handbook.</li> </ul>
	<p>Managed Care covered benefits vs non covered benefits.</p>	<ul style="list-style-type: none"> <li>Marketing added language to the 2025 Welcome Kit to review the Member Handbook for details regarding member cost share per Medi-Cal Managed Care covered benefits vs non covered benefits.</li> </ul>

# 2024 Q1/Q2 Member Understanding Report

## Member Dissatisfaction Barrier Analysis

Root Cause/Barrier	Opportunities for Improvement	Actions Taken
<p>Members experience a delay in care due to a perceived mishandling of their provider selection.</p>	<ul style="list-style-type: none"> <li>Educate the member on how to ensure their preferred PCP is assigned, and available in the Plan’s network.</li> </ul>	<ul style="list-style-type: none"> <li>During call inquiries, the Plan’s CSAs proactively educated members on how the Plan receives the information from the State’s enrollment file, and promptly assists the members with selecting their preferred provider.</li> <li>The CHPIV website informed members that when they join CHPIV, they can choose and change their PCPs at any time. In Q3 2024, CHPIV added an electronic PCP Change Request Form functionality to the member website to improve member accessibility and experience.</li> </ul>

# 2025 Q1 Community Advisory Committee

# 2025 Q1 Community Advisory Committee

## Teledoc Health

### General Medicine

- Diagnose, treat, even prescribe medication
- Assist with referrals to specialty care, coordinated with PCP

### Behavioral Health

- Wide selection of providers and provider types
- Can receive ongoing support from same provider

# 2025 Q1 Community Advisory Committee

## Transportation Overview

### Description of Ride Types

- NEMT
- NMT

### How to Reserve a Ride

# 2025 Q1 Community Advisory Committee

## 2025 Health Equity Workplan

### Objective

- Ensure that Health Equity becomes a part of each division and department of the Organization

### Measuring Progress

- Description of Activity
- Measurable Objective
- Due Dates

# 2025 Q1 Community Advisory Committee

2025 CAC Goal Statement: **Increase awareness and utilization of preventative mental health care among CHPIV Members.**

## Rationale:

Based on feedback from CHPIV Members:

- Referral process for mental health services is unclear or difficult
- Uncertainty exists about accessing mental health services outside Imperial County Behavioral Services

# Questions & Comments