SPECIALIST PROVIDER SERVICES AGREEMENT
BETWEEN
IMPERIAL COUNTY LOCAL HEALTH AUTHORITY
AND
[PROVIDER NAME]

This Specialist Physician Provider Services Agreement (this "**Agreement**") is made by and between [PROVIDER NAME], a provider who is duly licensed to practice in the State of California ("Provider"), and the Imperial County Local Health Authority dba Community Health Plan of Imperial Valley, an independent public agency established pursuant to CA Welfare and Institutions Code Section 14087.51 ("CHPIV"). This Agreement shall become effective on January 1, 2026, thirty (30) calendar days following its date of execution by CHPIV or on the first (1st) day of the month following thereafter, whichever is later ("**Effective Date**"). CHPIV and Provider are collectively referred to as the "**Parties**" and individually as a "**Party**." The following Exhibits are attached to this Agreement and incorporated by reference herein:

[X] **Exhibit A – Medi-Cal Plan Program Requirements**
  [X] Exhibit A-1 – Covered Services / Compensation Rates (Medi-Cal)

[X] **Exhibit B – Medicare Plan Program Requirements**
  [X] Exhibit B-1 – Covered Services /Compensation Rates (Medicare)

[X] Exhibit C – Individual Members of Group / Service Locations
[X] Exhibit D – Disclosure Statement
[X] Exhibit E – General and Professional Liability Insurance Coverage Information Release
[X] Exhibit F – Risk-Bearing Contract Solvency Standards and Requirements (*not applicable*)
[X] Exhibit G – Operational Requirements
[X] Exhibit H – ICE Collaborative Fraud, Waste and Abuse Training Attestation
[X] Exhibit I – Electronic Funds Transfer (EFT) Authorization Form
[X] Exhibit J – Trading Partner Agreement

This Agreement is applicable to the following health plan lines of business. Lines of business indicated below as not included (box checked "No"), may be added at a future date by mutual Amendment.

Lines of Business	**Contract Status**
Community Advantage Plus – Medicare & Medi-Cal	▣ Yes ☐ No
Medi-Cal only	☐ Yes ▣ No

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives.

Principal with contract signature authority:

Provider

Executed by:

Signature

Print Name

Title

Address

City, State, Zip

Date

Specialty

California License #

Community Health Plan of Imperial Valley

Executed by:

Signature

Lawrence Lewis

Print Name

CEO

Title

512 Aten Road

Address

Imperial, CA 92251

City, State, Zip

Date

SPECIALIST PROVIDER SERVICES AGREEMENT
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RECITALS

A. CHPIV is a public entity and is licensed by the California Department of Managed Health Care ("DMHC") as a health care service plan in the State of California pursuant to Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code Section 1340 et seq.), and the regulations promulgated thereunder (collectively, the "Knox-Keene Act").

B. CHPIV has entered into agreements with various government agencies under which CHPIV agrees to provide or arrange healthcare services to Members. CHPIV entered into an agreement with the California Department of Health Care Services ("DHCS") (hereinafter referred to as the "DHCS Contract") and intends to enter into an agreement with the Centers for Medicare and Medicaid Services ("CMS") (hereinafter referred to as the "Medicare Contract").

C. Provider is an individual physician of medicine or osteopathy or a medical group that is duly licensed to practice medicine in the State of California, with a specialty in the area designated on Exhibit C (who meets the criteria for the applicable specialty as established by CHG), or other specialty as approved by CHG; is qualified to provide the professional medical services in his or her specialty as described in Exhibit C; and is a member in good standing of the medical staff of the Participating Hospitals (as defined herein below). In the event Provider is a medical group, the references in this Agreement to "Provider" shall include the medical group and the individual physician members of the medical group identified in Exhibit C.

D. Provider shall participate in providing Covered Services to Members and shall receive payment from CHPIV for the rendering of those Covered Services.

E. Both parties desire to demonstrate that effective and economical health care can be provided through a locally administered program.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, the Parties agree as follows:

ARTICLE 1 DEFINITIONS

1.1. "**Accreditation Organization(s)**" means the National Committee for Quality Assurance ("**NCQA**"), Joint Commission ("**JC**"), and/or Medical Quality Commission ("**MQC**").

1.2. "**Act**" is the Knox-Keene Health Care Service Plan Act of 1975, as amended (commencing at Section 1340 of the California Health and Safety Code), and the rules and regulations promulgated thereunder.

1.3. "**Applicable Requirements**" mean, to the extent applicable to this Agreement and the duties, right, and privileges hereunder, all federal, State, county, and local statutes, rules, regulations,

and ordinances, including, but not limited to, the Act and its implementing regulations, Welfare and Institutions Code and its implementing regulations, the Social Security Act and its implementing regulations, the Health Insurance Portability and Accountability Act ("**HIPAA**") and its implementing regulations, the Health Information Technology for Economic and Clinical Health ("**HITECH**") Act, the Deficit Reduction Act of 2005 and its implementing regulations, the Federal Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (collectively, "**Affordable Care Act**"), the California Consumer Privacy Act of 2018 and its implementing regulations, the California Confidentiality of Medical Information Act ("**CMIA**"); DHCS Medi-Cal Provider Manual; the Medi-Cal Contract; the SMAC;; all Regulatory Agency guidance, executive orders, instructions, letters, bulletins, and policies; and all standards, rules and regulations of Accreditation Organizations.

1.4. "**Authorization**" means written, telephonic, and/or electronic approval by CHPIV for the rendering of certain Covered Services, which shall be determined pursuant to the authorization procedures described in the CHPIV Provider Manual.

1.5. **"Block Transfer"** means a transfer or redirection of two thousand (2,000) or more Members by CHPIV from a terminated hospital to one or more contracting providers that takes place as a result of the termination or non-renewal of a hospital services contract.

1.6. "**California Children Services ("CCS")** " means a medical condition that qualifies children under the age of twenty-one (21) years to receive medical services under the CCS Program, as specified in Title 22, CCR, Section 41515.1 et seq.

1.7. "**CCS Program**" means a State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.

1.8. "**Capitated Provider**" means a Participating Provider that has agreed to provide Covered Services to Plan Members pursuant to a Capitation Fee.

1.9. "**Capitation Fee**" means the predetermined monthly payment to be made to Provider by CHPIV for Covered Services for each Member assigned to Provider for whom Provider and CHPIV have agreed to a capitated compensation arrangement.

1.10. "**CHPIV Partnership Medi-Cal Plan**" or "**Medi-Cal Plan**" means the benefit package that offers a specific set of health benefits to all people eligible for Medi-Cal and who live in the service area covered by CHPIV.

1.11. "**CHPIV Provider Manual**" means the CHPIV manual that describes administrative policies, procedures and other information necessary for Participating Providers to perform their respective duties under this Agreement (including, without limitation, administrative procedures, referral procedures, utilization management plan, utilization review and quality assurance procedures).

1.12. "**Compensation Rate**" means the negotiated rate of payment to Provider for the Covered Services set forth in the applicable Compensation Schedule.

1.13. "**Compensation Schedule(s)**" means Exhibits A-1, B-1, et seq. (each of which are identified as Exhibits to this Agreement in Article 14 below and each of which are attached hereto), as applicable to the specific Plan under which the Covered Services were provided.

1.14. "**Complete Claim**" means a completed UB-04 form, its successor form, or other form mutually agreed upon by Provider and CHPIV, that can be processed without obtaining additional information from the provider of the service or from a third party.

1.15. "**Copayment**" means payment for Covered Services that are charged to and collected by Provider or Participating Practitioners directly from a Member, as permitted by the Act and Member's Evidence of Coverage, in accordance with the CHPIV Provider Manual.

1.16. "**Covered Services**" means those medically necessary health care services and supplies which a Member is entitled to receive under the Member's Evidence of Coverage and is subject to payment under this Agreement.

1.17. **"Doula"** means a birth worker contracted with CHPIV who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum Members before, during, and after childbirth, otherwise known as the perinatal period, and provides support during miscarriage, stillbirth, and abortion (pregnancy termination).

1.18. **"Directed Payments**" means specific payments that DHCS requires CHPIV to pay to Providers for specific Covered Services as approved by CMS in accordance with 42 CFR 438.6(c).

1.19. "**D-SNP Member**" refers to a Dual Eligible Beneficiary enrolled in CHPIV's D-SNP.

1.20. "**Dual Eligible Beneficiary**" means an individual who is enrolled for benefits under Medicare Part A (42 U.S.C. § 1395c et seq.) and Medicare Part B (42 U.S.C. § 1395j et seq.) and is also eligible for medical assistance under the Medi-Cal State Plan.

1.21. "**Early and Periodic Screening, Diagnostic and Treatment ("EPSDT")**" means the provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC section 1396a(a)(43) and 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by Welfare & Institutions Code sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or behavioral health conditions.

1.22. "**Emergency**" or "**Emergency Medical Condition**" means a medical condition,

including a psychiatric 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 one or more of the following: (i) Placing the Member's health in serious jeopardy; (ii) Serious impairment to bodily functions, or (iii) Serious dysfunction of any bodily organ or part, or (iv) Death.

1.23. "**Emergency Services**" means inpatient and outpatient Covered Services that are furnished by a qualified health care provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and Health and Safety Code section 1317(a)(1).

1.24. "**Encounter Data**" means a the information that describes health care interactions between members and health care providers relating to the receipt of any item(s) or service(s) by a Member under this Agreement and subject to the standards of 42 CFR sections 438.242 and 438.818.

1.25. **"EPSDT Benefit"** means Early and Periodic Screening, Diagnostic, and Treatment services provided to eligible Medi-Cal Members under the age of twenty-one (21).

1.26. "**Evidence of Coverage**" means the document, and any amendments thereto, issued by CHPIV or the CHPIV Partnership Plan to a Plan Member that describes the benefits, limitations, and exclusions of the Plan in which the Member is enrolled.

1.27. "**Fraud, Waste, and Abuse**" means the intentional deception or misrepresentation made by persons including, but not limited to, Provider with the knowledge that such deception could result in some unauthorized benefit to Provider or some other person or entity. It also means practices that are inconsistent with sound fiscal and business practices or medical standards and result in unnecessary costs to the Medi-Cal program, or in payment for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. Fraud, Waste, and Abuse includes any act that constitutes fraud under applicable federal or State law including, but not limited to, 42 CFR section 455.2 and Welfare & Institutions Code section 14043.1(i), and the overutilization or inappropriate utilization of services and misuse of resources.

1.28. **"Health Equity"** means the reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable population.

1.29. "**Medi-Cal Member**" means an individual who has been determined to be eligible for the Medi-Cal Program in specific aid categories, resides within the zip code areas that comprise CHPIV's service area, has enrolled in the CHPIV Partnership Medi-Cal Plan, and agrees to abide by the rules, regulations and restrictions of said Plan, and for whom a State capitation payment is received by CHPIV for the month of enrollment.

1.30. "**Medical Director**" means the physician who is authorized by CHPIV to be responsible for administering CHPIV medical affairs.

1.31. **"Medical Home"** means a model of organization of primary care that delivers the

core functions of primary health care which is comprised of comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

1.32. "**Medically Necessary**" or "**Medical Necessity**" includes Covered Services or supplies that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to 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, as required under Welfare & Institutions Code section 14059.5(a) and 22 CCR section 51303(a). For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I Code sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

1.33. "**Medicare Plan(s)**" means any Plans provided under Title XVIII of the Social Security Act, as amended. For purposes of this Agreement, the term Medicare Plan also includes theD-SNP.

1.34. **"Minor Consent Services"** means those Covered Services of a sensitive nature that minor Members do not need parental consent to access, including, but not limited to, the following situations: a) sexual assault, including rape; b) drug or alcohol abuse for minors twelve (12) years or older; c) pregnancy; d) family planning; e) sexually transmitted diseases for minors twelve (12) years or older; f) diagnosis or treatment of infectious, contagious, or communicable diseases in minors twelve (12) years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and g) outpatient mental health care for minors twelve (12) years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the minors are the alleged victims of incest or child abuse.

1.35. "**New Member**" means a Plan Member who has never had, or currently does not maintain, an established relationship with Provider.

1.36. "**Non-Covered Services**" means those health care services that are not Covered Services or are not Medically Necessary health care services. Services designated by CHPIV clinical management unit as not Medically Necessary services shall be deemed Non-Covered Services.

1.37. "**Normal Business Hours**" means Monday through Friday 8:00 a.m. to 5:00 p.m.

1.38. "**Participating Hospital(s)**" means any hospital that has entered into an agreement with Plan to provide hospital services to CHPIV Members under the applicable Plan.

1.39. "**Participating Provider" or "Participating Practitioner**" means any individual and/or group of Primary Care Providers or Specialist Physicians (MD, DO), Dentists (DDS, DMD), Podiatrists (DPM), Doulas, Chiropractors (DC), behavioral health specialists (Psychologist, Medical Social Worker, and Marriage and Family Therapist), ancillary or allied health provider, or hospital, home health agency (HHA), skilled nursing facility (SNF), nursing home, or free-standing surgical center that has contracted with CHPIV to provide services to Plan Members in connection with a particular Plan(s).

1.40. "**Plan(s)**" or "**CHPIV Plan(s)**", for purposes of this Agreement, means any health plans offered by CHPIV and designated in Article 14 of this Agreement.

1.41. "**Plan Member(s)**" **or** "**Member(s)**" means an individual (or individuals) who is (are) enrolled in a Plan, as determined by CHPIV, and meets all the eligibility requirements for membership on the date of service. Member also includes a child born to a Member for the month of birth and the following month to the extent required by State law or applicable subscriber agreements.

1.42. **"Population Needs Assessment ("PNA")"** means CHPIV's process for: a) identifying Member health needs and health disparities; b) evaluating health education, cultural & linguistic, delivery system transformation and quality improvement activities and other available resources to address identified health concerns; and 3) implementing targeted strategies for health education, cultural & linguistic, and quality improvement programs and services.

1.43. "**Primary Care Provider**" or "**PCP**" a means a provider contracted with CHPIV who is responsible for supervising, coordinating, and providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For SPD Members, a PCP may also be a Specialist or clinic.

1.44. **"Program Data"** means data that includes, but is not limited to, the following: grievance data, appeals data, medical exemption request denial reports and other continuity of care data, out-of-network request data, and PCP assignment data as of the last calendar day of the reporting month.

1.45. "**Provider**" is an individual physician of medicine or osteopathy or a medical group that is the signatory to this Agreement (and whose members are signatories to this Agreement, identified on the signature page or otherwise identified to CHPIV by Provider as Provider's Participating Practitioners, and each of whom must satisfy the following qualifications), and duly licensed to practice medicine in the State of California, with a specialty in the area designated on the signature page (who meets the criteria for the applicable specialty as established by CHPIV), and is qualified to provide the professional medical services in his or her specialty as described in the signature page, and also more particularly described in Exhibit A attached hereto and is a member in good standing of the medical staff of the Participating Hospitals (as defined herein below). In the event Provider is a medical group, the references in this

Agreement to "Provider" shall include the medical group and the individual physician members of the medical group.

1.46. **"Provider Data"** means, but is not limited to, information about the contractual relationship between Provider, Participating Providers, Subcontractors, and/or CHPIV's subcontractors; information regarding the facilities where Covered Services are rendered; and information about the area(s) of specialization of Provider, as applicable.

1.47. "**Quality Improvement and Health Equity Committee ("QIHEC")"** means the committee facilitated by CHPIV's Medical Director, or the Medical Director's designee, in collaboration with the Health Equity officer, to meet at least quarterly to direct all QIHETP findings and required actions.

1.48. **"Quality Improvement and Health Equity Transformation Program ("QIHETP")"** means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and the Medi-Cal Contract.

1.49. "**Regulatory Agency(ies)**" means federal, State, county, and local government agencies and entities with regulatory or other authority over CHPIV, Provider, Participating Physician, Participating Provider, and/or this Agreement. Regulatory Agency includes, but is not limited to, the California Department of Managed Health Care ("**DMHC**"), California Department of Insurance ("CDI"), DHCS, State Auditor, United States Department of Health and Human Services ("**HHS**") and its agents ("**Secretary**"), DHHS Inspector General, CMS, Office of the Attorney General - Division of Medi-Cal Fraud and Elder Abuse ("DMFEA"), U.S. Department of Justice ("**DOJ**"), and Comptroller General of the United States.

1.50. "**Routine Non-Urgent Appointment**" means an appointment for routine Covered Services that do not meet the definition of Emergency or Urgently Needed Care Within Service Area, as more specifically set forth in the CHPIV Provider Manual.

1.51. "**Senior and Person with Disability (SPD) Member**" means a Member who falls under a specific SPD aid code as defined by DHCS.

1.52. "**Sensitive Services**" means Covered Services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes Covered Services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a Member with the capacity to legally consent to the specific Covered Service.

1.53. "**Service Area**" means the geographic area in which CHPIV is allowed to operate pursuant to the approval of DHCS and DMHC and the SMAC.

1.54. "**Specialist**" or **"Specialist Physician"** means a Participating Provider who has completed advanced education and clinical training in a specific area of medicine or surgery, is either Board Certified or qualified for certification, and meets the criteria for practice in such specialty or subspecialty as may be established by CHPIV, and is not a Primary Care Provider. Specialists include, but are not limited to, those Specialists listed in Welfare & Institutions Code section 14197.

1.55. "**State**" means the State of California.

1.56. "**Subcontract**" means an agreement between Provider and a Subcontractor(s) for provision of Covered Services to Members under this Agreement.

1.57. "**Subcontractor**" means another Participating Provider or any other entity that provides Covered Services to Members pursuant to a direct or indirect contract, agreement or other arrangement with Provider.

1.58. **"Template Data**" means data reports submitted to DHCS by CHPIV, which includes, but is not limited to, data of Member populations, health care benefit categories, or program initiatives.

1.59. "**Urgent Appointment**" means an appointment for Urgently Needed Care Within the Service Area.

1.60. "**Urgently Needed Care Within Service Area**" means the Covered Services obtained within the Service Area that are required prevent a serious deterioration of the Member's health following the onset of an unforeseen condition or injury.

1.61. "**Utilization Management/Quality Improvement (UM/QI) Program**" means the programs, processes, and standards established and carried out by CHPIV to authorize and monitor the utilization and quality of Covered Services provided to Members in conformance with Applicable Requirements, and the CHPIV Provider Manual.

1.62. "**Working Days**" means Monday through Friday, except for State holidays as identified at the California Department of Human Resources State Holidays page .

ARTICLE 2 PROVIDER SERVICES AND OBLIGATIONS

2.

2.1. **Participation in CHPIV Plans, Licensure, and Credentialing.**

(a) Participation Requirements. If Provider is an individual physician, Provider shall maintain in good standing an unrestricted license or certificate to practice medicine as a Specialist Physician in the State of California, and, if Provider is a medical group, shall require each of the Participating Practitioners in Provider's group practice to maintain in good standing an unrestricted license or certificate to practice medicine as a physician in the State of California. Additionally, Provider must

remain eligible for participation in the Medi-Cal Program. Provider shall not appear on any Medi-Cal suspended provider list or any other list that would exclude or suspend Provider from participating in any other state or federal health care program. Provider and its Participating Practitioners agree to participate, pursuant to the terms of this Agreement, in each of the CHPIV Plans described in Article 14 of this Agreement and any additional plans designated by CHPIV in writing from time to time. The terms and conditions of Provider's and its Participating Practitioners' participation in any such plans shall be on the terms and conditions as set forth in this Agreement, including compensation rates, unless otherwise agreed to in writing by Provider and CHPIV. In no event, however, is Provider or its Participating Providers required to accept additional patients if, in the reasonable judgment of such Provider, accepting additional patients would endanger patients' access to, or continuity of, care. If Provider receives capitation or is otherwise at risk under this Agreement and the addition of a plan materially changes the Member risk profile, upon Provider's prior written notice to CHPIV, the Parties agree to negotiate the terms of such additional plan in good faith.

(b) Notification. Provider shall notify CHPIV within twenty-four (24) hours should any disciplinary or other action of any kind be initiated against Provider or any Participating Practitioner in Provider's medical group, which would result in (i) the suspension, revocation, or termination of such Provider or Provider's Participating Practitioner's licensure or certification, (ii) the imposition of sanctions against Provider or any of Provider's Participating Practitioners under any federal or state health care program, or (iii) the revocation, suspension, or restriction of Provider's or any of Provider's Participating Practitioners' Drug Enforcement Agency's Number, or (iv) any change in Provider or any of Provider's Participating Practitioners' Medicare or Medi-Cal provider status, including, but not limited to, any decision to opt out of Medicare or Medi-Cal or any exclusion from participation in Medicare, Medi-Cal, or any state or federal health care program. After providing such notices to CHPIV, Provider shall keep CHPIV advised of the progress and outcome of such action. Provider shall notify CHPIV within ten (10) days of settlement or judgment in a civil action involving Provider (or any of Provider's Participating Practitioners) that includes a professional liability claim.

(c) Credentialing. Provider and Provider's Participating Practitioners shall comply with all aspects of CHPIV's credentialing and re-credentialing policies and procedures and furnish to CHPIV such evidence of licensure, Medi-Cal and Medicare enrollment certification, and qualifications as CHPIV may reasonably request.

(d) CCS Program Approval. Provider and Provider's Participating Practitioners agree that Provider and/or Provider's Participating Practitioners treating Members under the age of twenty-one (21) will receive CCS-approved paneling status. Any health care services rendered to Members by Provider or its Participating Practitioners for CCS-eligible conditions are not rendered in good faith if Provider and all of its Participating Practitioners are not CCS-paneled, and CHPIV will not pay for any such services.

(e) Fraud, Waste, and Abuse. Provider shall comply with all aspects of CHPIV's Fraud, Waste, and Abuse policies and procedures. Provider shall promptly provide notice to CHPIV of any

suspected Fraud, Waste, and Abuse and allow CHPIV to share such information with DHCS in accordance with the provisions of the CHPIV Provider Manual and the Medi-Cal Contract. This notice must be given as soon as possible and no later than ten (10) Working Days of Provider discovering any suspected Fraud, Waste, and Abuse

(f) Adequate Capacity. Provider shall maintain adequate networks and staff to ensure that it has sufficient capacity to provide and coordinate care for Covered Services in accordance with 22 CCR section 53853, Welfare & Institutions Code section 14197, 28 CCR section 1300.67.2.2, and all requirements in the Medi-Cal Contract.

2.2. **Provider Services.** Provider and Provider's Participating Practitioners agree to provide to Plan Members all Medically Necessary Covered Services that are within Provider's and such Participating Practitioners' professional competence and specialty, including, but not limited to, preventive health services required pursuant to the applicable guidelines established and published in the CHPIV Provider Manual. Non-Emergency, elective inpatient and outpatient Covered Services may require prior Authorization by CHPIV in accordance with Section 2.4 below. All Provider referrals require notice to CHPIV in accordance with Section 2.5 below. Provider, its Participating Practitioners, and Subcontractors, if any, shall render Covered Services to Members in an economic and efficient manner, consistent with professionally recognized standards of health care. Provider shall render Covered Services to Members in the same manner and in accordance with the same standards, and within the same time availability, as offered to non-Members consistent with existing medical, ethical, or legal requirements for providing continuity of care to any patient. Prior to delivering services to Members, Provider shall review the Medi-Cal eligibility record for the presence of Other Health Coverage ("OHC"). If the Member has active OHC, Provider must compare the OHC code as set forth in Appendix A of DHCS APL 22-027 to the requested service. If the requested service is covered by the OHC, Provider shall instruct the Member to seek the service from the OHC carrier. Regardless of the presence of OHC, Provider shall not refuse a covered Medi-Cal service to a Medi-Cal Member. Provider must report new OHC information not found on the Medi-Cal Eligibility Record or OHC information that is different from what is found on the Medi-Cal Eligibility Record to CHPIV within ten (10) calendar days of discovery.

2.3. **EPSDT Benefits**. EPSDT Benefits. Provider and Provider's Participating Practitioners agree to comply with all Applicable Requirements relating to the EPSDT Benefit, including the requirement to complete EPSDT-specific training no less than every two (2) years. Provider or Provider's Participating Practitioners who provide(s) the EPSDT Benefit to eligible Members shall provide such Covered Services, including, but not limited to, developmental surveillance in every periodic pediatric health visit, developmental screening services, vision services and hearing services, in accordance with the current American Academy of Pediatrics' "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care" (known as the "periodicity schedule"). Developmental screenings must be provided by Provider in accordance with Bright Futures Guidelines for Members at nine (9) months, eighteen (18) months, and thirty (30) months and when Medically Necessary based on developmental surveillance. Provider shall document which standardized tool it used which meets CMS criteria, including that the completed screen was reviewed, the results of the screen, the interpretation of the results, discussion with the Member and/or family, and any appropriate actions taken.

2.4. **Coordination of Care.** Provider acknowledges that each Member will be required to select a Primary Care Provider who shall be responsible for providing the Member primary care and for coordinating the provision of all health care services, including the Covered Services provided by Provider. The Member's Primary Care Provider is responsible for the medical care and treatment of the Member and for maintaining the physician-patient relationship with each Member. Provider shall cooperate with Member's Primary Care Provider and CHPIV to assure the timely and efficient monitoring, coordination, and management of Member's care and stabilization care by Provider, as may be reasonable and appropriate, including, without limitation, the development of a plan of treatment. To keep the Member's PCP apprised of the care provided by Participating Providers that are Specialist Physicians and so that the PCP can incorporate aspects of the Member's care provided by Specialist Physician Providers into the overall care plan and coordinate Member's care, Provider (and its Participating Practitioners, if any) and PCP shall communicate periodically, as appropriate, about the treatment and care provided by the Specialist Physician Provider, including, but not limited to, any hospitalization or surgery. Nothing in this Agreement shall be interpreted to interfere with the Specialist Physician-patient relationship, delay or require PCP consent or approval of any request for prior authorization of services proposed by the Specialist Physician or to limit a Specialist Physician Provider's ability to discuss all treatment options with Members (including risks, benefits, consequences of treatment or non-treatment and the right to refuse treatment) or to provide other medical advice or treatment such as the Specialist Physician deems appropriate, subject to any applicable requirements that the Specialist Physician obtain prior Authorization in accordance with article 2.5 below.

2.5. **Prior Authorization.** Provider agrees to obtain Authorization from CHPIV for those Covered Services that are identified in the CHPIV Provider Manual as requiring Authorization. The purpose of the Authorization is to verify that the patient is an eligible Member, that the service(s) to be provided is (are) Covered Services under the Member's Evidence of Coverage, that the facility and level of care at which the service(s) are to be rendered are appropriate, and that the Covered Services are Medically Necessary and will be provided in an efficient and cost-effective manner. If a Provider designated as a Member's Primary Care Provider determines that Medically Necessary Covered Services should be provided by another health care provider, such PCP shall: (a) provide (except in an Emergency) a written referral for such services to the appropriate Specialist Physician who is a Participating Provider, which shall state the scope of the services authorized; (b) coordinate hospital admissions by the Specialist Physician as may be indicated by the Member's medical condition and (c) obtain any applicable prior Authorization from the Medical Director, if required for such services under the CHPIV Provider Manual. CHPIV reserves the right to define certain specialty services as being exclusively provided by capitated Specialist Physicians, and to deny Authorization for such services to be performed by non-capitated providers who may be Participating Providers. The Authorization process may be conducted telephonically, electronically through an Internet solution, Electronic Health Record ("**EHR**"), or via facsimile by CHPIV's clinical management staff. There are three (3) components to the Authorization process: (i) submission of request for Authorization by the requesting Provider or Participating Provider, as applicable; (ii) review and determination of medical necessity and coverage in accordance with the CHPIV Provider Manual; and (iii) notification of determination to Provider or Participating Provider, as applicable. For purposes of

Authorization, "coverage" means either the determination of (a) whether or not the particular service or treatment is a covered benefit pursuant to the terms of the particular Member's Plan and Evidence of Coverage, or (b) where Provider is required to comply with CHPIV's patient management programs. The Authorization process also allows CHPIV to identify and register Members for pre-service discharge planning and specialized programs, such as disease management, case management or prenatal programs. Failure of Provider to obtain Authorization when required may result, at CHPIV's option, in CHPIV's nonpayment to Provider for those Covered Services provided by Provider to the Member without Authorization. CHPIV and Provider agree that prior authorization requirements are not applied to Emergency Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, Human Immunodeficiency Virus (HIV) testing, initial mental health and substance use disorder (SUD) assessments, and Minor Consent Services.

For non-elective inpatient hospital admissions and other emergency services for which CHPIV has not provided a prior authorization, Provider agrees to notify CHPIV and CCS of any potential or suspected CCS condition immediately, and in no event later than twenty-four (24) hours after, Provider's receipt of notice of any non-elective hospital admission or emergency service(s) (not pre-authorized by CHPIV) to ensure timely notification to CCS of any potential or suspected CCS condition. If Provider fails to notify CHPIV or CCS within said twenty-four (24)-hour time period of any non-CHPIV preauthorized, non-elective hospital inpatient admission or other emergency service(s) provided to any Provider patient that is a CHPIV Member and the Member is determined to have a CCS condition that would have been covered by CCS if timely notice of such admission or emergency service had been given to CHPIV or CCS, then Provider shall be financially responsible for the costs of services that would have been covered by CCS had timely notice been provided. In the event CHPIV has not been given timely notice by Provider of services as required by this section, then CHPIV shall immediately upon its receipt of actual notice of such services, appeal to CCS to seek coverage for such services. To the extent there is any dispute regarding whether CHPIV or Provider should have financial responsibility for such non-elective hospital inpatient admissions or other emergency services that would have been covered by CCS had timely notice been given as required herein above, then Provider may submit a dispute to the Plan for resolution in accordance with the provisions of Article 10 below. Provider shall cooperate with the CHPIV utilization review process and allow CHPIV to conduct medical reviews on-site, telephonically and/or electronically. CHPIV's requests for telephonic reviews shall be provided in a timely manner, not to exceed twenty-four (24) hours from time of request. Provider shall ensure that CHPIV shall have concurrent access to all clinical information contained in the Members' medical records including access to EHRs. To obtain referral authorization status, Provider must check CHPIV's online portal.

2.6. **Referrals.** Primary Care Providers are responsible for initiating referrals to Specialist Physicians within CHPIV's network of Participating Providers in accordance with the CHPIV Provider Manual, unless the services required by the Members are not available in the network. A Member's Primary Care Provider may not refer a Member to himself/herself for Specialist Physician services or receive Specialist Physician compensation for Specialist Physician services provided to such Member, unless approval is first obtained from CHPIV's Medical Director. In the event the Primary Care Provider determines, in consultation with the Specialist Physician and Medical Director, that a Member

requires continuing specialty care over a prolonged period of time when the Member has been diagnosed with certain qualifying diagnoses, then the Member may be referred in accordance with the Standing Referral Policy set forth in the CHPIV Provider Manual. Except in an Emergency, Provider (and its Participating Providers) shall not, without the prior approval of CHPIV: (i) admit a Member to a hospital as an inpatient; or (ii) refer Member to a hospital, other than a Participating Hospital selected by the Medical Director or his or her delegate. Failure of Provider (and its Participating Providers) to follow CHPIV's referral procedures may result, at CHPIV's option, in nonpayment for those Covered Services provided in connection with such a referral, charges to Provider (or deductions from any and all future payments due Provider) for those services provided to Plan Members at the rate(s) paid by CHPIV to the non-Participating Practitioners and non-Participating Providers, and/or in any sanctions incorporated in the CHPIV Provider Manual.

2.7. **Verification of Eligibility.** CHPIV assumes no responsibility, financial or otherwise, for patients representing themselves as Plan Members whose eligibility is not verified by Provider. Provider shall verify the eligibility of a Member to receive the Covered Services requested in accordance with the provisions of the CHPIV Provider Manual. Provider shall use Provider's best efforts to obtain such verification prior to the first day of service or on the next Working Day, should services be arranged after Normal Business Hours, on a weekend, or on an Emergency basis. CHPIV shall not be obligated to compensate Provider for services rendered to a person who is not an eligible Member at the time such services were provided if Provider fails to verify or re-verify the eligibility of such Member. Patient care management and decisions concerning a patient's plan of care are the ultimate responsibility of Provider and the Member. Provider shall re-verify eligibility in accordance with the CHPIV Provider Manual.

2.8. **Referrals to Non-Participating Hospitals.** Members shall be referred to and admitted only to Participating Hospitals that have contracted with CHPIV; provided, however, that Members may be referred or admitted to non-participating hospitals if: (i) prior approval of the Medical Director is obtained; or (ii) an Emergency exists where Covered Services are not readily available from Provider and Provider notifies CHPIV, in accordance with the CHPIV Provider Manual, of the Emergency within the first Working Day after such referral or admission.

2.9. **Repatriation.** If a Member is admitted to a non-Participating Hospital or an out-of-area hospital for an Emergency, Provider will, upon the request of CHPIV, cooperate with CHPIV to facilitate the transfer and repatriation of the Plan Member to a Participating Hospital as soon as the Member's medical condition has stabilized.

2.10. **Access and Availability.** Provider shall ensure that Covered Services provided under this Agreement are readily available and accessible during Normal Business Hours, and provided in a prompt and efficient manner without delays in wait times, prior authorization, scheduling or rescheduling of appointments, accessibility to interpreter services as required by applicable laws, all in a timely manner appropriate for the nature of the Plan Member's condition, consistent with good professional practice, and shall note in the Member's medical record if an applicable waiting time for a particular appointment is extended on the basis that waiting will not have a detrimental impact of the Member's health . Provider

shall ensure compliance with CHPIV's "Timely Access to Care" policies and procedures, which include standards for (i) waiting times for appointments with physicians, including Primary Care Provider and Specialist (and requisite time periods for Urgent Appointments, Routine Non-Urgent Appointments, preventive care services and follow-up care); (ii) timeliness of care in an episode of illness, including the timeliness of referrals and obtaining other services, if needed; (iii) waiting time to speak to a physician, registered nurse, or other qualified health care professional acting within his or her scope of practice who is trained to screen or triage a Plan Member who may need care. Provider shall ensure compliance by applying the metrics and standards developed by applicable Regulatory Agencies for measuring and monitoring the adequacy of CHPIV's contracted provider network to provide Plan Members with timely access to needed health care services and shall cooperate with respect to any reporting requirements established to ensure compliance with such standards. Provider agrees to provide timely access to Covered Services in accordance with Applicable Requirements, including but not limited to, 42 CFR section 438.206, Welfare & Institutions Code section 14197, 28 CCR section 1300.67.2.2, the Medi-Cal Contract, the Provider Manual, and the policies and procedures of CHPIV. Provider shall provide Emergency Services or Urgently Needed Care Within Service Area within the Service Area or direct Members promptly to providers of Emergency Services or Urgently Needed Care Within Service Area within the Service Area and provide or arrange for medical advice and supervision seven (7) days a week and twenty-four (24) hours a day, either directly or through adequate coverage arrangements. Provider shall be available for telephone consultations with Members and other Participating Providers as may be appropriate to meet the needs of Members and other Participating Providers, and shall follow up on missed appointments in accordance with Applicable Requirements. Provider agrees to offer hours of operation to Members that are no less than the hours of operation offered to other patients, or to Medi-Cal fee-for-service beneficiaries if Provider serves only Medi-Cal beneficiaries. Failure of Provider (and its Participating Providers) to follow CHPIV's Timely Access to Care policies and procedures, reporting requirements, subcontractual requirements, state or federal law, or DHCS's requirements, may result, at CHPIV's option, in a Corrective Action Plan or any sanctions incorporated in the CHPIV Provider Manual.

(a) Emergency Services. Provider shall ensure availability of Emergency Covered Services to Plan Members twenty-four (24) hours per day, seven (7) days per week. In an Emergency, Provider shall immediately provide Medically Necessary Covered Services to the Member, which are within Provider's license and professional competence to provide, including, to the extent applicable, calling an ambulance for transporting the Member to an emergency room.

(b) Urgently Needed Care. Provider shall provide to Members prompt Urgently Needed Care Within Service Area on a same-day basis within Provider's Normal Business Hours when Medically Necessary.1918)

(c) Access. Provider shall maintain daily appointment hours for Provider services that are sufficient to serve Members. Without limiting the generality of the foregoing, Provider shall make appointments available to Members immediately when Emergency or Urgently Needed Care Within Service Area is required, and in the case of Routine Non-Urgent Appointments, within the time periods established by CHPIV, based upon applicable Accreditation Organization guidelines and the CHPIV

Provider Manual. Provider shall provide Covered Services promptly and in a manner that assures accessibility and continuity of care and is consistent with generally accepted standards of medical practice, including reasonable hours of operation.

(d) DHCS Corrective Action Plan. In the event CHPIV is placed under an Annual Network Certification Corrective Action Plan by DHCS, Provider must adhere to the mandates within the Corrective Action Plan and comply with any applicable out-of-network access requirements.

2.11. **Agents and Employees.** Provider shall, at Provider's sole cost and expense, employ or contract with such staff and employees and engage such Subcontractors, as Provider deems necessary to perform Covered Services. CHPIV may not control, direct, or supervise Provider's agents or employees in the performance of Covered Services. All of Provider's employees, Subcontractors and agents shall hold and maintain in good standing, at all times during the term of this Agreement, all valid State licenses, registrations, and certifications (when applicable) required by state or federal law for the scope of services they perform and shall be covered by Provider's professional liability insurance policy or shall be covered by professional and general liability insurance policy acceptable to CHPIV. Provider shall not employ or contract with individuals excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act, or who have opted out of the Medicare or Medi-Cal programs. Provider shall notify CHPIV immediately in the event that Provider, any Participating Practitioner, employee or Subcontractor is excluded from participation in or opts out of any federal health care program or fails to maintain requisite insurance.

2.12. **Continuing Education.** Provider, its staff, employees and agents shall satisfy the continuing professional education requirements prescribed by the State of California, CHPIV, applicable Accreditation Organizations and other recognized professional associations. Provider shall participate in and complete all necessary trainings regarding the Medi-Cal Program conducted by CHPIV in accordance with the Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.2.5 (*Network Provider Training*), Members' rights as required under Exhibit A, Attachment III, Section 3.2 (*Provider Relations*), and Advanced Directives in accordance with 42 CFR sections 422.128 and 438.3(j) set forth in and Exhibit A, Attachment III, Provision 5.1.1, Subsection C.3) (*Members' Right to Advance Directives*), and any other requirements set forth in the Medi-Cal Contract.

2.13. **Facilities, Equipment and Supplies; Inspections.** Provider shall furnish all facilities, equipment, and supplies that may be required to perform the Covered Services, and shall maintain such facilities and equipment in good order and repair. All such facilities and equipment, to the extent required by applicable laws and regulations, shall be licensed or registered in accordance with applicable state and federal laws and regulations. The operating personnel for such equipment shall be licensed or certified as required by applicable laws and regulations. Upon reasonable prior notice, Provider shall permit CHPIV, the Director of DMHC, the Secretary of DHHS and their authorized designees and any other duly authorized federal or state official to inspect said facilities and equipment, medical records and all phases of professional and ancillary medical care provided to Members by Provider.

2.14. **Provider- Patient Conflict.** In the event of provider-patient conflict, Provider must document in the Member's medical record the conflict and any attempts for resolution. If, in Provider's judgment, the conflict cannot be satisfactorily resolved, Provider may, following prior notice to CHPIV and compliance with the requirements and procedures for patient termination in the CHPIV Provider Manual, discharge the Member from his/her practice. Provider shall assist CHPIV in arranging for continuity of care by another Participating Provider.

2.15. **Location of Services.** Except where medically indicated (e.g., when a Member is hospitalized or requires more sophisticated treatment facilities than are available in Provider's offices), Provider shall render Covered Services to Members in Provider's offices, the location(s) of which are identified in **Exhibit B** attached hereto, or via telehealth modalities subject to the requirements set forth in Exhibit A.

2.16. **Acceptance of Members.** Provider agrees to accept Plan Members of CHPIV as new patients, and to treat current patients pursuant to the Plan should they become Plan Members, to the extent the individual Provider's volume of Plan Members is within CHPIV's established and approved Provider/Member ratios, and in the reasonable professional judgment of the Provider(s), the acceptance of additional Members would not endanger Member access to, or continuity of, care. If Provider is accepting patients from any other third-party payor, it shall accept Members of CHPIV. Provider acknowledges that CHPIV shall have the right to immediately withdraw Members from the care of Provider or any of its Participating Practitioners in the event the health or safety of Members is jeopardized by the actions of Provider or such Participating Practitioner or by reason of Provider's or such Participating Practitioner's failure to provide Covered Services in accordance with CHPIV's UM/QI Program.

2.17. **Treatment Options.** Provider shall ensure that all information about treatment options, including the option of no treatment, is provided to Members in a culturally competent manner to all Members, including those with limited English proficiency or reading skills and diverse cultural and ethnic backgrounds in accordance with all applicable federal and state laws and regulations. Provider shall ensure that Members with disabilities are able to communicate effectively in making decisions regarding treatment options.

2.18. **Moral Objection**. In the event Provider has a moral, religious, or ethical objection to perform or otherwise support the provision of certain non-Emergency Covered Services, Provider shall provide CHPIV with a written statement indicating the moral, ethical, or religious basis for refusal to participate in the non-Emergency Covered Service. Should a Member request the non-Emergency Covered Service to which Provider has an objection, Provider must (1) immediately alert CHPIV of the Member's request, and (2) so that CHPIV can assist the Member in locating a Participating Provider who will perform the non-Emergency Covered Service to ensure compliance with CHPIV's "Timely Access to Care" policies and procedures and Applicable Requirements.

2.19. **Nondiscrimination.** Provider shall not unlawfully differentiate or discriminate against, harass, or allow harassment against any employee or applicant for employment or against any

Member or eligible beneficiary because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, gender, gender identity, gender expression physical or mental disability, medical condition, genetic information, or health status, , or identification with any other persons or groups defined in Penal Code section 422.56, in accordance with Title IV of the Civil Rights Act of 1964; 42 USC Section 2000d; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; the Unruh Civil Rights Act; Government Code sections 7405 and 11135; Welfare and Institutions Code section 14029.91; and the rules and regulations promulgated pursuant thereto; or as otherwise provided by Applicable Requirements. For the purposes of this Agreement, health status includes, but is not limited to, claims' experience, utilization of services, medical history, evidence of insurability, disability or any other prohibited classification or factor (including cancer, HIV and AIDS). For the purposes of this Section, genetic information includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. For the purpose of this Agreement, the prohibition on discrimination on the above listed grounds includes, but is not limited to, the following:

(a) Denying any Member any Covered Services or availability of a facility;

(b) Providing to a Member any Covered Service that is different, or is provided in a different manner or at a different time from that provided to other Members under this Agreement except where medically indicated;

(c) Subjecting a Member to segregation, separate treatment, or harassment in any manner related, to the receipt of any Covered Service;

(d) Restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or eligible beneficiary differently from others in determining whether he or she satisfies any admission, enrollment, quota, eligibility, membership, or adding other requirements or conditions which individuals must meet in order to be provided any Covered Service;

(e) Assigning times or places for the provision of Covered Services on the basis of the race, color, national origin, creed, ancestry, ethnic group identification, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, identification with any other persons or groups defined in Penal Code 22.56 or any other protected characteristic(s) of the participants to be served;

(f) Utilizing criteria or methods of administration that have the effect of subjecting individuals to discrimination;

(g) Failing to make Auxiliary Aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and

(h) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and Potential Members.

Provider shall take affirmative action to ensure that Members are provided Covered Services without regard to race, color, national origin, creed, ancestry, ethnic group identification, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, gender expression, health status, physical or mental disability, medical condition, genetic information, health status, identification with any other persons or groups defined in Penal Code 422.56 or any other protected characteristic(s) of Members, except where medically indicated Provider shall not impose any limitations on the acceptance of Members for care or treatment unless such limitations are applied generally to all patients.

Provider shall provide reasonable access and accommodation to Members with disabilities to the extent required under the Americans with Disabilities Act ("**ADA**") (P.L. 101-365) or any Applicable Requirements. Provider, Provider's employees, and Provider's Subcontractors under the Agreement shall not request, demand, require or otherwise seek, directly or indirectly, the transfer of, or termination of any Member based upon the Member's need for or utilization of Medically Necessary Covered Services or in order to gain financially or otherwise from such termination. Without limiting the generality of the foregoing, Provider and its Subcontractors, as well as their agents and employees, shall comply with the all Applicable Requirements, including but not limited to, the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (Title 2, CCR, Section 11000 et seq.); Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. Section 2000d et seq.), and the rules and regulations promulgated pursuant thereto; Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Section 794) and the regulations promulgated thereunder; Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Section 1681 et seq.); the Age Discrimination Act of 1975, as amended (42 U.S.C. Section 6101 et seq.); Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended (42 U.S.C. Section 9849); and the ADA. Provider shall give written notice of its obligations under this Section to labor organizations with which it has a collective bargaining or other agreement. Provider shall include the nondiscrimination and compliance provisions of this Agreement in all Subcontracts, if any, to perform work under the Agreement.

2.20. **Effective Communication/Language Assistance.** Provider shall ensure that policies and procedures are in place to comply with relating to Plan Members who are sensory impaired and/or have limited English proficiency. Provider shall make available to CHPIV the language assistance policies of Provider. Without limiting the generality of the foregoing, Provider shall comply with CHPIV's standards developed in accordance with Section 1300.67.04 of Title 28 of the CCR, and Health and Safety Code Sections 1368 and 1367.04, including Member assessment, standards for providing language assistance services, standards for staff training and standards for compliance monitoring. Provider will facilitate and/or arrange for interpretive and translation services for those Members with limited English proficiency or with a visual or other communicative impairment, and will facilitate availability of, or provide

for, auxiliary aids, including sign language interpreters for sensory impaired Members. Provider shall not use an adult or minor child accompanying a limited English proficient ("LEP") Member as an interpreter or to facilitate communication, except under the following circumstances: (a) If the LEP Member specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances; or (b) In the case of an emergency, if a qualified interpreter is not immediately available. To the extent that Provider is unable to accommodate a Plan Member's linguistic needs, Provider shall access the translation and interpretation services available through CHPIV. These services shall be provided at no cost to Member or Provider. CHPIV and Provider shall document on their respective records the Member's refusal to accept the services of a qualified interpreter.

2.21. **Cultural Competency & Health Equity.** Provider shall ensure that its cultural and Health Equity linguistic services programs align with CHPIV's Population Needs Assessment. Provider also agrees to comply with DHCS guidance, such as the Population Health Management Policy Guide and DHCS Comprehensive Quality Strategy, including all relevant requirements regarding health education and cultural and linguistic needs. Provider agrees to and shall require any of Subcontractors rendering Covered Services to Members to, participate in CHPIV's Diversity, Equity, and Inclusion Training Program that encompasses cultural competency and cultural humility, Health Equity, sensitivity, and diversity trainings within 90 days of the Effective Date, during times of re-credentialing or Agreement renewal, and on a bi-annual basis.

2.22. **Compliance with Laws and Professional Standards.** Provider and Provider's Participating Practitioners, employees, agents, and Subcontractors shall provide the Covered Services in full compliance with all Applicable Requirements, including, but not limited to, the Act, federal or state health care program laws, regulations, guidelines and policies, the Clinical Laboratory Improvement Act of 1967, the regulations, federal and state laws regarding advance directives, ethical codes of conduct, and current professional standards of practice and currently approved methods, including any additions, amendments, and modifications thereto during the term of this Agreement. Provider shall meet and comply with the requirements and standards for licensure by the State of California and the federal conditions of participation and all Applicable Requirements of any federal or state health care programs. In addition, Provider shall require that all facilities utilized by Provider and Provider's Participating Practitioners to provide Covered Services to Members comply with facility standards established by the applicable Regulatory Agencies, to the extent applicable. Provider shall cooperate with CHPIV to the extent reasonably necessary to enable CHPIV to comply with Applicable Requirements. CHPIV is subject to the requirements of the Act, and the regulations promulgated thereunder, and any provision required to be in this Agreement by the Act, and the regulations promulgated thereunder, and the State or federal health care program requirements shall bind CHPIV and Provider whether or not expressly provided in this Agreement.

2.23. **Compliance with CHPIV Provider Manual.** Provider agrees to perform its duties under this Agreement in a manner consistent with and shall comply with the CHPIV Provider Manual. The provisions of the CHPIV Provider Manual in the performance of their duties and obligations shall govern

both Provider and CHPIV under this Agreement. CHPIV shall have provided a paper or access to an electronic copy of such CHPIV Provider Manual at least fifteen (15) Working Days prior to the execution of this Agreement. Any material revisions to the CHPIV Provider Manual shall comply with Section 13.2 (Amendments Required by Law or Accreditation Organizations and Material Changes).In the event there is a conflict or inconsistency between this Agreement and the CHPIV Provider Manual, where this Agreement contains express and detailed terms or processes and procedures that conflict with the provisions of the CHPIV Provider Manual, this Agreement shall control. In the event the CHPIV Provider Manual contains processes and procedures not inconsistent with express terms of this Agreement, then the CHPIV Provider Manual shall control.

2.24. **Participation in UM/QI Program and QIHETP.** Provider shall cooperate with CHPIV in carrying out an effective UM/QI Program and QIHETP, including, but not limited to, pre-admission Authorization and concurrent and retrospective review of hospitalizations. Provider agrees to participate with CHPIV and other providers from the community to the extent reasonably requested by CHPIV to be involved as an integral part of CHPIV's UM/QI Program and QIHETP , and may serve on CHPIV's UM/QI Program committees and QIHEC as necessary for each committee's functions. CHPIV shall maintain and implement appropriate procedures to keep Participating Providers informed of CHPIV's written UM/QI Program and QIHEC activities and outcomes. For purposes of concurrent review, Provider shall promptly and within twenty-four (24) hours of request of CHPIV, furnish without charge such information from medical records, including EHRs, of Members as may be required by CHPIV for its UM/QI Program. For purposes of retrospective review, Provider shall promptly and within seven (7) days of request of CHPIV, furnish without charge such information from medical records of Plan Members as may be required by CHPIV for its UM/QI Program. Provider shall also participate in the audit procedures of CHPIV and comply with all reasonable recommendations resulting from such audits. Provider shall permit Regulatory Agencies and Accreditation Organizations to conduct on-site examinations and medical surveys on an unannounced basis, and periodic quality assurance studies and medical audits using staff with appropriate quality assurance/medical audit credentials. Without limiting the generality of the foregoing, Provider agrees to participate in, comply with, and cooperate with CHPIV, including any independent review organizations approved by applicable Regulatory Agencies, in the implementation and operation of, and abide by the requirements of the UM/QI Program established by CHPIV. CHPIV shall have provided a paper copy or access to an electronic copy of such UM/QI Program and/or QIHETP at least fifteen (15) Working Days prior to the execution of this Agreement. Any material changes or modifications to the UM/QI Program and/or QIHETP will be made as provided in section 13.2 (Amendments Required by Law or Accreditation Organizations and Material Changes). Provider shall participate with CHPIV in monitoring the quality of care provided to all Members under this Agreement, including, but not limited to, timely submission of data, any supporting documents requested by CHPIV, timely responses to concerns or queries by CHPIV's QI staff. Provider shall also assist CHPIV in its efforts to enhance the efficient and cost-effective use of the Provider services. Failure of Provider to comply with the UM/QI Program and/or QIHETP shall constitute a material breach of this Agreement. Provider agrees to cooperate with any independent quality review and improvement organization's activities pertaining to the provision of services for Members.

2.25. **Member Emergency Preparedness Plan.** For purposes of this Section,

"Emergency" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by public health crises, natural and man-made hazards, or disasters.

1. Provider shall annually submit evidence of adherence to CMS Emergency Preparedness Final Rule 81 FR 63859 to CHPIV.
2. Provider shall advise CHPIV as part of Provider's Emergency plan; and
3. Provider shall notify CHPIV 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.

2.26. **Mental Health Parity.** Provider agrees to comply with all applicable mental health parity requirements set forth in 42 CFR section 438.900 et seq.

2.27. **Pharmaceutical Formularies**. Unless medical necessity dictates otherwise, Provider will comply with pharmaceutical formularies developed and/or adopted by CHPIV.

ARTICLE 3 RIGHTS AND OBLIGATIONS OF CHPIV

3.

3.1. **Administrative Services.** CHPIV shall perform or arrange for the performance of administrative, accounting, claims processing, credentialing, utilization management, quality improvement, enrollment and other functions consistent with the administration and the terms and conditions of this Agreement and appropriate for the marketing and administration of Member benefit programs and this Agreement.

3.2. **Utilization Management and Quality Improvement.** CHPIV shall establish UM/QI Program committees to monitor all utilization policies and protocols, medical necessity and quality of all Covered Services furnished by Provider to eligible Members.

3.3. **Confidentiality of UM/QI and QIHETP Records .** All records and proceedings of the UM/QI Program committees and QIHETP shall be maintained on a confidential basis in accordance with the immunities and privileges set forth in Section 43.7 of the California Civil Code, Section 1370 of the Health and Safety Code, and Section 1157 of the California Evidence Code, to the extent they are applicable. With respect to the proceedings and records of the UM/QI Program committees and QIHEC referred to in this Agreement, CHPIV and Provider shall affirm and assure, to the extent possible, the conformance of their activities to such legal requirements to preserve the privileges.

ARTICLE 4 RELATIONSHIP OF THE PARTIES

4.

4.1. **Independent Contractors.** In the performance of the work, duties and obligations and in the exercise of the rights granted under this Agreement, it is understood and agreed that Provider, its Participating Providers and CHPIV are at all times acting and performing as independent contractors in

providing Covered Services pursuant to this Agreement and are not acting as an employee, partner, agent or joint venture of the other. CHPIV shall neither have, nor exercise, any control or direction over the manner and means by which Provider, its Participating Practitioners, employees or agents shall perform and administer the provision of Covered Services; provided, however, that Provider agrees to perform its obligations and responsibilities hereunder and function at all times in accordance with approved methods and practices as set forth in the CHPIV Provider Manual. It is understood and agreed that the sole interest of CHPIV and Provider is to assure that Covered Services rendered by Provider shall be performed in a competent, efficient and satisfactory manner and in accordance with all applicable state and federal law. Neither party shall have any claim against the other under this Agreement for sick leave, retirement benefits, social security, workers' compensation, disability or unemployment insurance benefits or employee benefits of any kind, for the other or for any agents or employees of the other.

4.2. **Payment of Taxes and Benefits.** Each party acknowledges and agrees to be solely responsible for and to file, on a timely basis, all tax returns and payments required to be filed or made to any federal, state or local tax authority, on its own behalf, including, without limitation, amounts required to be paid for (i) social security, (ii) federal, state or any other employee payroll taxes, (iii) federal unemployment taxes, (iv) workers' compensation, (v) disability insurance, and (vi) similar items. Each party shall indemnify, defend, and hold harmless the other for any liability, loss, damages, claims, costs and expenses (including reasonable attorneys' fees, court costs, and other expenses, including expert witnesses, appeal and enforcement of judgments), fines, and penalties paid or incurred by said other party by reason of a party's failure to perform such responsibilities. Provider will be solely responsible for expenses incurred in the course of providing Covered Services under this Agreement. CHPIV will regularly report amounts paid to Provider by filing Form 1099-MISC with the Internal Revenue Service if required by law.

4.3. **Non-Exclusive Agreement.** This Agreement is a non-exclusive agreement and Provider and CHPIV shall be free to enter into contracts to provide Covered Services through other organizations and entities, provided such contracts do not cause Provider to violate the terms of this Agreement. Provider acknowledges that this Agreement shall not obligate CHPIV to refer or assign Plan Members to Provider. This Agreement shall not be construed as a guarantee, warranty or promise that Plan Members will be referred to Provider by CHPIV or Participating Providers. CHPIV does not guarantee any minimum level of income or specific assignment of Members to Provider. CHPIV, at its sole discretion, reserves the right to reassign Members to another provider.

4.4. **Plan Directories and Updates.** CHPIV shall be allowed to use the name of Provider, its Participating Practitioners and Subcontractors, if any, in its Provider listings or directories and in other materials and marketing literature of CHPIV and the Plans, whether in paper or electronic form without the prior consent of Provider, Participating Practitioner or Subcontractor, which listings and directories may be made accessible on the Plans' websites to the public, potential enrollees, DHMC, other state and federal agencies and providers without any restrictions or limitations. Consistent with Section 1367.27 of the Act, or to the extent required by other applicable laws and regulations, Provider shall provide CHPIV information as and when reasonably requested by CHPIV, and no less frequently than every six (6)

months, to update its provider directories, including: (1) name of Provider's practice, including the name of each affiliated "**Provider Group**" (as defined below) currently under contract with the Plans through which Provider sees Plan Members; (2) the practice addresses ((including address, city, zip code) for Provider; (3) telephone number(s) and other contact information for Provider (including email address(es) for Provider's office); (4) Plan products in which Provider participates; (5) California license number and type of license; (6) Provider's area of specialty and board certification, if any; (7) Provider's NPI, admitting privileges to identified hospitals; (8) tier, if applicable; (9) the non-English language, if any, spoken by a Provider or other medical professional, as well as non-English language spoken by a qualified medical interpreter; and (10) whether Provider (and/or its Participating Practitioners) are accepting new patients. Provider shall provide CHPIV information relative to the above referenced components for any Provider Group providers (within the time parameters noted above for Providers) and notice of any change in any of Provider Group's providers' association with Provider relative to the above-referenced components of the Provider's practice within no more than thirty (30) days of any such change or within thirty (30) days of any request of CHPIV or the CHPIV Partnership Plan to provide updated Provider information, provided, however, that: Provider or Provider Groups shall notify CHPIV and the CHPIV Partnership Plan immediately and no later than five (5) Working Days from the date of such change of the following: (A) Provider or a Provider Group is not accepting new patients; (B) Provider had not previously been accepting new patients, and the Provider is currently accepting new patients; (C) a member of a Provider Group is no longer contracted with the Group; and (D) a new member is added to a Provider Group.

CHPIV and the CHPIV Partnership Plan may delay payment owed to a Provider when Provider fails to respond to the Plans' attempts to verify the Provider's information as required under Section 1367.27, which include contacting the Provider in writing, electronically, and by telephone to confirm whether the Provider's information is correct or requires updates. If CHPIV and/or the CHPIV Partnership Plan does not receive an affirmative response and confirmation from the Provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory within thirty (30) Working Days, CHPIV or the CHPIV Partnership Plan shall notify the Provider ten (10) Working Days prior to seeking a delay in payment or reimbursement to Provider. CHPIV and the CHPIV Partnership Plan may seek to delay payment or reimbursement owed to a Provider or Provider Group only after the ten (10) Working-Day notice period described in Section 1367.27 paragraph (4) of subdivision (l) has lapsed. For a Provider or Provider Group that receives compensation on a capitated or prepaid basis, CHPIV may delay no more than 50 percent of the next scheduled capitation payment for up to one calendar month. For any claims payment made to a Provider or Provider Group, CHPIV may delay the claims payment for up to one calendar month beginning on the first day of the following month. If CHPIV or the CHPIV Partnership Plan delays payment or reimbursement pursuant to Section 1367.27, , CHPIV or the CHPIV Partnership Plan shall reimburse the full amount of any payment or reimbursement subject to delay to the Provider or Provider Group according to either of the following timelines, as applicable: (A) No later than three (3) Working Days following the date on which CHPIV receives the information required to be submitted by the Provider or Provider group or (B) at the end of the one calendar month delay if Provider fails to provide the information require to be submitted. If CHPIV delays payment or reimbursement pursuant to this provision, it shall document each instance a payment or reimbursement was delayed and report this information to DMHC in such format as may be required by DMHC. A Provider

Group is not subject to the payment delay described above if all of the following occurs: (A) A Provider Group member does not respond to the Provider Group's attempt to verify the Provider Group member's information; (B) the Provider Group documents its efforts to verify the provider's information; and (C) the Provider Group reports to CHPIV that the Provider Group's member should be deleted from the Provider Group in the Plan(s) directory or directories. CHPIV may terminate this Agreement for a pattern or repeated failure of the Provider or Provider Group to alert CHPIV to a change in the information required to be in the directory or directories pursuant to Section 1367.27 of the Act in accordance with the terms and conditions Section 1367.27 and the provisions of Article 7 of this Agreement. If CHPIV or the CHPIV Partnership Plan is unable to verify whether Provider (or Provider Group's) information is correct or requires updates, CHPIV and/or the CHPIV Partnership Plan shall notify Provider (or Provider Group ten (10) Working Days in advance of removal of that Provider (or Provider Group) shall be removed from the provider directories or directory in accordance with the provisions described in Section 1367.27 paragraph (4) of subdivision (l); provided, however, that Provider (or Provider Group) shall not be removed from the provider directory or directories if Provider (or Provider Group) responds before the end of the ten (10)-Working Day notice period. For purposes of this section, "**Provider Group**" means a medical group, independent practice association, or other similar group of providers and providers that are members of a Provider Group may also be referred to as Participating Practitioners or Subcontractors in this Agreement**.** The directories may be inspected by, and are intended to be used by, Plan Members, Participating Providers and others. Neither Provider nor any of its Participating Practitioners shall use CHPIV or the CHPIV Partnership Plan's name or logo in any material without CHPIV's prior written consent.

4.5. **Patient Advocacy.** CHPIV encourages open communication between physicians, and other licensed health care providers and their patients regarding treatment alternatives. Participating Providers are encouraged to advocate for Medically Necessary Services for their patients in accordance with Section 2056(b) of the California Business and Professions Code. CHPIV shall not limit the ability of, or retaliate against, or otherwise penalize, Participating Providers and other licensed health care providers, who freely discuss all pertinent details of a Plan Member's condition with such Member, including treatment and medication options, regardless of whether the particular treatment or medication is a Covered Service.

4.6. **Prohibited Waivers.** CHPIV shall not require or allow Provider or any other Participating Provider to waive any right conferred upon Provider or the Participating Provider or any obligation imposed upon the Plan that are prohibited waivers as defined in Health and Safety Code Section 1375.7, as amended from time to time, including, without limitation, Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of CCR Title 28, relating to claims processing or payment. Any contractual provision of this Agreement purporting to constitute, create or result in such a waiver shall be null and void.

4.7. **Confidentiality.** None of the parties shall disclose this Agreement or the terms hereof to any third party, except as provided in this Agreement to the party's legal counsel for advice or as otherwise required by law (including the Act and as may be required to participate in any federal or state health care program), without the prior written consent of the other party or parties. Provider recognizes

and acknowledges that Provider, its Participating Practitioners and its employees and agents may have access to certain confidential and proprietary information of CHPIV, including, but not limited to: (a) Member lists, eligibility lists and any other information containing the names, addresses and telephone numbers of Members which have been compiled by CHPIV; (b) CHPIV Provider Manuals and CHPIV administrative service manuals and all forms related thereto; (c) the financial arrangements between CHPIV and any Participating Providers, including Provider; and (d) any other information compiled or created by CHPIV that is proprietary to CHPIV, including, but not limited to, operations, clients, treatment protocols, UM/QI Program protocols, and other know-how, processes, and practices (collectively, the "**Confidential Information**"), and that such Confidential Information constitutes valuable, special, and unique property of CHPIV. For purposes of this Agreement, Confidential Information shall not include any information which is publicly known, and which was not disclosed in breach or violation of any obligation or covenant to maintain confidentiality. Neither Provider nor its Participating Practitioners shall, during or after the term of this Agreement, without the express written consent of CHPIV, disclose or suffer to be disclosed to any person, firm, corporation, association, or other entity for any reason or purpose whatsoever, except as may be ordered by a court or governmental agency, or use, cause, or suffer to be used in competition with, or in any manner adverse to, CHPIV any such Confidential Information.

4.8. **Non-Solicitation; Non-Interference.** During the term of this Agreement, or any renewal thereof, and for a period of one (1) year from the date of termination, Provider, its Participating Practitioners and its officers, agents, employees, Subcontractors and their affiliates shall not advise or counsel any Member to disenroll from the Plans and shall not directly or indirectly solicit any Member to enroll in any other HMO, PPO or other health care service plan or insurance program for the primary purpose of securing financial gain. The non-interference, non-solicitation prohibition in this Section is not intended to and shall not apply to Provider or any Participating Provider's communications with a Plan Member regarding his or her health status, medical or health care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided by the Plan, including, without limitation, communications regarding treatment options, alternative plans or coverage arrangements or advocating for medically appropriate health care.

4.9. **Injunctive Relief; Survival.** These foregoing confidentiality and non-solicitation agreements shall survive the expiration or termination of this Agreement. In the event of a breach or threatened breach by Provider of the provisions of such provisions, CHPIV shall be entitled to an injunction restraining Provider from disclosing in whole or in part any Confidential Information. Nothing herein shall be construed as prohibiting CHPIV from pursuing any other remedies available to it for such breach or threatened breach, including the recovery of damages from Provider. Upon the effective date of termination of this Agreement, Provider shall return to CHPIV or destroy the Confidential Information in its possession or under its control in a reasonable manner to be specified by CHPIV.

ARTICLE 5 PARTICIPATING PRACTITIONERS / SUBCONTRACTORS

5.

5.1. **Covering Physician/Call Group Physician.** If Provider is, from time to time,

unable to provide Covered Services when and as needed, Provider may secure the services of a qualified covering physician who shall render such Covered Services otherwise required of Provider; provided, however, that the covering physician must be a Participating Practitioner or physician approved by CHPIV to provide Covered Services to Members and the duration and frequency of such covering physician's services to Members shall be subject to CHPIV's approval. Provider understands that the services of a covering physician shall be utilized only when Provider is not available to provide Covered Services and such occurrence should generally not occur on a regular basis during normal hours of operation of Provider's practice. This includes a partner of Provider or other physician located in the same office as Provider. Provider shall be solely responsible for securing the services of such covering physician and paying said covering physician for those Covered Services provided to Members by the covering physician. Provider shall ensure that the covering physician agrees in writing to comply with the requirements of Section 5.2 below regarding Subcontractors. Provider understands that CHPIV may seek recourse against Provider if the covering physician fails to comply with the requirements of Section 5.2 regarding Subcontractors, which may include CHPIV deducting the full amount of all monies due and owing to the covering physician, hospital or ancillary service from the amounts owed to Provider.

5.2. **Requirements for Subcontractors.** Provider shall ensure that all Subcontractors will: (i) accept CHPIV's credentialing, peer review, quality management and utilization review procedures; (ii) except for Copayments, not bill Members for Covered Services under any circumstances; (iii) prior to all elective procedures, obtain Authorization in accordance with the CHPIV Provider Manual; (iv) maintain professional liability coverage in amounts no less than required of Provider under this Agreement; (v) look solely to Provider for payment of said Covered Services if Provider is capitated for said Covered Services; (vi) if Provider is not capitated for said Covered Services, will accept as payment in full the same rate that Provider would have received if Provider provided said Covered Services; (vii) prior to all elective hospitalizations obtain Authorization in accordance with CHPIV's utilization management program; (viii) notify CHPIV of all Emergency hospitalizations within one (1) Working Day of each such hospitalization when possible; (ix) utilize only Participating Providers, including hospitals or ancillary services under contract with CHPIV; and (x) fully comply with the terms hereof. Each Subcontract shall also require the Subcontractor to make the representations and undertake the obligations under this Agreement that are applicable to Provider to the extent such representations and obligations relate to the Covered Services to be performed by such Subcontractor.

5.3. **Credentialing.** Provider agrees to comply with, and, if Provider is a group, to cause its Participating Practitioners to comply with, all aspects of CHPIV's credentialing and re-credentialing policies and procedures, including, but not limited to, the timely submission of credentialing/ re-credentialing information on behalf of such Participating Practitioners. CHPIV shall have the right to disapprove any Subcontractor as a Participating Practitioner at any time during the term of this Agreement with or without cause. Provider agrees to provide, or cause its Subcontractors and Participating Practitioners to provide, CHPIV with proof of current State Licensure, copies of Board Certification (if applicable), copies of current DEA license, proof of current professional and general liability insurance coverage and any other information required by NCQA or any other governmental agency for credentialing providers and their employees and agents and to sign and require that its Subcontractors sign a statement

indicating any limitations or inability to perform the essential functions of the position, with or without accommodation, verification of current enrollment in the Medi-Cal and Medicare programs. Provider grants CHPIV permission to gain access to any and all information, records, summaries of records, reports, files or data relative to its Subcontractors' qualifications including, without limitation, verification of completion of training and education, sanctions or limitations on licensure, sanctions or limitations on participation in Medicare, Medicaid or any federal health care program, board certification, mental or physical fitness or the quality of care rendered by such Participating Provider and such Participating Provider's employees and agents from any hospital, governmental or private agency or association (including the National Practitioner Data Bank and the Medical Board of California) or any other entity or individual. Provider agrees for and on behalf of its Participating Providers to provide CHPIV with any authorizations, consents or releases which CHPIV may require from said Participating Providers and their respective employees and agents to obtain the information described above.

5.4. **Release of Information.** Provider, for itself and on behalf of its Participating Practitioners, hereby authorizes CHPIV to release any and all information, records, summaries of records and statistical reports specific to Provider and such Participating Practitioners, including, but not limited to, physician utilization profiles pertinent to such physician's use of Covered Services, professional qualifications and credentialing information to other peer review organizations without receiving Provider's or such Participating Practitioner's prior written consent.

5.5. **Required Subcontract Provisions.** In addition to any requirements applicable to Subcontractors set forth in the attachments or exhibits to this Agreement, Provider shall: (1) Maintain and make available to CHPIV and Regulatory Agencies, upon request, copies of all Subcontracts and to ensure that all Subcontracts are in writing and require the Subcontractor(s) to: (a) make premises, facilities, equipment, books, records, computer and other electronic systems pertaining to their obligations and functions undertaken pursuant to the Subcontract available for the purposes of an audit, inspection, evaluation, examination or copying at all reasonable times for inspection, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Medi-Cal Contract, Exhibit E, Provision 1.22 (*Inspection and Audit of Records and Facilities*), by CHPIV, DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, DMFEA, DHCS's EQRO contractor, and DMHC, or their designees or any other Regulatory Agencies, and (b) retain such books and records for a term of at least ten (10) years from the final date of the Medi-Cal Contract period or from the date of completion of any audit, whichever is later;); (2) Prepare and maintain, in a form maintained in accordance with good business practices and generally accepted accounting principles , including all Encounter Data; (3) Assist CHPIV in ensuring the continuity and transfer of care pursuant to Article 7 in the event of termination or expiration of this Agreement or in the event that Subcontractor's contract to provide services is terminated for any reason; (4) Notify the State in the event this Agreement is amended or terminated (Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class certified mail, postage prepaid); (5) Warrant that any payment which is not paid in accordance with Article 8 of this Agreement (or equivalent provision in any Subcontract) shall automatically include interest at the same rate as CHPIV is required to pay Provider pursuant to the Act and warrants that any interest payment which is not paid in accordance with the foregoing clause shall include such additional penalty, if any, as

CHPIV is required to pay to Provider pursuant to this Agreement and the Act; (6) Resolve any disputes in a fast, fair and cost-effective mechanism; (7) Comply with the CHPIV Provider Manual and cooperate with and comply with all decisions rendered in connection with CHPIV's credentialing, peer review, UM/QI Programs; (8) Recognize that assignment or delegation of this Agreement shall be void unless prior written approval is obtained from Regulatory Agencies; (9) Hold harmless both the State and Plan Members in the event CHPIV cannot or will not pay for services performed by Provider pursuant to this Agreement; (10) Gather, preserve and provide to Regulatory Agencies, in the form and manner specified by Regulatory Agencies, any information specified by Regulatory Agencies, subject to any lawful privileges, in Provider's possession, relating to threatened or pending litigation by or against any Regulatory Agency. Provider shall immediately notify CHPIV of any subpoenas, document production requests, or requests for records received by Provider related to this Agreement; (11) Comply with all Applicable Requirements and relevant provisions of this Agreement, including, but not limited to, those pertaining to discrimination and reporting requirements; and (12) Provide CHPIV with the disclosure statement set forth in 22 CCR 51000.35, prior to commencing services under this Agreement.

5.6. **Information Regarding Subcontractors.** Within ten (10) Working Days after CHPIV's request, Provider shall provide its forms of Subcontract with Subcontractors, along with executed signature pages to each such contract, to CHPIV and to such Regulatory Agencies and Accreditation Organizations as CHPIV may request. Provider shall notify CHPIV within thirty (30) days after Provider alters or amends any Subcontract. Provider shall terminate the provision of services under this Agreement of any individual provider or Subcontractor immediately upon the earlier of a good faith request of CHPIV or upon receipt of actual notice of: (i) any failure to comply with CHPIV's UM/QI Program or credentialing criteria; (ii) any misrepresentation or fraud in the credentialing process; (iii) any conduct that falls below the standard of care; (iv) failure to maintain professional liability insurance; and (v) failure to comply with any of the terms and conditions set forth herein above. As applicable, Provider shall ensure that all Subcontractors will be credentialed and recredentialed in accordance with CHPIV's policies and procedures, including checking for Subcontractor's status with the Medi-Cal and Medicare programs to ensure Subcontractor is not excluded or suspended from such programs.

5.7. **Termination of Subcontractors and Individual Participating Practitioners in Provider's Group Practice.** Provider shall provide at least sixty (60) days prior written notice to its Subcontractors, if any, before terminating any Subcontract without cause; provided, however, that Provider shall notify CHPIV of the termination of a Provider Subcontract at least seventy-five (75) days prior to the proposed termination date, so that CHPIV may notify affected Plan Members and DMHC and/or CMS within the time period required by federal and/or state law of such termination. Provider shall notify CHPIV in writing at least seventy-five (75) days prior to the effective date of any action by Provider to terminate a Participating Practitioner member of Provider's group practice or a Subcontractor's relationship with Provider or whenever an individual Participating Practitioner or Subcontractor fails to renew his or her agreement with Provider. In the circumstances where there is no advance notice, Provider shall notify CHPIV as soon as practicable after any termination of an individual Participating Practitioner or Subcontract with Provider.

ARTICLE 6 REPRESENTATIONS AND WARRANTIES

6.

6.1. **Representations by CHPIV.** CHPIV represents and warrants to Provider that it is a California nonprofit public benefit corporation, in good standing with the California Secretary of State and licensed by the DMHC as a health care service plan in California.

6.2. **Representations and Warranties of Provider.** Provider makes the following representations and warranties to CHPIV:

(a) Provider represents and warrants that Provider is physician of medicine or osteopathy licensed to practice medicine in the State of California with a specialty in the area designated on the signature page or Provider's list of Participating Practitioners (who meet the criteria for such Specialist Physicians as may be established by CHPIV), and is qualified to provide the professional medical services in his or her specialty as described in the signature page or physician list or a professional medical corporation duly organized and validly existing and in good standing in the State of California, which employs or is comprised of physicians licensed to practice medicine or osteopathy in the State of California, with a specialty in the area designated and is qualified to provide the professional medical services in his or her specialty as described in the attached signature page or physician list. Provider also represents and warrants that it is enrolled in the State Medi-Cal Program and that its name does not appear on any Medi-Cal suspended provider list.

(b) Provider warrants that it, its Participating Practitioners, if Provider is a group practice, and its Subcontractors, if any, are in compliance with applicable local, state, and federal laws and licensing requirements and federal and state conditions of participation relating to the provision of the Covered Services.

6.3. **Certification of Accuracy of Data.** Provider acknowledges that CHPIV may be required to certify the accuracy, completeness, reasonableness, timeliness and truthfulness of data that CMS and other Regulatory Agencies and Accreditation Organizations request. Such data includes Encounter Data, Provider Data, Template Data, Program Data, payment data, and any other information provided to CHPIV by its Participating Practitioners and its Subcontractors ("Data"). Provider agrees to submit complete, accurate, reasonable, and timely claims and/or Data. Provider hereby represents and certifies that all Data submitted to CHPIV by Provider, whether in the form of Data or claims, will be accurate, complete, reasonable, timely, and truthful. Upon request, Provider shall make such certification in the form and manner specified by CHPIV in order to meet regulatory and accreditation requirements. By submitting claims or Data to CHPIV, Provider will be deemed to have certified the completeness, reasonableness, timeliness, and truthfulness of the claim or data. CHPIV will be relying to its detriment on that certification when it submits the data to Regulatory Agencies, including CMS, and certifies to those Regulatory Agencies the completeness, reasonableness, timeliness, and truthfulness of the aggregated Data. Provider understands that the completeness of the claims and accuracy of claims and Data can affect the premium paid to CHPIV and that the failure to be truthful in certifying the completeness and accuracy of

the submission of such Data can be considered Medicare and/or Medi-Cal Fraud, Waste, and Abuse.

6.4. **Representations and Warranties Regarding Subcontractors.**

(a) Provider represents and warrants that where it is paid directly by CHPIV for Covered Services which have been subcontracted, Provider will pay its Subcontractors within the time periods set forth in Article 8 below after receipt of a properly submitted complete and undisputed claim, or within such other time frame as may be required by law under similar circumstances. Provider further represents and warrants that should Provider pay Subcontractors beyond said period, Provider will automatically include interest with all late payments at the same interest rate that is required by law of CHPIV under the same circumstances. Provider represents and warrants that should Provider fail to automatically include interest on late payments to Subcontractor, it will include such additional penalty, if any, which is required by law under similar circumstances and if Provider or any of Provider's Subcontractors fails to fulfill such obligations, resulting in a penalty or assessment against CHPIV by any Regulatory Agency, CHPIV may offset an amount equal to such penalty or assessment against any future payment to Provider.

(b) Provider represents and warrants that it will create a forum that will permit its Subcontractors, direct and indirect, to resolve all claims payment disputes in a fast, fair and cost-effective manner.

(c) Provider represents and warrants that it will submit reports for direct and indirect Subcontractors indicating the timeliness of payments made by Provider or Subcontractor for Covered Services, any interest or late payment penalties paid, and any claims payment disputes initiated and resolved, as requested by CHPIV, and which is reasonably necessary for CHPIV to comply with the reporting requirements imposed upon by law or otherwise to comply with requirements of governmental regulators or accreditation organizations.

ARTICLE 7 TERM AND TERMINATION

7.

7.1. **Term.** The initial term (the "**Initial Term**") of this Agreement shall commence thirty (30) calendar days following its date of execution by CHPIV or on the first (1st) day of the month following thereafter, whichever is later, and shall continue for a period of one (1) year. After the expiration of the Initial Term, this Agreement shall automatically renew for successive one (1) year terms unless this Agreement is terminated by either party as provided in this Agreement. Upon the renewal of the Initial Term and all subsequent terms, this Agreement shall continue on the same terms and conditions set forth herein and that the applicable Compensation Rates specified in this Agreement shall apply unless otherwise agreed upon by the parties in writing or this Agreement is terminated in accordance with the terms and conditions hereof.

7.2. **Termination Without Cause.** This Agreement may be terminated without cause

by either party by giving at least one hundred eighty (180) days prior written notice to the other party. In the event that written notice of termination is given, this Agreement shall terminate effective as of the end of the calendar month in which the one hundred eighty (180) day notice period ends, subject to the continuity of care requirements.

7.3. **Partial Termination Without Cause by CHPIV.** CHPIV may, without cause, terminate Provider's participation in any one or more of the CHPIV Plans and/or lines of business described in Section 1.27 and Article 14 (the "**CHPIV Business Line(s)**") for which Provider delivers Covered Services under this Agreement (without terminating this Agreement with respect to the other CHPIV Business Lines for which Provider provides Covered Services by giving at least ninety (90) days prior written notice to Provider (referred to herein as a "**Partial Termination**"). CHPIV's notice of Partial Termination shall identify specifically the CHPIV Business Line to be terminated. In the event of a Partial Termination with respect to any CHPIV Business Line, the provisions of this Agreement that are triggered by a termination of this Agreement generally shall also be triggered and apply with respect to the specific CHPIV Business Line for which participation by Provider under this Agreement has been terminated.

7.4. **Termination With Cause.** In the event that the other party is in material breach of this Agreement, and such non-breaching party has given the breaching party written notice of such breach and such breach has not been cured within thirty (30) days after such notice was provided, the non-breaching party may terminate this Agreement by providing written notice to the other unless otherwise provided in this Agreement or unless immediate termination is permitted by the terms below:

(a) Termination by CHPIV. Notwithstanding any other provision of this Agreement, CHPIV shall have the right to terminate this Agreement immediately (without notice or right of cure, unless the CHPIV Provider Manual provides for a fair hearing in the event of such termination and Provider is entitled by law to a fair hearing, in which case such procedures shall be implemented) upon the occurrence of any of the following events:

(i) In the event of insolvency or bankruptcy of Provider or if Provider makes a general assignment for the benefit of creditors.

(ii) If Provider is a professional corporation, in the event Provider's corporate status as a professional corporation in the State of California is dissolved, suspended, or is restricted.

(iii) In the event Provider's Drug Enforcement Administration ("**DEA**") Controlled Substance Certificate is revoked, expired, or suspended or subject to terms or conditions of probation without regard to whether or not such restriction or conditions of probation have been finally adjudicated.

(iv) In the event Provider is excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act , including but not limited to, Medicare, Medi-Cal, or the Medicaid program in any state, or Provider's Medicare or

Medi-Cal agreement is terminated for any reason.

(v) In the event Provider fails to maintain the insurance required in this Agreement, then (a) this Agreement shall be automatically terminated as of the date of the termination of such insurance, unless a replacement insurance policy is obtained by Provider and no gap in coverage has occurred, and (b) Provider shall indemnify, defend and hold CHPIV harmless against any and all damage, loss, liability, and expense (including attorneys' fees and costs) resulting from any risk for which such insurance should have been maintained, and this indemnity provision shall survive the termination of this Agreement.

(vi) Provider engages in conduct which, for any cause or reason determined by CHPIV to be unethical, detrimental to patient safety or to the delivery of quality patient care (subject to Provider grievance dispute resolution rights as specified in Article 10 unless the health and welfare of Members is jeopardized), contrary to the CHPIV Provider Manual or contrary to the professional or clinical standards of CHPIV, availability and accessibility standards or performance standards established by CHPIV or Provider consistently improperly bills for Covered Services provided or does not report Encounter Data in a timely and accurate manner, or denies Medically Necessary Covered Services to Members inappropriately, as determined by CHPIV or any Regulatory Agency without regard to whether or not such matter has been finally adjudicated or Provider is unavailable to provide Covered Services to Members for a continuous period of greater than three (3) months during any one (1) year period during the term of this Agreement.

(vii) CHPIV or Regulatory Agency determines that Provider has committed Fraud, Waste, or Abuse.

(viii) CHPIV or Regulatory Agency determines that Provider has not performed satisfactorily.

(b) Termination as to Individual Participating Practitioners or Subcontractors. Notwithstanding any other provision of this Agreement, CHPIV shall have the right to terminate this Agreement immediately (without notice or right of cure, unless the CHPIV Provider Manual provides for a fair hearing in the case of such termination and/or Subcontractor or Participating Practitioner is entitled by law to a fair hearing, in which case such procedures shall be implemented) with respect to an individual Participating Practitioner in Provider's group practice or Subcontractors upon the occurrence of any of the following events:

(i) In the event Participating Practitioner's or Subcontractor's DEA Controlled Substance Certificate is revoked, expired, or suspended or subject to terms or conditions of probation without regard to whether or not such restriction or conditions of probation have been finally adjudicated.

(ii) In the event Participating Practitioner or Subcontractor is excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act or Provider's Medicare or Medi-Cal Hospital agreement is terminated for any reason.

(iii) In the event Participating Practitioner or Subcontractor fails to maintain the insurance required in this Agreement, then (a) this Agreement shall be automatically terminated as of the date of the termination of such insurance, unless a replacement insurance policy is obtained by said Participating Provider and no gap in coverage has occurred, and (b) Provider shall indemnify, defend and hold CHPIV harmless against any and all damage, loss, liability, and expense (including attorneys' fees and costs) resulting from any risk for which such insurance should have been maintained, and this indemnity provision shall survive the termination of this Agreement.

(iv) Participating Practitioner or Subcontractor engages in conduct which, for any cause or reason determined by CHPIV to be unethical, detrimental to patient safety or to the delivery of quality patient care (subject to grievance dispute resolution rights as specified in Article 10 unless the health and welfare of Members is jeopardized), contrary to the CHPIV Provider Manual or contrary to the professional or clinical standards of CHPIV, availability and accessibility standards or performance standards established by CHPIV or Participating Practitioner or Subcontractor consistently improperly bills for Covered Services provided or does not report Encounter Data in a timely and accurate manner, or denies Medically Necessary Covered Services to Members inappropriately, as determined by CHPIV or any Regulatory Agency without regard to whether or not such matter has been finally adjudicated or Participating Practitioner or Subcontractor is unavailable to provide Covered Services to Members for a continuous period of greater than three (3) months during any one (1) year period during the term of this Agreement.

(c) Termination by Provider. Provider shall have the right to terminate this Agreement immediately upon written notice to CHPIV in the event of:

(i) Revocation by any Regulatory Agency of any certification or license of CHPIV necessary for the performance of this Agreement.

(ii) Upon providing written notice to CHPIV within ninety (90) Working Days of Provider's receipt of CHPIV's notice of CHPIV's intent to change a material term of the Agreement if Provider rejects a material amendment to this Agreement proposed by CHPIV and the parties have not been able to reach an acceptable agreement regarding the proposed amendment after good faith efforts.

7.5. **Adverse Governmental Action.** In the event that, during the term of this Agreement, federal and/or state laws and regulations are enacted, amended or interpreted so as to prohibit, restrict, limit or in any way substantially alter either party's rights or obligations hereunder, either party may give the other party ninety (90) Working Days written notice of intent to amend this Agreement in a fashion that is equitable to each party considering such prohibition, restriction, limitation or change unless the change in law or regulation requires a shorter timeframe. The parties agree to negotiate in good faith to accomplish such amendment. If an agreement on the amendment is not reachable, either party shall have the right to terminate this Agreement within the ninety (90) Working Days of receipt of the notice and prior

to the implementation of the change by providing written notice to the other party. CHPIV may also amend the Agreement consistent with the requirements in Section 13.2.

7.6. **Final Proposed Action of a Peer Review Body.** Notwithstanding the foregoing provisions of Article 7, upon receipt by CHPIV of a true copy of a written decision after formal peer review hearing or a final proposed action of a peer review body for which a report is required to be filed with a Provider, Participating Practitioner or Subcontractor's licensing authority, CHPIV may terminate this Agreement or suspend or restrict an individual Subcontractor or Participating Practitioner's contractual right under this Agreement to provide services to Members; and in doing so: (a) CHPIV shall have the right to rely solely upon such written decision or final proposed action; (b) CHPIV need not conduct a hearing into the facts and circumstances giving rise to the written decision or final proposed action; and (c) such written decision or final proposed action shall be conclusive for purposes of action by CHPIV under this Section.

7.7. **Suspension.** The CHPIV Provider Manual may provide for immediate suspension of an individual Subcontractor or Participating Practitioner in circumstances where there is an imminent threat to the health and welfare of a Member or other personnel. To the extent required by the applicable laws, CHPIV shall provide such Participating Practitioner or Subcontractor with such notification of the reason for suspension or termination of this Agreement as may be required.

7.8. **Termination Not an Exclusive Remedy.** Any termination by either party is not meant as an exclusive remedy and such terminating party may seek whatever action in law or equity as may be necessary to enforce its rights under this Agreement.

7.9. **Termination of Delegation Agreement(s).** In the event Provider and CHPIV have entered into a Delegation Agreement or Agreements ("**Delegation Agreements**") with CHPIV wherein Provider agrees to perform certain services, any failure by Provider to satisfactorily perform the duties set forth in the Delegation Agreements may subject Provider to revocation by CHPIV of Provider's right to provide such delegated services, and, in such event, CHPIV shall have the right to terminate the Delegation Agreements and revoke all matters, rights and duties.

7.10. **Changes in Compensation.** Provider and CHPIV acknowledge that CHPIV's compensation from governmental payors may be reduced. In such event, CHPIV will, after forty-five (45) Working Days' notice to Provider, reduce the Compensation Rates set forth in the applicable Compensation Schedule, by an equivalent percentage. If Provider does not agree to the proposed compensation reduction, then CHPIV may terminate this Agreement by providing written notice to Provider.

7.11. **Rights Upon Termination.** Provider shall continue to provide Covered Services to Members during the term of this Agreement notwithstanding CHPIV's failure to perform its obligations hereunder, and Provider shall at no time request or seek payment from Members for such services except as otherwise expressly provided in this Agreement. Upon termination of this Agreement, all rights and obligations of the parties under this Agreement shall immediately cease; provided, however, CHPIV shall be liable for Covered Services rendered by Provider (other than for Copayments and deductibles) to a Member who retains eligibility under the applicable Plan or by operation of law under the care of Provider at

the time of such termination until the Covered Services being rendered to the Plan Member by Provider are completed, unless Provider and CHPIV make reasonable and medically appropriate provision for the assumption of such Covered Services by another Participating Provider, and Provider shall remain responsible for providing such Covered Services until the Covered Services being rendered to the Member by Provider are completed, unless CHPIV makes reasonable and medically appropriate provision for the assumption of such Covered Services by another Participating Provider; provided, however, that at the request of a Member, Provider shall continue to provide the completion of Covered Services for a Member who was receiving Covered Services from a terminated Participating Provider for one of the conditions described in Health and Safety Code Section 1373.96, in accordance with the provisions of said Section. Further, Provider shall continue to provide Covered Services to those Members who are hospitalized on an inpatient basis at the time this Agreement is no longer in effect until the Member is discharged from the hospital. No amendment or modification of the provision of this Section shall be allowed without the prior written approval of the Secretary or the Secretary's designee. For Covered Services rendered by Provider to eligible Members pursuant to this Section, CHPIV shall pay Provider on a fee-for-service basis in accordance with the terms of the applicable Compensation Schedule, and Provider shall accept such payment, together with any authorized Copayment and deductible, as payment in full for the Covered Services.

7.12. **Block Transfer**. In the case of a Block Transfer, all necessary notifications shall be provided in accordance with Health and Safety Code Section 1373.65 and DHCS APL 21-003, and Provider shall cooperate and work with CHPIV to comply with all applicable Block Transfer requirements.

7.13. **Obligations After Termination**. In the event of termination of this Agreement, Provider shall, at the request of the Members, provide for the completion of Covered Services to Members who are receiving active treatment at the time of termination of this Agreement for the following conditions and as stated herein:

a. **Acute Condition**. An "**Acute Condition**" is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Provider shall provide Covered Services for Acute Conditions for the duration of the Acute Condition.

b. **Serious Chronic Condition**. A "**Serious Chronic Condition**" is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Provider shall provide Covered Services for Serious Chronic Conditions for the period of time necessary to complete the course of treatment and to arrange for a safe transfer to another health care provider, but not to exceed twelve (12) months from the Agreement termination date.

c. **Pregnancy**. "**Pregnancy**" is the three trimesters of pregnancy and the immediate postpartum period. Provider shall provide Covered Services for Pregnancy for the duration of the Pregnancy. Provider shall also provide Covered Services for a Member who has written documentation of being diagnosed with a maternal mental health condition from Provider, but such provision shall not exceed

twelve (12) months from the diagnosis or from the end of Pregnancy, whichever occurs later.

d. **Terminal Illness**. A "**Terminal Illness**" is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Provider shall provide Covered Services for Terminal Illnesses for the duration of a Terminal Illness, which may exceed twelve (12) months from the Agreement termination date.

e. **Newborn Child**. "**Newborn Child**" is a child between birth and age thirty-six (36) months. Provider shall provide Covered Services for the care of a Newborn Child, but not to exceed twelve (12) months from the Agreement termination date.

f. **Surgery/Other Procedure**. To the extent applicable, Provider shall perform any surgery or other procedure that is authorized by CHPIV as part of a documented course of treatment and has been recommended and documented by Provider to occur within one hundred eighty (180) days of the Agreement termination date.

7.14. **Other States' Laws.** Nothing in this Agreement shall be interpreted as allowing CHPIV to terminate or not renew this Agreement or otherwise penalize Provider based solely on a civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state, if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in this State.

ARTICLE 8 COMPENSATION

8.

8.1. **Compensation Rates.** CHPIV shall pay Provider in accordance with the Compensation Rates set forth in the applicable Compensation Schedule. CHPIV shall pay Provider for the provision of Covered Services appropriately delivered through telehealth services on the same basis and to the same extent that CHPIV is responsible for payment for the same service if delivered in-person. Provider agrees to accept payment in accordance with said Compensation Rates, less any Copayments and deductibles, as payment in full for authorized Covered Services to Members pursuant to this Agreement. The Compensation Rates set forth in the applicable Compensation Schedule shall be in effect as of the Effective Date of this Agreement.

8.2. **No Member Billing.** Provider acknowledges that the Compensation Rates set forth in the applicable Compensation Schedule for each Covered Service reflect the full amount that Provider shall receive for each such Covered Service. Provider acknowledges that the collection of all Copayments and deductibles shall be the responsibility of Provider and not CHPIV. Provider shall look only to CHPIV for compensation for Covered Services and shall at no time seek compensation from Members for Covered Services (other than any permitted Copayments or deductibles or for Non-Covered Services, as otherwise provided in this Agreement). Provider's Participating Practitioners shall not seek any payment from Plan Members in the event CHPIV fails to pay Provider and in the event Provider fails to pay its

Participating Practitioners for Covered Services. No surcharge to any Member shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to be any additional fee not provided for in the Member's Evidence of Coverage. Should CHPIV receive notice that Provider charges a surcharge to a Member for Covered Services, CHPIV shall take appropriate action pursuant to requirements of the Act. Except as otherwise expressly provided in this Agreement, Provider agrees that in no event, including, but not limited to, non-payment by CHPIV, insolvency of CHPIV or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, a person acting on the Member's behalf, DHCS or any Medi-Cal Plans, for Covered Services provided pursuant to this Agreement. Provider shall not bill Members or CHPIV for a Member's failure to keep scheduled appointments. Provider shall hold harmless the State of California, the DHCS Medi-Cal Program and Members in the event that CHPIV cannot or will not pay for Covered Services performed by Provider or its Participating Practitioners or Subcontractors pursuant to this Agreement. Dual Eligible Beneficiaries shall be held harmless and will not be liable for Medicare Part A and B cost sharing when the State of California is responsible for paying such amounts and Provider agrees to (a) accept CHPIV payment as payment in full or (b) bill the appropriate State of California source. Notwithstanding the above or any other provisions to the contrary, Provider agrees that, in the event CHPIV ceases operations for any reason, including insolvency, Provider and its Participating Providers shall provide Covered Services and shall not bill, charge, collect or receive any form of payment other than an authorized Copayment, nor shall Provider collect a deposit from any Member or persons acting on their behalf, nor have any recourse against a Member or persons acting on their behalf, for Covered Services provided after CHPIV ceases operations. To the extent required by applicable federal laws, no modification, addition or deletion to the provisions of this Section shall be made by CHPIV without prior written approval of the applicable federal Regulatory Agency. In the event Provider fails to reimburse Plan Members, CHPIV reserves the right to make said payments and deduct said payments from any future payments due Provider. Notwithstanding the foregoing, Provider may bill or look to Plan Members for any allowable Copayments. Provider shall include these requirements in all Subcontracts, if any, related to this Agreement.

8.3. **Billing Procedures.** Claims for Covered Services must be submitted to CHPIV in accordance with procedures set forth in the CHPIV Provider Manual. Provider shall follow the billing procedures set forth in the CHPIV Provider Manual, including, but not limited to, procedures for billing "bundled" services and prohibitions against "unbundling" services for billing. Provider shall submit all fee-for-service claims for Covered Services rendered to Members in accordance with instructions provided by CHPIV and set forth in the CHPIV Provider Manual. Provider shall submit to CHPIV a CMS 1500 or UB-04 Claim Form, or an electronic claim in ANSI 837 format or such successor formats as may be adopted from time to time, as applicable ("**Claim Form**"), as set forth in the CHPIV Provider Manual for all Covered Services rendered by Provider to a Member hereunder within ninety (90) days following the date of service as a condition for payment, unless a longer period is expressly provided by this Agreement or except as otherwise required or permitted under applicable federal and state laws or regulations.

(a) Electronic Data Interchange (EDI). Provider shall conform to the prevailing American National Standards Institute (ANSI) standard. Such compliance shall include the

submission of (i) valid Member identification number; (ii) valid Member name, first and last; (iii) Member date of birth; (iv) valid diagnosis(es) and Current Procedural Terminology (CPT) codes; (v) valid provider/vendor National Provider Identification (NPI) number; and (vi) valid taxpayer identification number for the billing provider and submitted in the REF*EI segment.

(b) Claims Submission; Secondary Carrier. Provider is required only to include with claims submitted for Covered Services all "reasonably relevant information" and all "information necessary to determine payor liability" (as each such term is defined in Title 28, CCR, Section 1300.71(a)(10) and (a)(11)). Failure of Provider to submit said Claim Form within ninety (90) days of delivery of Covered Services may, at CHPIV's option, result in CHPIV's nonpayment of Provider for such Covered Services. When CHPIV is the secondary carrier, Provider must bill CHPIV within ninety (90) days of primary carrier's payment or date of contest, denial or notice from the primary payor. Claims denied because of untimely submission may be subject to adjudication pursuant to Health and Safety Code Section 1371 or 1371.35, whichever is applicable, and Title 28, CCR, Section 1300.71.

8.4. **Payment.** CHPIV shall pay Complete Claims promptly according to applicable Regulatory Agencies' standards and comply with all payment provisions of state and federal law. Provider shall bill, and collect from the Member, and retain, all applicable Copayments specifically permitted in the Plan Member's Evidence of Coverage.

(a) Fee-For-Service Claims. For those services to be paid by CHPIV on a fee-for-service basis, CHPIV shall pay Provider for undisputed Complete Claims, or if disputed, any undisputed portion thereof, in accordance with the Compensation Rates set forth in the applicable Compensation Schedule, within forty-five (45) Working Days or within such earlier time frame as may be required by applicable federal or state laws and regulations, following CHPIV's receipt of a properly submitted, complete and undisputed Claim Form, as applicable. Claims payments delayed due to coordination of benefits are excluded from the minimum payment time frames.

In the event that the billed amount is less than the Compensation Rate set forth in the applicable Compensation Schedule, payment shall be for the amount billed. All payments to Provider shall be considered final unless (1) adjustments are requested in writing in accordance with the procedure set forth in the CHPIV Provider Manual or (2) CHPIV notifies Provider of adjustments and deducts charges from future payments due to Provider in accordance with this Agreement and the CHPIV Provider Manual. Tender of any payment provided for herein shall be accomplished by depositing such payment with the U.S. Postal Service to Provider's business address, as set forth in Section 13.4 (Notices) of this Agreement.

(b) Capitation Payments. For those services, if any, to be paid by CHPIV on a capitated basis, CHPIV shall pay Provider in accordance with the Compensation Rates set forth in the applicable Compensation Schedule, on or before the twenty-fifth (25th) day of each calendar month, unless otherwise stated in the applicable Compensation Schedule. To the extent Provider's compensation is capitation based, Provider shall be financially responsible for, and shall pay when due, all charges for Covered Services rendered to a Plan Member by any health care provider rendering such Covered

Services that are the financial responsibility of Provider pursuant to this Agreement. In addition to the foregoing, Provider shall pay, within forty-five (45) Working Days of receipt by Provider or CHPIV (which shall promptly forward the claims to Provider for payment), all uncontested claims for Covered Services. If Provider fails to pay any charges required to be paid by Provider pursuant to this Agreement, CHPIV may pay such charges and deduct all amounts paid by CHPIV from any amounts due, or which subsequently become due, from CHPIV to Provider.

(c) Contesting or Denying Claims. Provider agrees to reasonably cooperate with CHPIV's Claims Department and Utilization Management Department in the proper adjudication of claims submitted; provided, however, that Provider shall not be required to provide information that is not reasonably relevant nor necessary to determine CHPIV liability. CHPIV reserves the right to review claims for accuracy of codes utilized, unbundling, medical necessity, prior Authorization, and assign codes to services delivered based upon documentation provided and issue payment accordingly. If any Covered Service is deemed not Medically Necessary or non-authorized, payment for such Covered Services may be denied. CHPIV may contest or deny a claim, or portion thereof, by notifying Provider, in writing, that the claim is contested or denied, within forty-five (45) Working Days after the date of receipt of the claim by CHPIV or such earlier time frame as may be required by applicable federal or state laws and regulations.

(d) Appeals. Provider may appeal claims payment following appeals procedure detailed in the CHPIV Provider Manual. No payment shall be made to Provider by CHPIV for appeals received by CHPIV later than three hundred sixty-five (365) days from the action on the claim that is being disputed. In the event of inaction on the claim, appeals must be received no later than three hundred sixty-five (365) days after CHPIV's issuance of the remittance advice for such claim. Claims appeals will be reviewed and a decision will be rendered within forty-five (45) Working Days of receipt of the written appeal.

(e) Interest and Penalties. Interest and penalties on any late payments will be paid by CHPIV at the same rate as required of CHPIV by 28 CCR Section 1300.71(i).

(f) Coordination of Benefits. When a Plan Member receives Covered Services for which a third party may be liable, such as, but not limited to, personal injury or workers' compensation, Provider shall notify CHPIV and obtain such information from the Member as may be necessary to recover from said third party, and CHPIV will coordinate health care coverage, based on the provisions of the CHPIV Provider Manual, including the Birthday Rule and Coordination of Benefits guidelines established in accordance with National Association of Insurance Commissioners (NAIC) guidelines for order of benefit determination, subject to applicable federal and state regulations, including, without limitation, the Medicare regulations and requirements of the Medicare Secondary Payer Procedures set forth in the Medicare Managed Care Manual applicable to Medicare Plans and Title 28, CCR, Section 1300.67.13. Provider shall determine whether any other payor has primary responsibility for the payment of a claim for services that Provider renders to a Plan Member. If another payor is primarily responsible for payment of the claim, CHPIV will remit payment only for the difference, if any, between the lesser of the

primary payor allowable and CHPIV's negotiated rate with Provider. For Medi-Cal Members with other coverage, CHPIV is always the payor of last responsibility.

8.5. **Confidentiality of Compensation.** Provider and its Participating Practitioners shall hold confidential the Compensation Rates set forth in this Agreement. Provider shall not make any disclosure of said rates to any third party other than to applicable Regulatory Agencies with jurisdiction over CHPIV or Provider.

8.6. **Member Additions and Cancellations.** Capitation Payments or other payments made to Provider for Plan Members who are retroactively disenrolled from any CHPIV Plan by CMS or CHPIV Partnership Plan by DHCS or who voluntarily disenrolled (collectively referred to in this Article 8.6 as ("**Retroactively Disenrolled Member**") shall be deducted from any and all future payments due to Provider by CHPIV, unless such services were preauthorized by CHPIV and provided to the Retroactively Disenrolled Member by the Provider's Participating Provider(s) in "good faith", subject to the provisions of this Article 8.6. "**Good faith**", includes, without limitation, that the Provider or Provider's Participating Provider(s) reverified eligibility (including continued enrollment in the applicable CHPIV Plan or CHPIV Partnership Plan via CHPIV's eligibility tool or through the online Automated Eligibility Verification System ("AVES")) within forty-eight (48) hours of the delivery of any and all Covered Services, including any Covered Services that were pre-authorized by CHPIV or the Provider. In the event that the Retroactively Disenrolled Member is not reenrolled in a new plan, which is now responsible for such Member's coverage, Provider may bill the Member on a fee-for-service basis (in accordance with the Provider's usual and customary fees) for Covered Services provided after the effective date of the Member's disenrollment by CMS or DHCS or voluntary disenrollment from the CHPIV Plan or CHPIV Partnership Plan where such services provided were not pre-Authorized. If Provider has requested prior Authorization for a Covered Service from CHPIV and CHPIV (or Provider through its delegation from CHPIV)granted Authorization based upon available eligibility information at the time Authorization was requested, and Provider renders the Covered Services in "good faith", meaning that the Provider or the Provider's Participating Provider(s), prior to the time the Authorized Covered Services were rendered, had no: (i) actual notice or knowledge of the disenrollment or termination of the Plan Member's participation in the applicable CHPIV Plan by CMS, CHPIV Partnership Plan by DHCS, voluntarily by the Member or otherwise by CHPIV as permitted in the Member's Evidence of Coverage; or (ii) actual notice of rescission of the prior Authorization (48 hours prior to the time the pre-Authorized Services were rendered); and (iii) re-verified the Member's eligibility for Services through the CHPIV Plan or CHPIV Partnership Plan (as applicable) AVES (as required by this Agreement and CHPIV's Provider Manual) within forty-eight (48) hours of the delivery of the Authorized Covered Services, then CHPIV shall be responsible for payment to Provider for such Covered Services as were actually provided within the scope of such Authorization, but may deduct any Capitation Payments paid to Provider for such "**Retroactively Disenrolled Member**". However, if Provider renders Authorized Covered Services when any of the conditions referenced subsections (i) or (ii) above are true (e.g., Provider or Provider's Participating Providers had actual notice of disenrollment, termination, cancellation or rescission) or Provider (or Provider's Participating Provider(s)) failed to re-verify the Member's eligibility as required in subsection (iii) above, even if CHPIV gave a prior Authorization for Covered Services, where such Authorized Covered Services were not rendered within forty-eight (48) hours of the Authorization,

then Provider shall be financially responsible for such services rendered after the disenrollment, cancellation, termination or rescission, and, ,except as otherwise provided, Provider can bill Member directly and collect any amounts due (up to usual and customary charges) from Member, unless such Member has become a member of another plan which is now responsible for such Member's coverage. To the extent Provider or Provider's Participating Provider(s) have any dispute regarding the payment for Covered Services rendered by Provider Participating Provider(s) to a disenrolled Plan Member, it can submit to the Plan's fast, fair, and cost-effective dispute resolution mechanism.

8.7. **Non-Covered Services.** CHPIV shall have no responsibility to compensate Provider for any Non-Covered Services rendered by Provider to Members. The Provider may only provide Non-Covered Services to a Plan Member if the Plan Member agrees in writing with signature affirming agreement that such services are not covered by the Member's Plan. Provider shall not bill Members if Covered Services are deemed not Medically Necessary Services.

8.8. **Effect of Suspension or Exclusion**. Provider shall not be eligible for compensation from CHPIV for services rendered after Provider has been suspended or excluded from the Medi-Cal Program. Provider may not seek any payment from Members for services rendered during the time of the exclusion or suspension from the Medi-Cal Program. In the event Provider's payment suspension is lifted, CHPIV will then compensate Provider for Covered Services rendered during the suspension.

ARTICLE 9 RECORDS AND REPORTS

9.

9.1. **Medical and Business Records.** In accordance with generally accepted business and professional record keeping standards and procedures and consistent with and as required by community standards, Accreditation Organizations, Regulatory Agencies and applicable state and federal law, including, but not limited to, the Act, Provider shall prepare and maintain, for each Plan Member receiving Covered Services, clear and complete medical, business and financial records, which reflect all health care services rendered to each Member, in a timely and accurate manner. Provider agrees to maintain and make available (including, without limitation, in accordance with 42 CFR Sections 422.504(d), 422.504(e)(2), 422.504(e)(3), 422.504(i)(2)(ii) and 422.504(e)(4)) for inspection, examination, audit or evaluation or copying by CHPIV (including any CHPIV designees, as directed by CHPIV) and Regulatory Agencies, its and its Subcontractors' and Participating Practitioners' premises, physical facilities and equipment and all books, records, documents, pertinent contracts, source data related to cost and utilization reports submitted to CHPIV and other evidence of accounting procedures and practices, contracts, medical records, patient care documentation and other records of Provider and/or its Subcontractors or transferees, pertaining to any aspect of the services rendered under the terms of this Agreement and sufficient to: Accommodate periodic auditing of the financial records, enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under this Agreement and the facilities of Provider; enable CMS to audit and inspect any such books and records that pertain to the ability of the organization to bear the risk of potential financial losses, or to services

performed or determinations of amounts payable under the contract; properly reflect all direct and indirect costs claimed to have been incurred; to the reconciliation of benefit liabilities; the determination of amounts payable under the contract; and/or as the Secretary of the DHHS may deem necessary (collectively, "**Books and Records**"). Books and Records are to be maintained in accordance with the general standards applicable to such Books and Records and all financial records are to be maintained according to generally accepted accounting principles ("**GAAP**").

Provider, its Subcontractors and Participating Practitioners shall maintain in an accurate and timely manner a health record for each Member in accordance with standards established by CHPIV, consistent with professional standards of practice. The medical record shall be a single standard medical record in accordance with the general standards applicable to such record keeping, containing such information as may be required by the laws, rules and regulations of the State of California and, to the extent applicable, JC and/or NCQA. It is understood that the medical records referenced above shall be and remain the property of Provider or its Subcontractors or Participating Practitioners, as applicable. These records shall be treated as confidential so as to comply with the applicable state and federal laws and regulations regarding confidentiality of patient records. A Member's medical record shall reflect whether or not the Member has executed an advance directive. Provider shall be fully bound by the requirements in Title 42 Code of Federal Regulations ("**CFR**") Section 2.1 et seq., relating to the maintenance and disclosure of Member records received or acquired by federally assisted alcohol or drug programs, to the extent applicable. Provider and its Subcontractors and Participating Practitioners shall maintain and preserve such Books and Records for a period of at least ten (10) years from the end of the contract period or from the date of completion of any audit, whichever is later, and in the event Member is a minor, until said minor's twenty-first (21st) birthday; provided, however, that in the event Provider has been duly notified of a federal or state audit or investigation related to such records or patients or Plans, the records shall be maintained until the date such matter has resolved and formally concluded and in accordance with applicable federal and state laws and regulations. Provider agrees that these obligations to maintain, preserve and provide access to Books and Records shall not terminate upon the expiration or termination of this Agreement whether by rescission or otherwise, but shall survive the expiration or termination of this Agreement.

9.2. **Access to Records.**

(a) CHPIV Access. Subject to all applicable federal and state laws and regulations relating to privacy, confidentiality, and Member consent, including, without limitation, the Health Insurance Portability and Accountability Act, including the regulations promulgated thereunder (collectively, "**HIPAA**"), CHPIV (including any CHPIV designees, as directed by CHPIV) shall have access at reasonable times upon demand to the books, records and papers of Provider relating to the health care services provided to Members, to the cost of services, to payments received by Provider from Members (or from others on their behalf) and, unless Provider is compensated on a fee-for-service basis, to the financial condition of Provider and shall be allowed to make notes and copies as needed at no charge to CHPIV or its designees. Such access includes review and duplication of any data or other records maintained on Plan Members which relate to this Agreement or as required under applicable state and federal laws, including, but not limited to, records relating to billing, clinical care, including electronic records, payment,

assignment, coordination of benefits claims and disclosure of other coverage which may be subject to coordination of benefits, records and claims regarding liability for injuries or illnesses caused or alleged to be caused by third parties or covered under other liability insurance (including disclosure of other liability insurance which may cover the services provided), or in furtherance of UM/QI Program, QIHETP, and Grievance Resolution. Provider shall provide to CHPIV (including any CHPIV designees, as directed by CHPIV) concurrently, retroactively or prospectively, at no cost to CHPIV or its designees, access to and copies of Member's medical records for purposes of conducting quality assurance, case management, and utilization reviews, credentialing, peer review, claims processing, verification and payment, resolving Member grievances and appeals, and other activities reasonably necessary for compliance with the standards of Accreditation Organizations and the requirements of state and federal law. Such access shall include provision of such records, including the duplication thereof at Provider's cost, to other providers of health care services for the purpose of facilitating the delivery of appropriate health care services. Nothing in this Agreement is intended to be, and CHPIV's or its designees' access to such records shall not be, a waiver of the privileges and immunities authorized by law, including California Evidence Code Section 1157 and California Health and Safety Code Section 1370.

(i) Electronic Health Records. Provider shall provide Electronic Health Records ("**EHR**") training to, and access (including remote access) by, CHPIV-designated clinical management staff of Plan Members' EHRs through the term of this Agreement. Provider shall provide such training within thirty (30) days of execution of this Agreement. Provider shall permit EHR access for multiple CHPIV staff members, as directed and designated by CHPIV.

(b) Knox-Keene Act Access to Books and Records. Provider shall provide access to CHPIV, Accreditation Organizations and Regulatory Agencies, as applicable, (including the Director of the DMHC and his or her designees), at all reasonable times, upon demand, to the books, records and papers of Provider relating to the provision of services to Members, to the cost of such services, to payments received by Provider from Members, and except for fee-for-service compensation, to the financial condition of the Provider.

(c) Access to Books and Records. In compliance with United States Code Section 1395x(v)(1)(I) and its implementing regulations and any other federal laws or regulations applicable to CHPIV and Provider and any Subcontractors of same shall make available to the Secretary, the Comptroller General, and their duly authorized representatives written contracts between CHPIV, Provider and its Subcontractors, if any, and to Provider's and Subcontractor's books, documents, papers, and records that pertain to any aspect of the services performed, reconciliation of benefit liabilities and determination of amounts payable under the contract for inspection, evaluation and audit. Such access shall be granted until the expiration of ten (10) years from the final date of the contract period, or periods exceeding ten (10) years for reasons specified in applicable federal regulations, and such access shall be subject to the provisions of 42 CFR Part 420 and its related subparts.

(d) Notice of Request for Disclosure. If Provider or its Subcontractors are requested to disclose any books, documents, or records as required by this Section, Provider shall notify CHPIV of the nature and scope of such request and shall make available all such books, documents, or

records.

9.3. **Reporting Requirements.** Provider shall furnish CHPIV (including any CHPIV designees, as directed by CHPIV) in a complete, accurate, reasonable, and timely manner with any and all information pertaining to services rendered by Provider to Members, necessary for CHPIV to meet all federal and state reporting requirements. Provider shall fully cooperate in providing such information and assistance regarding Members and Provider's performance under this Agreement as may reasonably be required in filing such reports, and, to the extent applicable, shall certify the completeness and truthfulness of all Data. In addition to any other reporting requirements in this Agreement, Provider shall provide CHPIV (quarterly at CHPIV's option or annually) with all reports, contracts or other information required of CHPIV by any Accreditation Organization or Regulatory Agency applicable to Provider's services. Provider will identify, collect and provide CHPIV with data relating to Medi-Cal Members' social drivers of health ("SDOH"), including, but not limited to data, for DHCS's 25 Priority SDOH Codes. Provider agrees that CHPIV shall be permitted to prepare and disclose to third parties a "Quality Data" report to be limited to: (a) utilization data of CHPIV's Participating Providers in the aggregate; (b) Healthcare Effectiveness Data and Information Set ("**HEDIS**") reporting data, to the extent applicable; (c) Member satisfaction data; (d) overall compliance with Accreditation Organization quality standards; and (e) Member disenrollment data; provided, however, that quality data shall not include any information that identifies an individual Member or individual Participating Provider or that is privileged or confidential under applicable laws. To the extent that Provider is determined, pursuant to the Act, to be a risk-bearing provider under the Plan, then Provider shall provide to CHPIV such financial information and shall meet such other financial requirements established by CHPIV as may be necessary to comply with the Act. CHPIV shall provide such information as is required by the Act and applicable DMHC regulations. Provider shall provide to CHPIV, at reasonable times upon demand, information and records to demonstrate Provider's financial condition and ability to meet all financial obligations of this Agreement, as required by the Act and the regulations. Provider shall make all Books and Records pertaining to the goods and services rendered under the terms of this Agreement (subject to ethical and legal confidentiality requirements) available for inspection, examination, or copying by CHPIV (including any CHPIV designees, as directed by CHPIV) and any applicable Regulatory Agencies, at no cost to CHPIV, its designees or such agencies, at all reasonable times at Provider's place of business or at such other mutually-agreeable location in California. This obligation shall not cease upon termination of this Agreement. If Provider is paid on a capitated basis, Provider shall submit, as a condition to payment under this Agreement, to CHPIV Encounter Data for those Covered Services provided to a Member, in the CMS 1500 claims format and/or any other format required by CHPIV, within forty-five (45) calendar days following the provision of Covered Services to said Member or any earlier date required by CHPIV.

9.4. **Confidentiality, Privacy and Security of Patient Information.**

(a) Safeguards and Security. Provider shall safeguard the privacy and provide for the security of any information that identifies a particular patient or client and shall maintain all patient and business records in compliance with all applicable federal and state laws, regulations, and requirements, regarding confidentiality, security, privacy, record accuracy and access thereto, including, without limitation, the HIPAA (45 CFR Part 160 et seq.), the Health Information Technology for Economic

and Clinical Health ("HITECH") Act, the Deficit Reduction Act of 2005 and its implementing regulations, the Federal Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (collectively, "Affordable Care Act"), the California Consumer Privacy Act of 2018 and its implementing regulations, the California Confidentiality of Medical Information Act ("CMIA"), and the Confidentiality of Alcohol and Drug Abuse Patient Records regulations (42 CFR Part 2), as amended from time to time. Without limiting the generality of the foregoing, each of the parties shall ensure the confidentiality and privacy and provide for the security of all protected health information (as defined by HIPAA and applicable state law) including, but not limited to, information relating to Sensitive Services, in compliance with all applicable laws, regulations, and requirements concerning the confidentiality, privacy, and security thereof, including without limitation, HIPAA and the regulations promulgated thereunder, comply with all confidentiality and Member record accuracy requirements in accordance with 42 CFR Sections 422.504(a)(3)(iii) and 422.118, shall safeguard the privacy of any information that identifies a particular Member, shall have procedures that ensure that Member medical records and information are released only in accordance with applicable state and federal laws, including, but not limited to, HIPAA and the privacy and security regulations promulgated thereunder, and Title 42 CFR Section 2.1 et seq., relating to Member records received or acquired by federally assisted alcohol or drug programs.

(1) Provider and any Subcontractors shall have policies and procedures in place to guard against unlawful disclosure of protected health information, private information, and any other confidential information to any unauthorized persons or entities.

(2) With respect to Minor Consent Services, Provider is prohibited from disclosing any information relating to such services without the express consent of the minor Member.

(3) Notwithstanding any other provision of the Agreement, Provider will comply with all confidentiality requirements relating to the receipt of Sensitive Services, including, but not limited, those set forth in the CMIA

(b) Members Receiving Public Social Services. Notwithstanding any other provision of this Agreement, names of Members receiving public social services hereunder are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., and Section 14100.2 of the California Welfare and Institutions Code and its successor provisions and regulations adopted thereunder. For the purpose of this Agreement, all information, records, data, and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by Provider from unauthorized disclosure.

(c) Plan Members. With respect to any identifiable information concerning a Plan Member that is obtained by Provider, Provider (i) shall not use any such information for any purpose other than carrying out the express terms of this Agreement; (ii) shall promptly transmit to the applicable Regulatory Agency(ies) and CHPIV all requests for disclosure of such information; (iii) shall not disclose, except as otherwise specifically permitted by this Agreement, any such information to any party

other than the applicable Regulatory Agency(ies) and CHPIV, without prior written authorization specifying that the information is releasable under Title 42 CFR, Section 431.300 et seq., and Section 14100.2 of the California Welfare and Institutions Code, and their successor provisions and regulations adopted thereunder; and (iv) shall, at the expiration or other termination of this Agreement, return all such information to the applicable Regulatory Agency(ies) or maintain such information according to written procedures sent to CHPIV by the applicable Regulatory Agency(ies) for this purpose.

9.5. **Transfer of Records.** Following the expiration or termination of this Agreement, at the request of CHPIV, Provider shall copy all requested Member medical records in its possession and forward such files to another provider designated by CHPIV, provided that such transfer is not otherwise prohibited by applicable confidentiality and privacy laws and regulations or objected to by such Members. The copies of such medical records may be in summary form. The cost of copying such patient medical records shall be borne by Provider. The access rights provided pursuant to Section 9.2 and the privacy, confidentiality and security obligations provided pursuant to Section 9.4 shall apply to and be binding upon all transferees of the records of Provider.

9.6. **Audits.** CHPIV shall at all times during and after the term of this Agreement have the right to review and, at its sole cost and expense, to access, audit and or copy Provider's records to confirm the accuracy of claims and services provided. Provider shall allow CHPIV and its agents access during reasonable business hours to all information and documents reasonably required for such review or audit. CHPIV shall not request reimbursement for overpayment of a claim, including requests made pursuant to Health and Safety Code Section 1371.1, unless CHPIV sends a written request for reimbursement to Provider within three hundred sixty-five (365) days of the date of payment on the over-paid claim in accordance with Section 1371.1 of the Act; provided, however, this 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of Provider.

(a) For purposes of certifying payment levels and appropriateness of payments and otherwise implementing the provisions of this Agreement, CHPIV may conduct audits on its own or through an External Review Agency ("**Agency**") from time to time, either in person, or through electronic means, if available, as selected by CHPIV or Agency. The costs of any outside auditors or agents engaged by CHPIV for such audits and CHPIV's own internal costs related to such audits shall be paid by CHPIV. Provider's costs related to Provider's compliance with such audits shall be paid by Provider. Provider acknowledges that audits are a necessary element of CHPIV's claims payment process and that to the extent Provider determines that any patient authorizations are necessary to allow CHPIV to process claims submitted by Provider, Provider shall obtain such authorizations prior to submitting claims to CHPIV. This audit policy and all of its components and/or subparts shall supersede any and all contrary internal policies of Provider and shall survive the termination of this Agreement.

(b) CHPIV or Agency shall notify Provider of its intent to conduct an audit no later than twenty-four (24) months after the Plan Member's date of discharge. Provider shall allow CHPIV or Agency to conduct an audit no later than three (3) months from the date of the letter of intent.

The letter of intent shall state the purpose of the audit and shall include: i) Plan Member's name, ii) admission and discharge date, and iii) medical record number or Provider's patient account number, if known to CHPIV.

(c) Provider shall, upon request by CHPIV or Agency and at no cost to CHPIV or Agency, make available any and all documents, records, papers, claims and bills for audit, inspection, and copying by CHPIV or Agency. Any Agency selected by CHPIV shall have the same access to papers and documents as if CHPIV were to conduct the audit. Upon request of CHPIV or Agency, Provider shall provide, either on-site or through electronic means, at the discretion of CHPIV or Agency and at no cost to CHPIV or Agency, complete itemized bills, UB-04s, CMS 1500s and support charts.

9.7. **Risk-Bearing Contract Solvency Standards and Requirements.** To the extent that Provider and any of its Participating Practitioners are determined, pursuant to the Act, to be risk-bearing providers under any CHPIV Plan, then Provider and such Participating Practitioners shall provide to DMHC and CHPIV such financial information and shall meet such other financial and other requirements established by DMHC and CHPIV as may be necessary for CHPIV, Provider and/or such Participating Practitioners to comply with the financial solvency requirements set forth in the Act (, including, without limitation, Title 28 Sections 1300.75.4 through 1300.75.4.8 and the provisions set forth in **Exhibit E** to this Agreement (collectively, the "**Solvency Standards**"), and shall comply with the cash-to-claims ratio requirements and cooperate with CHPIV and DMHC to prepare any Corrective Action Plans as may be required by Title 28 Section 1300.70(b)(2)(H)(1). To the extent that Provider and any of its Participating Practitioners are determined, pursuant to the Act, to be risk-bearing providers under any CHPIV Plan, CHPIV will provide such information to Provider as is required by the Solvency Standards to be provided to a Capitated Provider in accordance with the applicable requirements of the Solvency Standards and the CHPIV Provider Manual, including, without limitation, such monthly, quarterly and annual reports as are required by the Solvency Standards. Provider (and any of its Participating Providers) shall not delegate any risk under this Agreement without the prior written approval of CHPIV, which may be withheld at CHPIV's sole discretion.

9.8. **Non-compliance with Record and Reporting Requirements.** Failure by Provider to fully and satisfactorily comply with the requirements of this Article 9 shall constitute a material breach of this Agreement.

ARTICLE 10 PROVIDER APPEALS, DISPUTES, COMPLAINTS

10.

10.1. **Claims Payment Dispute Resolution.** CHPIV shall provide Provider with a fast, fair and cost-effective claims payment and other dispute resolution mechanism under which Provider may submit all claim payment disputes (the "**Claims Payment Dispute Procedures**"). The Claims Payment Dispute Procedures will be as set forth in the CHPIV Provider Manual and shall comply with the Act. The arbitration procedures set forth in this Agreement are not intended to constitute the dispute resolution

mechanism required by the Act. Provider must submit a notice indicating its interest in resolving a claim payment dispute, including, but not limited to, any outstanding directed payments, under the Claims Payment Dispute Procedures in accordance with the notice requirements, set forth in CHPIV Provider Manual provisions for Claims Payment Dispute Procedures, including the location or telephone contact where information regarding claims payment disputes may be submitted. In the event Provider is a capitated Provider and submits a claim dispute to CHPIV's capitated provider's dispute resolution mechanism(s) involving an issue of medical necessity or utilization review, Provider shall have an unconditional right of appeal for that claim dispute to CHPIV's Provider Claims Payment Dispute Procedures for a de novo review and resolution within sixty (60) Working Days from capitated Provider's "Date of Determination" (as defined pursuant to the provisions of section 1300.71.38(a)(4) of Title 28). If Provider is not satisfied with the outcome of procedure provided for in this Article 10, Provider may then elect to resolve a claim payment dispute by exercising the rights and obligations set forth at Section 13.8. Should Provider fail to file a timely request for claims payment dispute resolution pursuant to the Claims Payment Dispute Procedure or arbitration, as provided in this Agreement and the CHPIV Provider Manual, the decision of CHPIV shall become final.

10.2. **Non-Claims Payment Disputes.** Should Provider have non-claims payment complaints or concerns that cannot be settled or resolved through negotiation, related to any action taken by CHPIV with respect to the oversight and administration of Provider's provision of health care services, including, but not limited to, scope of service determinations, Authorization decisions, and the assignment or reassignment of Members, or related to performance by CHPIV of its contractual obligations herein (but not including claims payment disputes as addressed in article 10.1), Provider shall submit a written notice to CHPIV in accordance with the Non-Claims Payment Dispute Process set forth in the CHPIV Provider Manual (the "**Non-Claims Payment Dispute Process**"). CHPIV shall notify Provider of its decision within the time periods prescribed by applicable laws and regulations in accordance with the CHPIV Provider Manual. Should Provider be dissatisfied with the decision of CHPIV pursuant to the Provider Non-Claims Payment Dispute Process, Provider may, following receipt of such decision, file a written request for arbitration pursuant to Section 13.8 of this Agreement. Should Provider fail to file a timely request for the Provider Non-Claims Payment Dispute Process or arbitration, as provided in this Agreement and the CHPIV Provider Manual, the decision of CHPIV shall become final. Provider recognizes that, in addition to the Claims Payment Dispute Procedures and the Provider Non-Claims Payment Dispute Process provided by CHPIV, there exists a Member Grievance Procedure that shall be followed in the event a grievance is filed by a Member against Provider. Provider hereby agrees to comply with the Member Grievance Procedure described in Article 11 below.

10.3. **Arbitration.** Any dispute arising from or related to this Agreement and not resolved pursuant to Sections 10.1 and 10.2 above shall, at the request of either Party, be resolved by binding arbitration before a single arbitrator knowledgeable in the health care industry in accordance with the commercial rules of the American Arbitration Association or JAMS. The arbitrator shall apply California substantive law and federal substantive law where State law is preempted and in any such arbitration. The arbitrator shall have the power to grant all legal and equitable remedies and award compensatory damages provided by California law, except that punitive damages shall not be awarded. The arbitrator shall prepare

in writing and provide to the Parties an award including factual findings and the legal reasons on which the decision is based. The arbitrator shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California Code of Civil Procedure Sections 1286.2 or 1286.6 for such error. Notwithstanding the above, in the event either CHPIV or Provider wishes to obtain injunctive relief or a temporary restraining order, such Party may initiate an action for such relief in a court of law and the decision of the court of law with respect to the injunctive relief or temporary restraining order shall be subject to appeal only through the courts of law. The courts of law shall not have the authority to review or grant any request or demand for damages or declaratory relief. Separate and apart from the provider grievance procedures outlined in Sections 10.1 and 10.2 above, all disputes are subject to the provisions of the California Government Claims Act (Government Code § 905 et seq.). Arbitration must be initiated within one (1) year of the earlier of the date the dispute arose, was discovered, or should have been discovered with reasonable diligence; otherwise, it shall be deemed waived and forever barred.

10.4. **Attorneys' Fees.** If any legal action, arbitration, or other proceeding is commenced that is related to this Agreement, including, but not limited to, arbitration, each Party shall be responsible for their own attorneys' fees and expenses incurred, including, but not limited to, those for expert witnesses and to those incurred in the preparation for, conduct of, or appeal or enforcement of judgment from the proceeding.

ARTICLE 11 MEMBER GRIEVANCE PROCEDURES

Provider shall comply with the terms and conditions of the CHPIV Provider Manual relating to grievances and appeals by Members, including Medicare Members, and resolution of disputes, a copy of which shall be provided to Provider as a part of the CHPIV Provider Manual, and shall cooperate with CHPIV in providing requested information in a timely manner, and shall adhere to appeals/grievance procedures and decisions. Provider shall provide promptly, upon request, CHPIV's grievance forms to Plan Members. Provider for itself and its Participating Practitioners agrees that CHPIV may cause Provider and its Participating Practitioners to be joined in any grievance or arbitration involving Covered Services under the Plan. Provider and its Participating Practitioners shall cooperate fully with CHPIV in the investigation and resolution of complaints by Members regarding Provider or Covered Services rendered by Provider, in compliance with all applicable federal and state laws, regulations, and requirements. When a Member complaint is brought to Provider's attention, Provider shall investigate such complaint and use its best efforts to resolve such complaint in a fair and equitable manner. Provider shall immediately inform CHPIV of any such complaints that are brought to Provider's attention. Upon CHPIV's request, Provider shall promptly provide CHPIV with any and all Plan Member medical records reasonably related to Plan Member's grievance. Provider shall promptly notify CHPIV of any action taken or proposed with respect to the resolution of such grievances in accordance with the requirements of the applicable Regulatory Agencies.

ARTICLE 12 INSURANCE AND INDEMNITY

11.

12.

12.1. **Workers' Compensation Insurance.** Provider agrees to provide, at Provider's sole cost and expense, workers' compensation insurance for Provider and Provider's employees throughout the entire term of this Agreement in accordance with the laws of the State of California as the same may be amended from time to time.

12.2. **Provider's Liability Insurance.** Provider shall provide and maintain, at Provider's sole cost and expense, throughout the entire term of this Agreement, a policy or policies of professional liability insurance reasonably necessary to cover Provider and Provider's Participating Practitioners, agents and employees with a licensed insurance company acceptable to CHPIV and admitted to do business in the State of California. The annual aggregate shall apply separately for each health care practitioner, including, without limitation, each Participating Practitioner, who is insured under the policy or policies provided by Provider. In the event any such policy is terminated or any such Participating Practitioner's relationship or employment by Provider is terminated, Provider shall purchase or ensure that such Participating Practitioner purchases a "tail" policy for a period of not less than five (5) years following the effective termination date of the foregoing policy. Said "tail" policy shall have policy limits in an amount no less than the primary professional liability policy. Provider will notify CHPIV within seventy-two (72) hours of any of the following events: (i) termination, modification, or restriction of Provider's liability insurance, or (ii) any settlement or judgment of a malpractice claim entered into on behalf of Provider. Provider will consent to release of information by Provider's malpractice carrier regarding any settlements or judgments of a malpractice claim entered into on behalf of Provider or any Participating Practitioner.

12.3. **Commercial Liability Insurance.** Provider shall provide at Provider's sole cost and expense, throughout the entire term of this Agreement, a policy or policies of commercial liability insurance covering Provider's place of business insuring Provider against any claim of loss, liability or damage committed or arising out of the alleged condition of said premises, or the furniture, fixtures, appliances or equipment located therein, together with standard liability protection against any loss, liability or damage as a result of Provider's, Provider's agents', servants' or employees' operation of a motor vehicle for business purposes and such other insurance as is required by law or advisable and customary for Provider's business and is acceptable to CHPIV.

12.4. **CHPIV's Insurance.** CHPIV shall provide and maintain, at CHPIV's sole cost and expense, throughout the entire term of this Agreement, a policy or policies of professional liability insurance reasonably necessary to cover CHPIV and CHPIV employees with a licensed insurance company acceptable to CHPIV and admitted to do business in the State of California.

12.5. **Proof of Insurance.** Provider and CHPIV shall provide the other with a minimum of ten (10) days prior written notice in the event any of the policies set forth in this Article 12 are canceled, or the coverage thereunder reduced, except in the case of cancellation for nonpayment of premiums or fraud, in which case five (5) days advance written notice shall be given. Each of CHPIV and Provider shall from time to time, on the reasonable request of the other, furnish to said other party certificates or other written evidence of insurance acceptable to said other party that the policies of insurance required under

this Article are in full force and effect. The certificate of insurance shall include the name, address and telephone number of the company providing coverage, the period of coverage and the policy numbers pertaining to the coverage.

12.6. **Responsibility for Own Acts.** CHPIV and Provider shall each be responsible for their own acts and/or omissions and are not responsible for the acts and/or omissions of the other, and any and all claims, liabilities, injuries, suits, and 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, its employees or representatives, in the performance or omission of any act or responsibility of that party under this Agreement. In the event that a claim is made against both parties, it is the intent of both parties to cooperate in the defense of said claim and to cause their insurers to do likewise. However, both parties shall have the right to take any and all actions they believe necessary to protect their interest.

ARTICLE 13 GENERAL PROVISIONS

13.

13.1. **Entire Agreement; Amendments.** Provider agrees to be bound by the terms and conditions of this Agreement. This Agreement, including the preamble, recitals, CHPIV Provider Manual, and any addenda, attachments, and exhibits attached hereto, each of which is incorporated herein for all purposes, constitutes the entire agreement between the parties hereto with respect to the subject matter hereof and supersedes any and all prior agreements, understandings, representations and offers between the parties, whether oral or written. Further, there are no representations, understandings or agreements relative hereto which are not fully expressed herein. No changes, amendments or alterations shall be effective unless agreed to in writing by both parties, except as set forth in Section 13.2 of this Agreement.

13.2. **Amendments Required by Law and Accreditation Organizations and Material Changes.** CHPIV and Provider agree that CHPIV may amend or modify this Agreement in order to reflect a change in a term necessary to make this Agreement consistent with (i) the Act, or other applicable state or federal laws, including all amendments and CHPIV's government program contracts; or (ii) the standards of Accreditation Organizations, including all changes to such standards. For such changes to a material term of the Agreement, CHPIV shall provide at least ninety (90) Working Days' notice of its intent to change the material term, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter time frame for compliance. Any amendment or modification required by applicable laws, regulations or accreditation standards shall be effective upon the earlier of ninety (90) Working Days' after CHPIV's notice is sent to Provider or the effective date of the applicable law(s), regulation(s) or accreditation standard(s). If any material change is made by amending a manual, policy or procedure document referenced in this Agreement, the Plan shall provide ninety (90) Working Days' notice to Provider of such proposed material change in such manual, policy or procedure document referenced in this Agreement, and Provider shall have the right to negotiate and agree to the change. Provider has the right to exercise Provider's intent to negotiate and agree to the change within thirty (30) Working Days of the Provider's receipt of CHPIV's notice. During the notice and negotiation period, Provider shall continue to provide services pursuant to this Agreement and shall not be

subject to the proposed changes to which Provider has objected, unless such changes are required by state or federal laws or regulations or the requirements of Accreditation Organizations. If Provider cannot agree to such proposed material change to the manual, policy, or procedure document or proposed amendment or modification to this Agreement, Provider shall have the right to terminate this Agreement prior to the implementation of the proposed material change, amendment or modification of the manual, policy or procedure document or the proposed material amendment of this Agreement by giving written notice to CHPIV of its termination of this Agreement as set forth in Section 7.4(c).. However, if the parties mutually agree, the ninety (90) Working Days' notice requirement may be waived. Nothing in this subparagraph limits the ability of the parties to mutually agree to the proposed change at any time after Provider has received notice of the proposed change. If Provider does not exercise Provider's right to negotiate the material change or the Provider's right to terminate the Agreement, the material change shall be effective ninety (90) Working Days from the date of CHPIV's notice of intent to amend the Agreement with a material change. Notwithstanding the foregoing, any provision required to be in this Agreement by any laws, rules, regulations and requirements whether or not set forth herein shall be incorporated by reference in this Agreement and shall bind both parties. In the event of a conflict between this Agreement and any applicable law, rule, regulation or requirement, the applicable law, rule or regulation will govern.

13.3. **Survival.** The provisions regarding (i) the prohibitions and limitations on Member billing and surcharges set forth in Article 8; (ii) maintenance and access to records set forth in Article 9; and (iii) insurance and indemnity set forth in Article 12 shall survive the termination of this Agreement with respect to services covered and provided pursuant to this Agreement during the time this Agreement was in effect, regardless of the reason for termination.

13.4. **Notices.** Any notice required or permitted to be given pursuant to the terms and provisions of this Agreement shall be in writing (including facsimile communication) and will be transmitted by personal delivery, facsimile, certified mail, or a reputable courier, as to each party hereto, to its address set forth below or at such other address as shall be designated by such party in a written notice to the parties hereto. Communications by CHPIV to Provider of changes in the CHPIV Provider Manual or UM/QI Program may be made by facsimile, e-mail or other forms of electronic communication. All such notices and communications shall be deemed as received the earlier of two (2) Working Days after deposit in the mail or when received. Either party may change the above addresses by giving the other party written notice of the new address as provided herein.

IF TO PROVIDER:	IF TO CHPIV:
_____	512 Aten Road
_____	Imperial, CA
Attention: _____	Attention: Director of Contract Administration
_____	
FAX: _____	FAX: 760-563-5187
E-MAIL: _____	E-MAIL: contracts@chpiv.org

13.5. **Waiver.** The waiver of any of the terms and conditions of this Agreement shall not be construed as a waiver of any other terms and conditions thereof. Failure of either party to insist upon strict performance of the CHPIV Provider Manual shall not be construed as a waiver or relinquishment for the future of such CHPIV Provider Manual.

13.6. **Governing Law.** This Agreement is governed by and shall be construed in accordance with the Act and all other California state and federal laws applicable to CHPIV,), and rules and regulations promulgated thereunder, as amended. In the event any Covered Services or any obligation of Provider under this Agreement is performed pursuant to the terms of a subcontract, such subcontract shall contain all provisions required by this Agreement, the Act or any other laws applicable to CHPIV and Provider.

13.7. **Severability.** If any provision of this Agreement shall to any extent be held in any proceeding to be invalid or unenforceable, the remainder of this Agreement, or the application of such provision to any person or circumstances other than those to which it was held to be invalid or unenforceable, shall not be affected thereby, and shall be valid and enforceable to the fullest extent permitted by law, but only if and to the extent such enforcement would not materially and adversely frustrate the parties' essential objectives as expressed herein.

13.8. **Authority and Execution.** By their signatures below, each of the Parties and signatories hereto represents that he, she, or it has the authority to execute this Agreement and does hereby bind the Party on whose behalf said execution is made.

13.9. **Assignment.** Except as otherwise specifically provided herein, this Agreement is not assignable by Provider in whole or in part, and Provider shall not delegate any obligation or duty hereunder except with the prior written consent of CHPIV and written approval of any applicable Regulatory Agencies. If Provider is an entity, "assignment" by Provider shall be deemed to include, but shall not be limited to, a transfer of fifty percent (50%) or more of the shares or other equity interests in Provider.

13.10. **Captions.** The captions used in this Agreement are for convenience only and shall not affect the interpretation of this Agreement.

13.11. **Attachments and Exhibits.** All attachments and exhibits attached to and referred to in this Agreement are fully incorporated by such reference. Each type of Plan may have separate attachments and exhibits specific to the type of Plan (i.e., Program Requirements, Exhibits A-1 (Covered Services/Compensation Rates), etc.).

13.12. **Execution by CHPIV.** This Agreement shall not be binding until executed by a person authorized to do so by CHPIV and the executed copy thereof is delivered to Provider.

13.13. **Counterparts.** This Agreement may be executed in duplicate counterparts with

the same effect as if all Parties hereto had signed the same documents, and all counterparts shall be construed together and shall constitute one agreement.

13.14. **Use of Names and Trademarks.** CHPIV and Provider each reserve the right to control the use of its respective name, symbols, trademarks, or other marks currently existing or later established. However, either Party may use the other party's name, symbols, trademarks or other marks with the prior written approval of the other Party. In addition, CHPIV shall be allowed to use the name of Provider in its provider listings without the prior consent of Provider.

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EXHIBIT A MEDI-CAL PLAN PROGRAM REQUIREMENTS
TO SPECIALIST PROVIDER SERVICES AGREEMENT

This Exhibit sets forth the applicable requirements that are required by DHCS All Plan Letter ("APL") 19-001, other applicable DHCS APLs, and the Medi-Cal Contract to be included in this Agreement and any other provisions necessary to reflect compliance with law. Any citations in this Exhibit are to the applicable sections of the Medi-Cal Contract, DHCS APL 19-001, other applicable DHCS APLs, or applicable law. This Exhibit will automatically be modified to conform to subsequent changes in law or government program requirements. In the event of a conflict between this Exhibit and any other provision of the Agreement, this Exhibit will control with respect to Medi-Cal. Any capitalized term utilized in this Exhibit will have the same meaning ascribed to it in the Agreement unless otherwise set forth in this Exhibit. If a capitalized term used in this Exhibit is not defined in the Agreement or this attachment, it will have the same meaning ascribed to it in the Medi-Cal Contract.

1. The parties acknowledge and agree that this Agreement specifies the services to be ordered, referred, or rendered by Provider. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.1; 22 CCR 53250(c)(1); APL 19-001, Attachment A, 1.)

2. This Agreement will be governed by and construed in accordance with all laws and applicable regulations governing the Medi-Cal Contract, including, but not limited to, the Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq. (unless expressly excluded under the Medi-Cal Contract); 28 CCR Section 1300.43 et seq.; W&I Code Sections 14000 and 14200 et seq.; 22 CCR Sections 53800 et seq.; and 22 CCR Sections 53900 et seq. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.4;; 22 CCR 53250(c)(2); APL 19-001, Attachment A, 2.)

3. This Agreement and any amendments thereto will become effective only upon approval by DHCS in writing. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.2, Subsections A.1 and A.2; 22 CCR 53250(c)(3); APL 19-001, Attachment A, 3.)

4. The parties acknowledge and agree that the term of the Agreement, including the beginning and end dates as well as methods of extension, renegotiation, phaseout, and termination, are included in this Agreement. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6. Subsection A.2;; 22 CCR 53250(c)(4); APL 19-001, Attachment A, 4.)

5. In the event and to the extent Provider is at risk for non-contracting emergency services, Provider shall pay claims for out-of-network emergency services rendered by an out-of-network provider who properly documents claims pursuant to Exhibit A, Attachment III, Provision 3.3.5 (*Claims Processing*) of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.3.16, Subsection A.5;l APL 19-001, Attachment A, 5.)

6. Provider will comply with all monitoring provisions in the Medi-Cal Contract and any monitoring

requests by DHCS. (Exhibit A, Attachment III, Provision 3.1.6, Subsection B.11; APL 19-001, Attachment A, 7.)

7. Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer, and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of the Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying including but not limited to Access Requirements and State's Right to Monitor, as set forth in Medi-Cal Contract, Exhibit E, Provision 1.22 (*Inspection and Audit of Records and Facilities*) as follows: (a) By CHPIV, DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), DMHC, or their designees; (b) At all reasonable times at Provider's place of business or at such other mutually agreeable location in California; (c) In a form maintained in accordance good business practices and generally acceptable accounting principles; (d) For a term of at least ten (10) years from final date of the Medi-Cal Contract period or from the date of completion of any audit, whichever is later; (e) Including all Encounter Data in accordance with good business practices and generally acceptable accounting principles for a period of at least ten (10) years from final date of the Medi-Cal Contract period or from the date of completion of any audit, whichever is later; (f) 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 Provider at any time; (g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate Provider from participation in the Medi-Cal program; seek recovery of payments made to Provider; impose other sanctions provided under the State Plan, and direct CHPIV to terminate the Agreement due to fraud. (Medi-Cal Contract, Exhibit A, Attachment II, Provision 3.1.6, Subsections A.8 and A.9; 22 CCR 53250(e)(1); 42 CFR 438.3(a) ; APL 19-001, Attachment A, 8.)

8. The parties acknowledge and agree that this Agreement contains full disclosure of the method and amount of compensation or other consideration to be received by Provider from CHPIV. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.3;; 22 CCR 53250(e)(2) ; APL 19-001, Attachment A, 9.)

9. Provider agrees that it will maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Subcontractor: (a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Agreement, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees; (b) Retain all records and documents for a minimum of ten (10) years from the final date of the Medi-Cal Contract period or from the date of completion of any audit, whichever is later. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.7; 22 CCR 53250(e)(3); 42 CFR 438.3(u) ; APL 19-001, Attachment A, 10.)

10. Provider agrees to assist CHPIV or, if applicable, CHPIV's subcontractor or downstream subcontractor, in the transfer of Member's care in accordance with Exhibit E, Section 1.17 (*Phaseout Requirements*) of the Medi-Cal Contract in the event of the Medi-Cal Contract termination, or in the event of termination of this Agreement for any reason. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.11; APL 19-001, Attachment A, 11.)

11. Provider agrees to notify DHCS in the event this Agreement is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. (Medi-Cal Contract, Exhibit E, Provision 1.12; 22 CCR 53250(e)(4) ; APL 19-001, Attachment A, 13.)

Department of Health Care Services
Medi-Cal Managed Care Division
MS: 4407, P.O. Box 997413
Sacramento, CA 95899-7413
Attention: Contracting Officer

12. Provider agrees that assignment or delegation of the Agreement will be void unless prior written approval is obtained from DHCS. (22 CCR 53250(e)(5) ; APL 19-001, Attachment A, 14.)

13. Provider agrees to hold harmless both the State and Members in the event CHPIV, or, if applicable, CHPIV's subcontractor, cannot or will not pay for Covered Services ordered, offered, or rendered by Provider pursuant to this Agreement. (Medi-Cal Contract, Exhibit III, Provision 3.1.6, Subsection A.13; 22 CCR 53250(e)(6) ; APL 19-001, Attachment A, 15.)

14. Provider agrees to timely gather, preserve and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies any records in Provider's possession in accordance with the Medi-Cal Contract, Exhibit E, Section 1.27 (*Litigation Support*). (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.10; APL 19-001, Attachment A, 16.)

15. Provider agrees to participate and cooperate in CHPIV's Quality Improvement System and Health Equity Transformation Program and Population Needs Assessment, as described in Exhibit A, Attachment III, Section 4.3.2 (*Population Needs Assessment [PNA]*) of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 2.2.4; APL 19-001, Attachment A, 19.)

16. If CHPIV delegates Quality Improvement activities, Provider and CHPIV will enter into a separate delegation agreement that contains the provisions stipulated in the Med-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 2.2.5; APL 19-001, Attachment A, 20.)

17. Provider agrees to comply with all applicable requirements specified in: the Medi-Cal Contract and subsequent amendments, DHCS Medi-Cal Managed Care Program, including but not limited to, federal and state Medicaid and Medi-Cal laws and regulations, and sub-regulatory guidance, Policy Letters, and APLs. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.5;

APL 23-012; APL 19-001, Attachment A, 21.)

18. Provider agrees to all remedies specified by the Agreement and the Medi-Cal Contract, including revocation of delegated functions or termination, in instances where DHCS or CHPIV determine that Provider has not performed satisfactorily. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.12; APL 19-001, Attachment A, 22.)

19. To the extent Provider is responsible for the coordination of care for Members, CHPIV agrees to share with Provider any utilization data that DHCS has provided to CHPIV, and the Provider agrees to receive the utilization data and use it as the Provider is able for the purpose of Member care coordination. (42 CFR 438.208; APL 19-001, Attachment A, 23.)

20. CHPIV agrees to inform Provider of prospective requirements added by State or federal law or DHCS related to the Medi-Cal Contract that would impact obligations undertaken by Provider before the requirement is effective, and Provider agrees to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS. ((Medi-Cal Contract, Attachment III, Provision 3.1.6, Subsection A.15; APL 19-001, Attachment A, 24.)

21. Provider agrees to submit to CHPIV either directly or through CHPIV's subcontractor or downstream subcontractor, as applicable, complete, accurate, reasonable, and timely Encounter Data, Provider Data, and any other data needed by CHPIV in order for CHPIV to meet its data reporting requirements to DHCS. In so submitting said data, Provider will be deemed to have certified to its accuracy. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.6; 22 CCR 53250(c)(5); APL 19-001, Attachment A, 6 & 25.)

22. Provider agrees that it is prohibited from balance billing a Medi-Cal member and will not bill a Member for Covered Services. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.14;; APL 19-001, Attachment A, 27.)

23. Partner agrees to ensure cultural competency, sensitivity, Health Equity, and diversity training is provided for employees and staff at key points of contact with Members in accordance with Exhibit A, Attachment III, Provision 5.2.11.C (*Cultural and Linguistic Programs and Committees*) of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.16; APL 19-001, Attachment A, 28.)

24. Parties agree and acknowledge that Provider shall have the right to access CHPIV's dispute resolution mechanism and submit a grievance pursuant to Health & Safety Code section 1367(h)(1). (Medi-Cal Contract, Attachment III, Provision 3.1.6, Subsection A.20;. Health & Safety Code § 1367 (h)(1); APL 19-001, Attachment A, 18 & 29.)

25. Provider agrees to provide interpreter services for Members and comply with CHPIV's Language Assistance Program standards developed and adopted pursuant to Health & Safety Code §

1367.04. (Medi-Cal Contract, Attachment III, Provision 3.1.6, Subsection A.17; APL 19-001, Attachment A, 30.)

26. Parties agree and acknowledge that Provider is entitled to all protections afforded them under the Health Care Providers' Bill of Rights pursuant to Health and Safety Code § 1375.7. (Medi-Cal Contract, Attachment III, Provision 3.1.6, Subsection A.20; APL 19-001, Attachment A, 31.)

27. If Provider is licensed pursuant to Health & Safety Code Section 1250, Provider agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child pursuant to Health & Safety Code Section 1261.

28. Provider agrees to provide CHPIV with the disclosure statement set forth in 22 CCR 51000.35, prior to commencing services under this Agreement. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.12.)

29. This Agreement and all information received from Provider in accordance with the subcontract requirements under the Medi-Cal Contract shall become public record on file with DHCS, except as specifically exempted in statute. The names of the officers and owners of Provider, stockholders owning more than 5 percent of the stock issued by Provider and major creditors holding more than 5 percent of the debt of Provider will be attached to the Agreement at the time the Agreement is presented to DHCS. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.12.)

30. Provider shall notify CHPIV and DHCS within ten (10) calendar days of discovery that any third party may be liable for reimbursement to CHPIV and/or DHCS for Covered Services provided to a Plan Member, such as for treatment of work related injuries or injuries resulting from tortious conduct of third-parties. Provider is precluded from receiving duplicate payments for Covered Services provided to Plan Members. If this occurs, Provider may not retain the duplicate payment. Once the duplicate payment is identified, Provider must reimburse CHPIV. If Provider fails to refund the duplicate payment, CHPIV may offset payments made to Provider to recoup the funds. (APL 21-007; Welfare & Institutions Code 14124.70 – 14124.791). The DHCS notice is to be sent to:

Department of Health Care Services
Third Party Liability and Recovery Division
Workers' Compensation Recovery Program, MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425

31. Provider shall not pay any provider claims nor reimburse a provider for provider preventable condition ("PPC")-Provider agrees to report, and require any of its Subcontractors to report, PPC-related encounters in a form and frequency as specified by CHPIV and/or DHCS. (Medi-Cal

Contract, Exhibit A, Attachment III, Provision 3.3.17; 42 CFR 438.3(g).)

32. Provider shall (i) report to CHPIV when Provider has received an overpayment, (ii) return the overpayment to CHPIV within sixty (60) calendar days of the date on which the overpayment was identified, and (iii) notify CHPIV in writing of the reason for the overpayment in accordance with Medi-Cal Contract, Exhibit A, Attachment III, Provision 1.3.6 (*Treatment of Overpayment Recoveries*) and 42 CFR section 438.608(d)(2). (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.19; APL 23-011; 42 CFR 438.608(d)(2).)

33. Provider will immediately report to CHPIV the discovery of a suspected breach, security incident, intrusion or unauthorized access of unsecured Medi-Cal Member protected health information (as defined in 45 CFR 160.103) or personal information (as defined in California Civil Code Section 1798.29), or potential loss of confidential information. (Medi-Cal Contract, Exhibit G, Provision 18.1.)

34. Provider will submit network data as directed by CHPIV for CHPIV to meet its administrative functions and requirements set forth in the Medi-Cal Contract. Provider certifies that all data submitted is complete, accurate, reasonable, and timely. Provider will promptly make any necessary corrections to the data, as requested by CHPIV, so that CHPIV may correct any deficiencies identified by DHCS in the time period required by DHCS. (42 CFR 438.242 and 438.606.)

35. Provider must be enrolled (and maintain enrollment) in the Medi-Cal Program through DHCS in accordance with its provider type. Provider shall provide verification of enrollment as well as a copy of the executed Medi-Cal Provider Agreement (DHCS Form 6208) between Provider and DHCS. In the event CHPIV assisted Provider with the enrollment process, Provider consents to allow DHCS and CHPIV share information relating to the Provider's application and eligibility, including but not limited to issues related to program integrity. Provider's enrollment documentation must be made available to DHCS, CMS or other authorized governmental agencies upon request. (APL 22-013; 42 CFR 438.602(b).)

36. Provider must notify CHPIV within ten (10) Working Days of any suspected Fraud, Waste, or Abuse and Provider agrees that CHPIV is allowed to share such information with DHCS in accordance with Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*) and Subsection 1.3.2.D.6 (*Confidentiality*) of the Medi-Cal Contract. (Medi-Cal Contract, Attachment III, Provision 3.1.6, Subsection A.18.)

37. To the extent required by the Medi-Cal Contract, Provider shall promptly report to CHPIV any changes in the status of Provider's executive-level personnel, including but not limited to the chief executive officer, chief financial officer, chief operations officer, the medical director, the chief health equity officer, the compliance officer, and government relations persons. CHPIV is required to report these changes to DHCS within 20 calendar days. (Medi-Cal Contract, Exhibit A, Attachment

III, Provision 1.1.8.)

38. To the extent required by the Medi-Cal Contract, Provider must comply with the Medical Loss Ratio ("MLR") reporting and remittance requirements mandated by 42 CFR section 438.8 and Section 1.2.5 of Exhibit A, Attachment III of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 1.2.5; 42 CFR § 438.230(c)(1).)

39. To the extent required by the Medi-Cal Contract, Provider must calculate and report a MLR as stated in 42 CFR sections 438.8 and 438.604(a)(3) in a form and manner specified by DHCS. Provider must distinguish which amounts are actually paid for benefits or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities in accordance with the CMCS Informational Bulletin published May 15, 2019 with the subject "Medical Loss Ratio Requirements Related to Third-Party Vendors." Payments to Provider that are not the amount actually paid to Provider for furnishing Covered Services must not be included in incurred claims. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 1.2.5, Subsection A.2).)

40. If applicable, Provider must provide a remittance to DHCS for a MLR Reporting Year in accordance with Welfare & Institutions Code and Exhibit B of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 1.2.5, Subsection K.)

41. To the extent Provider is delegated claims processing, Provider shall comply with the requirements of Exhibit A, Attachment III, Provision 3.3.5 (*Claims Processing*) of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.3.5.)

42. To the extent required by the Medi-Cal Contract, Provider shall pay its Participating Providers in accordance with the terms and conditions of each applicable pass-through payment established under 42 CFR section 438.6(d), in accordance with the CMS approved rate certification, and in a form and manner specified by DHCS through APLs or other technical guidance. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.3.19. Subsection B.)

43. To the extent required by the Medi-Cal Contract, Provider shall pay its Participating Providers in accordance with the terms and conditions of each applicable alternative payment model established by DHCS, in accordance with the CMS approved rate certification, and in a form and manner specified by DHCS through APLs or other technical guidance. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.3.19, Subsection C.)

44. To the extent required by the Medi-Cal Contract, Provider must comply with 22 CCR sections 53866, 53220, and 53222 with regard to the submission and recovery of claims for services provided under the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.3.6.)

45. Provider agrees to receive training from CHPIV and receive notice from CHPIV of any changes to CHPIV's Grievance and Appeals policies and procedures. (Medi-Cal Contract, Exhibit A,

Attachment III, Provision 4.6, Subsection I.)

46. To the extent required by the Medi-Cal Contract, Provider agrees to comply with the network adequacy and network ratio requirements per the Medi-Cal Contract. In the event Provider fails to meet network adequacy standards as set for in DHCS APL 21-006, CHPIV shall impose a corrective action plan and issue sanctions. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 5.2.13, Subsection D.)
47. To the extent required by the Medi-Cal Contract, Provider shall comply with CHPIV's reporting obligations under the Medi-Cal Contract in accordance with 42 CFR section 438.230(c)(1)(ii) with respect the obligations and functions of CHPIV undertaken by Provider pursuant to this Agreement. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection B.28).)
48. Provider agrees and acknowledges that DHCS is a direct beneficiary of the Agreement with respect to all obligations and functions undertaking pursuant to this Agreement and that DHCS may directly enforce any and all provisions of the Agreement. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection B.29).)
49. Provider, and Provider's employees, officers and directors, shall comply with the conflict of interest requirements set forth in Exhibit H of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit H, Provision A.)
50. Provider agrees that in the event Provider delegates its duties under this Agreement to a third party, the third party will be a Downstream Subcontractor. Provider must enter into a written agreement with the Downstream Subcontractor and ensure that the Downstream Subcontractor will comply with this Agreement and all of the applicable requirements in the Medi-Cal Contract, including but not limited to, Exhibit A, Attachment III, Provisions 3.1.1 and 3.1.6.
51. To the extent required by the Medi-Cal Contract, Provider must make available to Members the clinical criteria used in assessing Medical Necessity for Covered Services. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 2.3, Subsection E.)
52. To the extent required by the Medi-Cal Contract, Provider must have systems in place to track and monitor referrals requiring prior authorization and must furnish documentation of such referrals to CHPIV and DHCS upon request. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 2.3, Subsection H.)

53. To the extent Provider is delegated utilization management, Provider must make expedited authorization decisions for service request where Provider determines that, following the standard timeline for prior authorizations could jeopardize the Member's life, health or ability to attain, maintain, or regain maximum function in accordance with 42 CFR section 438.210 and Health & Safety Code section 1367.01. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 2.3.2, Subsection G.)
54. Provider represents and warrants that Provider and its affiliates are not debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549. Further, Provider represents and warrants that Provider is not excluded from participation in any health care program under section 1128 or 1128A of the Social Security Act. (42 CFR 438.610.)

55. If Provider is a Local Health Department (LHD), Provider agrees to adhere to all applicable scope and responsibilities to Members and coordination of medical information with CHPIV. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.10.B)

56. Provider agrees to complete training provided by CHPIV on CHPIV's billing, invoicing, Complete Claim, and Encounter Data submission protocols, as applicable, within thirty (30) Working Days of being placed on active status within CHPIV's network. (APL 23-020.)

57. To the extent Provider will deliver Covered Services to a Member via a telehealth modality, Provider must meet the requirements of Business and Professions Code (BPC) section 2290.5(a)(3), or be otherwise designated by DHCS as able to render Medi-Cal services via telehealth. Provider's provision of Covered Services via telehealth is subject to the following requirements:

(a) Provider may provide Covered Services to Members through telehealth modalities only if all the following criteria are satisfied:

i. Provider determined the provision of Covered Services through a telehealth modality is clinically appropriate based upon evidence-based medicine and/or Provider's best clinical judgment;

ii. Member provided verbal or written consent to receive Covered Services via telehealth prior to the initial delivery of services;

iii. Provider documented said consent in the Member's medical record;

iv. The medical record documentation substantiates that the Covered Services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service; and

v. The Covered Services provided via telehealth meet all state and federal laws regarding confidentiality of health care information and a Member's right to their own medical information.

(b) In addition to documenting Member's consent prior to initial delivery of Covered Services via telehealth, Provider shall explain the following to Members:

i. The Member's right to access Covered Services delivered via telehealth in-person;

ii. That use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Member without affecting their ability to access Medi-Cal Covered Services in the future;

iii. The availability of Non-Medical Transportation to in-person visits; and

iv. The potential limitations or risks related to receiving Covered Services through telehealth as compared to an in-person visit, if applicable.

(c) If Provider furnishes applicable Covered Services via audio-only synchronous interactions, then Provider must also offer those same Covered Services via video synchronous interactions as to preserve Member choice.

(d) If Provider furnishes Covered Services through video synchronous interaction or audio-only synchronous interaction, then Provider must either offer those same Covered Services via in-person, face-to-face contact, or arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Participating Provider to arrange for that care.

(e) Provider may establish a new patient relationship with a Member via synchronous video telehealth visits, but may establish new patient relationship with a Member via audio-only synchronous interaction only if one or more of the following criteria applies:

i. The visit is related to Sensitive Services,
ii. The Member requests an audio-only modality; and/or
iii. The Member attests they do not have access to video.

EXHIBIT A-1 COVERED SERVICES/COMPENSATION RATES
(MEDI-CAL)

Specialty	***Covered Services***	***Compensation Rates***
	Inpatient/Outpatient Services	Prevailing Medi-Cal rates

Footnotes:

1. Refer to the CHPIV Provider Manual for those Covered Services requiring prior Authorization.

2. Provider shall be reimbursed at prevailing Medi-Cal rates. Notwithstanding the foregoing, claims submission and payment for Authorized Covered Services shall be administered in accordance with the Medi-Cal Program billing guidelines

3. To qualify for payment, Prior Authorization number shall be submitted on the claim.

4. Provider, for billing purposes, shall utilize nationally-recognized coding structures including, but not limited to, AMA Current Procedural Terminology (CPT-4) as defined by the Uniform Billing Code, CMS Common Procedure Coding System (HCPCS), prevailing ICD Diagnosis and Procedure Codes, National Drug Codes (NDC), National Correct Coding Initiative (NCCI), relative values for the basis coding, and description, as amended from time to time, for services provided. An amendment to this Agreement is not required to effectuate coding changes unless there is a material change in the procedure, the cost associated with the procedure or service identified by such code(s).

5. Rate Not Established ("**RNE**") and by report procedures: Where no Medi-Cal rate has been established for authorized services, CHPIV shall pay fifteen percent (15%) of billed charges.

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EXHIBIT B MEDICARE PLAN PROGRAM REQUIREMENTS

This Exhibit sets forth Medicare program requirements that are required to be included in this Agreement with respect to the provision of any health care services under a Medicare Advantage Part C plan, including any D-SNP plan. All citations in this Exhibit are to the applicable sections of law or the SMAC. This Exhibit will automatically be modified to conform to subsequent changes in law or government program requirements. In the event of a conflict between this Exhibit and any other provision of the Agreement, this Exhibit will control with respect to Medicare Advantage. Capitalized terms utilized in this Exhibit will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this Exhibit. To the extent a capitalized term in not otherwise defined in the Agreement nor this Exhibit, it shall have the same meaning ascribed to it in the SMAC.

1. Downstream Compliance. Provider agrees (and will require its first tier, downstream, and related entities, such as Provider's Subcontractors, to agree in writing) to all the provisions contained in this Exhibit. The terms first tier, downstream and related entity as used in this Exhibit have the meaning ascribed to such terms in 42 CFR 422.2. (42 CFR 422.504(i)(2).)

2. Right to Audit. HHS, the Comptroller General, and other Regulatory Agencies, or their designees, have the right to audit, evaluate, collect, and inspect any books, contracts, records, computer or other electronic systems, including medical records and patient care documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under CHPIV's contract with CMS, or as the Secretary may deem necessary to enforce CHPIV's contract with CMS. Provider agrees to make available, for the purposes specified in 42 CFR 422.504(d), its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require. Provider must maintain such records and other information for ten (10) years from the end date of the Agreement or the completion date of an audit, whichever is later. HHS, the Comptroller General, other Regulatory Agencies, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2)-(4) and, 422.504(i)(2)(ii).)

3. Provider Enrollment. Provider must be enrolled in good standing with the Medicare program consistent with § 422.222. (42 CFR 422.504(i)(2)(v).)

4. Hold Harmless/Cost Sharing. Provider agrees that under no circumstance will a Member be liable to Provider for any sums owed by CHPIV to Provider. Provider is prohibited from imposing cost-sharing requirements on Members that would exceed the amounts permitted under the California Medicaid State Plan, Section 1852(a)(7) of the Social Security Act, and 42 CFR section 422.504(g)(1)(iii). Members who are dually eligible for Medicare and Medicaid will not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid managed care plan is responsible for paying such amounts. CHPIV will inform providers of applicable Medicare and Medicaid benefits and rules for eligible Members. Provider agrees to accept CHPIV's Medicare

payment as payment in full, or bill Medi-Cal as applicable for any additional Medicare payments that may be reimbursed by Medi-Cal. Provider shall comply with Welfare and Institutions Code section 14019.4. (42 CFR 422.504(g)(1)(i), 422.504(g)(1)(iii) and 422.504(i)(3)(i); W&I Code section 14019.4 SMAC, Exhibit A, Attachment 1, Section 10.A)-B).)

5. Accountability/Delegation. CHPIV will oversee and continually monitor Provider's performance and remains accountable to CMS. CHPIV may only delegate activities or functions to Provider in a manner consistent with the requirements set forth in 42 CFR 422.504(i)(4). (42 CFR 422.504(i)(3)(ii).) Such delegation of activities and reporting responsibilities may be revoked in instances where CHPIV or CMS determines Provider has not performed satisfactorily. If CHPIV delegates activities or functions to Provider, CHPIV and Provider will enter into a separate written delegation agreement. (42 CFR 422.504(i)(3)(ii).)

6. Contract Compliance. Any services or activities performed by Provider must be consistent and comply with CHPIV's contractual obligations to CMS. (42 CFR 422.504(i)(3)(iii).)

7. Selection of Providers. If CHPIV delegates the selection of providers, contractors, or subcontractors to Provider, CHPIV retains the right to approve, suspend, or terminate any such arrangement. (42 CFR 422.504(i)(5).)

8. Confidentiality. Provider will comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)

9. Reporting. To the extent applicable, Provider agrees to provide relevant data to support CHPIV in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310. (42 CFR 504(a)(8).)

10. Compliance with Medicare Laws and Regulations. Provider will comply with all applicable Medicare laws, regulations, and CMS instructions. To the extent a DHCS All Plan Letter (APL) or Policy Letter (PL) conflicts with Medicare requirements or regulation, Provider shall comply with Medicare requirements and regulations. For purposes of this Provision, an APL or PL shall conflict with Medicare requirements or regulations only to the extent that the APL or PL requires conduct that would violate Medicare requirements or regulations. (42 CFR 422.504(i)(4)(v).)

11. Continuation of Covered Services. To the extent applicable, Provider agrees to provide for continuation of Covered Services: (i) For all Members, for the duration of the period for which CMS has made payments to CHPIV for Medicare services; and (ii) for Members who are hospitalized on the date CHPIV's contract with CMS terminates, or, in the event of an insolvency, through discharge. (42 CFR 422.504(g)(2)(i), 422.504(g)(2)(ii) and 422.504(g)(3).)

12. Prompt Pay. CHPIV and Provider agree that CHPIV will pay all clean claims for services that are covered by Medicare within the time frame designated in the Agreement, provided that CHPIV

determines such claim is complete/clean. CHPIV reserves the right to deny any claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing. (42 CFR 422.520(b).)

13. Preclusion List. To the extent applicable, Provider will ensure that payments will ensure that payments are not made to individuals and entities included on the preclusion list as defined in 42 CFR 422.2. (42 CFR 422.504(i)(2)(v).)

14. Debarment and Suspension Certification. Provider represents and warrants: (i) Provider is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency; (ii) Provider has not within a three (3) year period preceding this Agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (iii) Provider is not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in (ii) herein; (iv) Provider has not within a three (3) year period preceding this Agreement had one or more public transactions (federal, State or local) terminated for cause or default; and (v) Provider shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State. (SMAC, Exhibit D(F), Section 19.B.6).)

15. Training. Provider agrees to participate in all appropriate training provided by CHPIV regarding the use of the Medi-Cal eligibility verification system interface and the appropriate interpretation of its eligibility results. (SMAC, Exhibit A, Attachment 1, Section 13.C.)

16. Integrated Appeals and Grievances. Provider acknowledges and agrees CHPIV provided information about CHPIV's Integrated Appeals and Grievance system, including, at a minimum, information on Integrated Appeals, Integrated Grievances, State Hearings, and Independent Medical Review (IMR) procedures and timeframes, as applicable, to Provider at the time of this contracting. (SMAC, Exhibit A, Attachment 1, Section 21.B.)

EXHIBIT B-1 COVERED SERVICES/COMPENSATION RATES
(MEDICARE)

Specialty	***Covered Services***	***Compensation Rates***
	Inpatient/Outpatient Services	Prevailing Medicare rates

Footnotes:

1. Refer to the CHPIV Provider Manual for those Covered Services requiring prior Authorization.

1. Provider shall be reimbursed at prevailing Medicare rates, other than applicable coinsurance, deductibles or copayments.

2. Medicare consultation codes are not accepted by Medicare, therefore not billable to CHPIV.

3. To qualify for payment, Prior Authorization number shall be submitted on the claim.

4. Provider, for billing purposes, shall utilize nationally-recognized coding structures including, but not limited to, AMA Current Procedural Terminology (CPT-4) as defined by the Uniform Billing Code, CMS Common Procedure Coding System (HCPCS), prevailing ICD Diagnosis and Procedure Codes, National Drug Codes (NDC), National Correct Coding Initiative (NCCI), relative values for the basis coding, and description, as amended from time to time, for services provided. An amendment to this Agreement is not required to effectuate coding changes unless there is a material change in the procedure, the cost associated with the procedure or service identified by such code(s).

5. Chemotherapeutic/Injectable drugs shall be reimbursed at Average Sale Price ("**ASP**") plus five percent (5%). Where no ASP rate has been established, CHPIV shall pay fifteen percent (15%) of billed charges.

6. Rate Not Established ("**RNE**") and by report procedures: Where no Medicare rate has been established for authorized services, CHPIV shall pay at Medi-Cal rates, if no Medi-Cal rates has been established, CHPIV shall pay at fifteen percent (15%) of billed charges.

THE REST OF THIS PAGE INTENTIONALLY LEFT BLANK

EXHIBIT C INDIVIDUAL MEMBERS OF GROUP/SERVICE LOCATIONS

The following individual members of the Provider's group practice and facility locations shall be included under and considered a part of this Agreement:

Provider Name/Specialty/License #/NPI/CAQH #Tax ID Address Telephone/Fax Email

Phone:
Fax:

Tax ID:
Billing NPI:

Physical Address	**Billing/Mailing Address**
Provider Roster	
Groups Contact	
Contact:	**Billing Contact:**

EXHIBIT D DISCLOSURE STATEMENT

(Welfare and Institutions Code Section 14452)

The undersigned hereby certifies that the following information regarding **PROVIDER NAME** (the "**Organization**") is true and correct as of the date set forth below.

1. Officers/Directors/General Partners:

2. Co-Owner(s):

3. Stockholders owning more than five percent (5%) of the stock of the Organization:

4. Major creditors holding more than five percent (5%) of the Organization's debt:

5. Form of Organization (Corporation, Partnership, Sole Proprietorship, Individual, etc.)

6. If not already disclosed above, is Organization, either directly or indirectly, related to or

affiliated with the Contracting Health Plan? Explain.

_____

_____

Dated: _____ Signature: _____

TIN: _____ Title: _____

EXHIBIT E GENERAL AND PROFESSIONAL LIABILITY INSURANCE COVERAGE
INFORMATION RELEASE

(PLEASE USE A SEPARATE FORM IF GENERAL AND PROFESSIONAL LIABILITY CARRIERS ARE DIFFERENT)

TO: _____

Name of insurance carrier *(please print)*

_____

Insurance carrier's address, city, state and zip code *(please print)*

_____

Policy number(s)

_____ _____

Insurance carrier's phone number Insurance carrier's fax number

RE: ***Continuous Authorization for General and Professional Liability Coverage Information Release***

I hereby authorize you to add Community Health Plan of Imperial Valley as a certificate holder. Community Health Plan of Imperial Valley is to be notified of general insurance information and any changes thereto.

Please forward a Certificate of Insurance identifying the insured's policy, effective and expiration dates, policy limits, endorsements and exclusions, if any, to:

Community Health Plan of Imperial Valley
Attention: Contracting Department
512 Aten Road
Imperial, CA 92251

SIGNATURE: _____

PROVIDER NAME

_____

Date

EXHIBIT F RISK-BEARING CONTRACT SOLVENCY STANDARDS & REQUIREMENTS

Not applicable to this Agreement.

EXHIBIT G INDUSTRY COLLABORATION EFFORT (ICE)

MEDICAID & MEDICARE GENERAL COMPLIANCE AND FRAUD, WASTE AND ABUSE TRAINING ATTESTATION FORM

Attestation Submission Instructions

Please go to www.CHPIV.org, click on Providers, then click on Anti-Fraud to access the Compliance Policies and Procedures and: 1) Complete the Medicare Part C&D Fraud, Waste and Abuse Training (FWA) and General Compliance; 2) Review The Code of Conduct and 3) Review the Compliance Plan. When completed, please sign and return the attestation to verify your employees received the required annual FWA training.

IPA/Medical Group/Hospital / Contractor Name: _____

Submitting Organization: _____
(Such as MSO, TPA, if other than IPA/Medical Group or Hospital or Contractor)

Date Submitted: _____

Principal Officer with Contract Signatory Authority:

Print Name: _____

Signature: _____

Please check (P) one or more of the following related to the annual training requirement:

☐ I have completed the CMS "Medicare Parts C&D Fraud, Waste and Abuse Training and General Compliance Training" for all employees, providers and contractors using the CMS Training documents. I also have integrated training into the new hire process and the process for contracting with new providers, pharmacies and contractors.

Date: _____

☐ I have completed alternate equivalent MA General Compliance and Fraud Waste and Abuse Training for all employees, providers and contractors. I also have integrated that alternate training into the new hire process and process to contract with new providers, pharmacies and contractors.

☐ I have completed alternate equivalent MA General Compliance Training for all employees, providers, pharmacies and contractors and separate Fraud Waste and Abuse training for employees and contractors who are not Medicare Providers. (The FWA training is deemed for Medicare Providers.) I also have integrated that alternate training into the new hire process and process to contract with new providers,

pharmacies and contractors.

☐ Other – Provide Explanation:

_____

_____

_____

_____

EXHIBIT H Electronic Funds Transfer (EFT) Authorization Agreement

NOTE: If your organization has multiple Community Health Plan of Imperial Valley provider / group practice numbers, a separate form must be completed and submitted for each number. The person(s) properly authorized by the provider / group practice must sign the Authorization Agreement on behalf of the provider or group practice.

Part I: Reason for Submission

New EFT Authorization – **This EFT Authorization Agreement must be returned with your executed contract.**

Part II: Payee Information

Individual Group Legal Business

Name:_____

Street Address: _____

City, State, Zip: _____

Tax I.D. Number:____ SSN (Social Security #) EIN (Employer Identification #)

National Provider Identifier (NPI):

Part III: Financial Institution Information

Financial Institution:

Street Address:

City, State, Zip:

Financial Institution Routing Number (ABA# - Must be Nine Digits):

Account Number with Financial Institution: Checking Savings

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verify your account number.

Part IV: EFT Contact Person

EFT Contact Person's Name (Print):_____ Title:

Telephone Number: Email Address:

Part V: Authorization

I (we) hereby authorize Community Health Plan of Imperial Valley (CHPIV) to initiate credit entries to my (our) account indicated herein, and if necessary, initiate debit entries and adjustments to such

account for any transactions credited in error. I hereby authorize the financial institution named herein to credit and/or debit the same to such account.

This Authorization Agreement is effective as of the signature date herein and will remain in full force and effect until CHPIV has received written notification from me (us) of its termination in such time and such manner as to afford CHPIV and the financial institution named herein a reasonable opportunity to act on it. CHPIV will continue to send EFTs to the financial institution indicated herein until notified by me (us) in writing that I (we) wish to change/revoke this Authorization Agreement. If any information contained herein changes, I (we) agree to submit an updated Authorization Agreement to CHPIV with thirty (30) day prior written notice of the effective date of such changes. Should any payment via EFT be rejected due to changes in underlying account information that has not been properly communicated to CHPIV and/or information being erroneously entered by me (us) on this Authorization Agreement, CHPIV may discontinue payment via EFT (reverting to payment via check) until such time that I (we) submit an updated Authorization Agreement.

Authorized Person's Name (Print):_____ Title:
Telephone Number: Email Address:

Authorized Person's Signature: Date:

EXHIBIT I TRADING PARTNER AGREEMENT
COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

This Trading Partner Agreement ("**Agreement**") is entered into by and between Community Health Plan of Imperial Valley, a California non-profit corporation ("**CHPIV**"), and PROVIDER NAME ("**Trading Partner**"). This Agreement shall become effective upon the date of its execution by CHPIV ("**Effective Date**").

ARTICLE 1
PURPOSE OF TRADING PARTNER AGREEMENT

1.1 In order to secure data that reside in CHPIV files, and data maintained by Trading Partner for purpose of treatment or care management of CHPIV recipients, and in order to ensure the integrity, security, and confidentiality of the aforesaid data, and to permit appropriate disclosure and use of such data as permitted by law, CHPIV and Trading Partner enter into this Agreement to address the conditions under which data will be exchanged between CHPIV and Trading Partner.

1.2 This Agreement indicates Trading Partner intends to conduct transactions with CHPIV in electronic form. Both parties acknowledge and agree that the privacy and security of data held by or exchanged between each party are of utmost priority. Each party agrees to take all steps reasonably necessary to ensure that all electronic transactions between each party conform to the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") and regulations promulgated thereunder. Trading Partner must require any entity with whom it contracts, and any subcontractors thereof, to comply with all applicable requirements and terms of this Agreement. Trading Partner will obtain satisfactory assurance and documentation of the satisfactory assurance, as required under 45 CFR 164.502(e), from any entity with whom it contracts, and any subcontractors thereof, (e.g., clearinghouse, third-party administrator, administrative service only contract, billing service, data transmission service, or network service vendor) that it will appropriately safeguard the protected health information covered by this Agreement.

ARTICLE 2
DEFINITIONS

2.1 "**Business Associate**" means a vendor that performs a function or activity on behalf of CHPIV.

2.2 "**CHPIV**" means Community Health Plan of Imperial Valley.

2.3 "**Companion Guide(s)**" means the CHPIV supplemental document to the National Electronic Data Interchange Transaction Set that defines the superset of business functionality for the Accredited Standards Committee ("**ASC**"). The Companion Guide provides additional clarity pertinent to data structures and data elements and describes how data elements relate to information contained in the information systems belonging to each Trading Partner.

2.4 "**Implementation Guide and Addendum**" means the HIPAA-mandated documents that provide specific requirements for EDI transmission, such as delimiters, enveloping, and related topics.

2.5 "**Trading Partner**" and "**Submitter**" mean the entity or contractor thereof that provides health care services for eligible CHPIV recipients.

2.6 "**Transaction and Code Set Regulations**" means the regulations set forth at 45 Code of Federal Regulations ("**CFR**") Part 160 et seq., promulgated under HIPAA.

ARTICLE 3
TERMS AND CONDITIONS

3.1 The parties agree as follows:

a) Each party will take reasonable care to ensure that the information submitted in each electronic transaction is timely, complete, accurate, and secure, and will take reasonable precautions to prevent unauthorized access to (i) its own and the other party's transmission and processing systems, (ii) the transmission(s), and (iii) the control structure applied to transmissions between each party.

b) Each party is responsible for all costs, charges, or fees it may incur by transmitting electronic transactions to, or receiving electronic transactions from, the other party.

c) Trading Partner will conform each electronic transaction submitted to CHPIV to the Implementation Guide and Addendum applicable to the transaction, and to the applicable Companion Guide. Trading Partner understands that there may be modifications to the Implementation Guide and Addendum and the Companion Guide at any time without amendment to this Agreement, but Trading Partner shall not be required to implement such modifications less than sixty (60) days after publication of the modified Implementation Guide and Addendum or Companion Guide, unless a shorter compliance period is necessary to conform to applicable federal law or regulation. Only the last-issued Implementation Guide and Addendum of each type will be effective as of the date specified in the Implementation Guide and Addendum. CHPIV may reject any transaction that does not conform to the applicable Implementation Guide and Addendum and the Companion Guide.

d) Submitter understands that Trading Partner or others may request an exception from the Transaction and Code Set Regulations from CHPIV. If an exception is granted, Submitter will participate fully with CHPIV in the testing, verification, and implementation of a modification to a transaction affected by the change.

e) Submitter understands that it is responsible for adhering to the Companion Guides for data elements and segments. Submitter further understands that extra data or data that are not X12N compliant will be rejected.

f) Before initiating any transmission in HIPAA standard transaction format, and thereafter

throughout the term of this Agreement, Trading Partner will cooperate with CHPIV and any Business Associates in such testing of the transmission and processing systems used in connection with CHPIV as CHPIV deems appropriate to ensure the accuracy, timeliness, completeness, and security of each data transmission.

3.2 Privacy and Use of Information

a) The individually identifiable health information described in this Agreement is confidential and subject to the provisions of the Privacy Act of 1974. Furthermore, the privacy rule under HIPAA (Standards for Privacy of Individually Identifiable Health Information) applies to all health plans, health care clearinghouses, and health care providers that transmit protected health information in electronic transactions. To assure that no records held confidential under the Privacy Act of 1974 and/or the HIPAA privacy rule are improperly used or disclosed, CHPIV and Trading Partner agree that any information furnished by the other party will be used only as authorized under the terms and conditions of this Agreement and may not be further disclosed. No party shall be permitted to disclose or use information that is of a proprietary nature, except as permitted by the terms of this Agreement.

b) Trading Partner agrees to the following conditions:

1) that each individual on whom the information is being provided is one in whom the Submitter has reason to believe the individual is CHPIV eligible; and

2) that it will safeguard the confidentiality and prevent unauthorized access to CHPIV data.

c) CHPIV agrees that it shall maintain the confidential nature of all non-public personal information obtained from Trading Partner on behalf of CHPIV recipients. Trading Partner and CHPIV shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to the data. The safeguards should provide a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III – Security of Federal Automated Information Systems, which sets forth the guidelines for security plans for automated information systems in federal agencies.

d) Trading Partner agrees to the establishment of the following procedures:

1) limit access to the data to only those employees, agents, and officials who need it to perform their duties in connection with the authorized use;

2) store and process the data in such a manner that unauthorized persons cannot retrieve information by any means, including computers, remote terminals, or other means; and

3) instruct all personnel and agents who will have access to the data regarding the

confidential nature of the information, the safeguards required, and the criminal sanctions. Web-based training and other non-classroom alternatives are acceptable means for providing this instruction.

e) Trading Partner agrees that, in the event CHPIV determines or has a reasonable belief that Trading Partner has made or may have made disclosure of CHPIV data that is not authorized by this Agreement or other written CHPIV authorization, CHPIV may, at its sole discretion, require Trading Partner to promptly:

1) investigate and report to CHPIV its determinations regarding any alleged or actual unauthorized disclosure, and

2) resolve any problems identified by the investigation, submit a formal written response to an allegation of unauthorized disclosure, and submit a corrective action plan with steps designed to prevent any future unauthorized disclosures, and/or return data files to CHPIV.

f) Trading Partner understands that, as a result of CHPIV's determination or reasonable belief that unauthorized disclosure(s) has or have taken place, CHPIV may refuse to release further data to Trading Partner, report the unauthorized disclosure(s) to the proper government authority, and terminate this Agreement.

3.3 Penalties for Unapproved Use of Disclosure of Data

a) Trading Partner hereby acknowledges that criminal penalties under Section 1106 of the Social Security Act (42 USC 1306(a)) may apply to disclosures of information that are covered by 1106 and that are not authorized by regulation.

b) Trading Partner acknowledges that criminal penalties under the Privacy Act (5 USC 552a(I)(3)) may apply if it is determined that Trading Partner, or any individual employed or affiliated therewith, knowingly and willfully obtained the individually identifiable data under false pretenses.

c) Trading Partner acknowledges that criminal penalties may be imposed under 18 USC 641 if it is determined that Trading Partner, or any individual employed or affiliated therewith, has taken or converted to its own use data files, or received the files knowing that they were stolen or converted.

d) Trading Partner acknowledges that civil and criminal penalties under HIPAA (Public Law 104-191) may apply if it is determined that a person wrongfully disclosed individually identifiable health information.

3.4 Limitation of Liability

a) Trading Partner shall use reasonable efforts to assure that the information, data, electronic files and documents supplied hereunder are accurate. However, CHPIV shall not be liable to Trading Partner or any other party for any damages or expenses, including, without limitation, direct or indirect,

special, incidental, consequential or punitive damages, court costs, and attorney fees or for damages in any amount incurred as a result of inaccuracies in any of the information, data, electronic files, or documents supplied hereunder.

b) Any notice, informational mail or other communication required under this Agreement or pertaining to this Agreement from either party to this Agreement shall be given in writing and mailed to the appropriate parties identified on the signature page herein and shall be deemed duly given when personally delivered or sent by overnight carrier or by certified mail, return receipt requested, postage prepaid. If either party to this Agreement changes its address during the term of this Agreement, that party shall provide notice of such change of address to the other party, pursuant to this paragraph and as required in CHPIV's provider agreement. In addition, notices and informational mail pertaining to this Agreement may be conveyed via e-mail or other electronic notice if both parties agree to the use of this medium. Such notices are deemed as given based on the date of receipt within the electronic system used by the receiving party.

ARTICLE 4
TERMS OF AGREEMENT

4.1 This Agreement may not be assigned and duties hereunder may not be delegated.

4.2 This Agreement, together with the Attachments, constitutes the whole agreement between Trading Partner and CHPIV and shall not be altered or varied by oral understanding or agreement or by any other means not contemplated herein.

4.3 This Agreement shall automatically renew for successive periods of one (1) year unless superseded or terminated.

4.4 Trading Partner or CHPIV may terminate this Agreement by giving at least sixty (60) calendar days' advance written notice to the other party. The provisions of Section 3.2 shall survive the expiration, cancellation, or termination of this Agreement.

ARTICLE 5
ATTACHMENTS

5.1 Attached and made a part of this Agreement is the following:

[X] Attachment 1 Provider/Practitioner Submitters

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives.

Principal Officer with Contract Signatory Authority:

Provider
Executed by:

Signature

Print Name

Title

Address

City, State, Zip

Date

Telephone Number

Email Address

Community Health Plan of Imperial Valley
Executed by:

Signature
Lawrence Lewis

Print Name
CEO

Title
512 Aten Road

Address
Imperial, CA 92251

City, State, Zip

Date

ATTACHMENT 1 PROVIDER / PRACTITIONER SUBMITTERS

1. Please indicate below those providers/practitioners for whom Trading Partner will submit transactions. Trading Partner agrees to notify CHPIV when its relationship with a CHPIV provider terminates or a new CHPIV provider is added and for whom Trading Partner intends to submit transactions.

CHPIV Provider Name *(attach additional page, if necessary)*	**CHPIV Provider TAX ID #**
PROVIDER NAME	

2. Electronic Transactions Requested

Transactions Trading Partner Intends to Submit/Receive	**Check All Transactions Requested**
837 Professional Claims/Encounter	
837 Institutional Claims	
835: Health Care Claim Payment/Advice	
EOB: Explanation of Benefits – Pdf Files	
Capitation Reports	

CHPIV will notify Trading Partner when the certification process may commence. For hardcopy execution, Trading Partner must sign two copies of this Agreement and forward to CHPIV at the address indicated on the signature page. CHPIV will return one copy of the fully executed Agreement to Trading Partner.