ADVENTIST HEALTH PLAN, INC.
PROVIDER AGREEMENT

This Provider Services Agreement ("Agreement") (Fee-for-Service) is made and entered into this _____ day of _________ of **2020,** by and between ADVENTIST HEALTH PLAN, INC. (hereinafter referred to as "Plan", a California Corporation and, **Tulare County Health and Human Services Agency** (hereinafter referred to as "Provider").

RECITALS

A. Plan holds a restricted Knox-Keene license issued by the California Department of Managed Health Care (**"DMHC"**) under the Knox-Keene Health Care Service Plan Act of 1975, as amended (the **"Knox-Keene Act"**); and

B. Plan has entered into one or more contracts with Full Service Health Plans ("Health Plan Sponsors" or "Plan Sponsors") which are licensed by the DMHC under the Knox-Keene Health Care Service Plan Act of 1975, as amended (the **"Knox-Keene Act"**); and

C. Plan is under contract with Plan Sponsors to provide certain professional and institutional services and other health care services for Plan Members ("Plan Members" or "Members") (as hereinafter defined); and

D. Provider has entered into contracts with physicians and other health care professionals and is qualified to provide or arrange Services (as hereinafter defined) to Members (as hereinafter defined) of Plan; and

E. Plan and Provider desire to enter into an agreement whereby Provider shall provide or arrange for the provision of Services to Plan Members.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, and for other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties agree as follows:

WHEREAS, Provider currently operates a medical practice at the following location(s) ("Office Site(s)"):

1. **2611 North Dinuba Blvd Visalia, Ca 93291**
2. **660 East Visalia Rd Farmersville, Ca 93223**
3. ______________________________

WHEREAS, Plan and Provider desire to enter into a contract whereby Provider agrees to provide Covered Services on behalf of Plan to Plan Members;

AGREEMENT

NOW, THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the parties agree as follows:

ARTICLE 1

DEFINITIONS

The following terms shall have the following meanings for purposes of this Agreement:

1.1 "Acts and Regulations" means the Federal and California codes and regulations that govern the services to be provided under this Agreement, and more fully described in Article VII of this Agreement.

1.2 "Attachment(s)" mean Attachments and Exhibits that are incorporated herein as set forth.

1.3 "Authorization" means the Plan's written or telephonic approval, to be obtained by Provider prior to: (i) admitting any Member to a hospital for Covered Services other than Emergency Services; (ii) making a Referral for Covered Services other than Emergency Services; or (iii) providing Services, other than Emergency Services, to any Member, in accordance with the

Plan Sponsor's and the Plan's Provider Manual. Services approved by Plan in accordance with the foregoing are "Authorized."

1.4 "Compensation" means the reimbursement paid by Plan under this Agreement for providing or arranging for the provision of Covered Medical Services to Plan Members.

1.5 "Coordination of Benefits ("COB") and Third Party Liability ("TPL") means the determination of which of two or more health benefit plan will apply, either as primary or secondary coverage, for the rendition of hospital, surgical or medical services to a Plan Member. Such coordination is intended to preclude the Plan Member from receiving an aggregate of more than one hundred percent (100%) of covered charges from all payors. When the primary and secondary benefits are coordinated, determination of liability and reimbursement will be in accordance with the usual procedures by the California Department of Insurance and any applicable state regulation.

1.6 "Copayment or Deductible" means those charges for professional services, which shall be collected directly by Provider from Plan Member as payment, in accordance with the Plan Member's evidence of Coverage from Plan Sponsors.

1.7 "Covered Health Care Services" means those Medically Necessary services and supplies set forth in Attachment A, including Covered Medical Services.

1.8 "Covered Medical Services" means those Covered Health Care Services that are set forth in Attachment B, and are to be provided to Plan Members by Provider, within the scope of its licensure, pursuant to this Agreement.

1.9 "DHS" means the California Department of Health Services.

1.10 "DMHC" means the California Department of Managed Health Care, the successor agency to the Department of Corporations, regulating health care service Plans and IPAs in California.

1.11 "Emergency Services" means those Covered Health Care Services, provided inside or outside the Services Area, which are required on an immediate basis for an illness or injury in order to prevent loss of life, permanent impairment of bodily function, or other severe medical consequences in judgment of Provider.

1.12 "Evidence of Coverage" means the document issued by the Plan Sponsor Plan that describes the Plan Member's Covered Medical Services.

1.13 "Health Insurance Portability & Accountability Act of 1996" or "HIPAA" shall mean the regulations enacted by the Federal Government which provisions regulate (i) privacy, (ii) standard coding and, (iii) security, as they are relevant to the health care industry.

1.14 "Health Professional" means any nurse, physician extender (e.g., nurse practitioner, physician assistant) and other allied health professionals, including but not limited to health educator, laboratory technologist, audiologist, speech pathologist, psychologist, podiatrist, dentist, chiropractor, physical therapist, occupational therapist, clinical social worker, marriage, family and child counselor, optometrist or dispensing optician, who is licensed by the State of California and who provides certain Covered Health Care Services to Plan Members through an agreement with Plan or Plan Sponsor.

1.15 "IPA" or "Medical Group" means an Independent Physician Association or physician network organization established as a professional medical corporation for the primary purpose of delivering professional medical services by entering into written provider or employment agreements or other arrangements with physicians and Health Professionals, and that has entered into an arrangement with Plan to provide and make available certain Covered Medical Services and coordinate the provision of other Covered Health Care Services to Plan Members.

1.16 "Medical Director" means a Participating Primary Care Physician who is authorized by Plan to be responsible for administering Plan's medical liaison to contracting Providers.

1.17 "Medically Necessary" means medical or surgical treatment that a Plan Member requires as determined by a Plan Provider, in accordance with accepted medical and surgical practices and standards prevailing at the time of treatment and in conformity with the professional and technical standards adopted by the Utilization Review Committee of Plan.

1.18 "Non-Covered Services" means those health care services that are not benefits under the Evidence of Coverage.

1.19 "Plan Hospital" means any institution licensed by the DHS which is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), is certified for participation under Medicare and Medicaid (Medi-Cal) as an acute care hospital, and provides certain Covered Health Care Services to Plan Members through an agreement with Plan.

1.20 "Plan Member" means a person certified as eligible for coverage under the Benefits Agreement through Plan Sponsor and who has been assigned by Plan Sponsor to the Plan.

1.21 "Plan Physician" means a licensed physician who has entered into a written agreement with a Plan to provide Covered Medical Services as a Plan Provider to Plan Members.

1.22 "Plan Providers" means the physicians, hospitals, skilled nursing facilities, home health agencies, pharmacies, ambulance companies, laboratories, X-ray facilities, durable medical equipment suppliers and other licensed health care entries or professionals which or who provide Covered Health Care Services to Plan Members through an agreement with Plan, a Primary Care Physician, a Plan Hospital, or another Plan Provider.

1.23 "Primary Care Physician ("PCP") means (i) a Plan Physician, chosen by or for a Plan Member; or (ii) a professional medical corporation or medical group partnership organized and in good standing under the laws of the State of California, which professional shareholder(s), partners and /or employee(s) or independent contractors, who and which is primarily responsible for providing initial care to the Plan Member, for maintaining the continuity of the Plan Member's care, and for providing or initiating referrals for Covered Health Care Services for the Plan Member, practicing in the area of general practice, family practice, pediatrics, internal medicine, primary care obstetrics/gynecology, or primary care occupational medicine.

1.24 "Protected Health Information (PHI) or Electronically Protected Health Information (EPHI)" shall mean any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual, or; the past, present or future payment for the provision of health care to an individual; and, (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, as defined under the HIPAA regulations.

1.25 "Provider Services Manual" means the Plan Quality Management and Utilization Management Programs, Covered Benefits, Plan or Plan Sponsors' Member Grievance Policy and Procedures, Encounter Data Reporting Requirements, and Disenrollment Procedures, as amended from time to time, provided herein as Attachment A, and that is incorporated in this Agreement by reference.

1.26 "Quality Management Program" means Plan's program that is designed to assure the provision of quality Covered Health Care Services to Plan Members; The Quality Management Program shall be available to Provider prior to provision of Services by Provider to Members and shall be included as Attachment A.

1.27 "RBRVS" means Resource Based Relative Value Scale published by the CMS and American Medical Association.

1.28 "Referral" or "Referral Procedure" means the process by which the Provider directs a Plan Member to seek and obtain Covered Health Care Services from a Provider, health professional, a hospital or any other provider of Covered Services.

1.29 "Service Area" means, in general, those geographical areas of California in which Plan is licensed by DHS, DMHC and/or CMS to operate.

1.30 "Provider" means (i) a Plan Physician, who is duly licensed to practice medicine in the State of California; or (ii) a professional medical corporation or medical group partnership organized and in good standing under the laws of the State of California, which professional corporation or partnership will provide services through its physician shareholder(s), partners and/or employee(s) or independent contractors practicing in the area(s) set forth in Attachment F, and whose agreement with Plan includes responsibility for providing Covered Medical Services in his or her designated specialty.

1.31 "Utilization Management Program" means Plan's program designed to review and manage the appropriation utilization of Covered Health Care Services provided to Plan Members. The Utilization Management Program shall be made available to Provider prior to provision of Services to Members and shall be included as Attachment A.

ARTICLE II
PLAN RESPONSIBILITIES

2.1 Plan shall perform the administrative operations, quality management, utilization management, regulatory compliance and reporting functions appropriate and necessary for the administration of Plan and in accordance with Plan Agreement(s) with Plan Sponsor(s).

2.2 Plan has entered into one or more Agreements with Plan Sponsors pursuant to which Plan is obligated to provide or arrange for the provision of Covered Health Care services to Plan Members through agreement with Providers.

2.3 Plan shall compensate Provider for Covered Medical Services, in accordance with the provisions of this Agreement.

2.4 Plan shall monitor the quality of health care provided to Plan Members in accordance with the Plan and Plan Sponsors' Provider Services Manuals and all applicable legal requirements.

2.5 Plan shall monitor and evaluate accessibility of care and address problems that develop, which shall include, with the assistance and coordination of Plan Sponsors, but not be limited to, waiting time and appointments; and may at least annually review Specialist Physician's standards of accessibility and availability and compliance with these standards.

2.6 Plan shall notify Provider of any change to regulations that may affect the normal operations and Business Associate Agreement, as incorporated into this Agreement, of the Provider pertaining to the HIPAA regulations and enforcement and shall make any amendment to this Agreement from time-to-time subsequent to newly promulgated provisions.

ARTICLE III
PROVIDER RESPONSIBILITIES

3.1 Provider agrees to provide Covered Medical Services to Plan Members. Covered Medical Services shall be performed at one of the Offices Sites or at a Primary Hospital. Provider shall not render said Covered Medical Services at any location other than an Office site or Primary Hospital unless such location has been approved by Plan. If there is more than one (1) Office Site and Provider ceases to operate its medical practice at one or more, but less than all, of the Office Sites, this Agreement shall continue in full force and effect with reference to the remaining Office Site(s). If there is only one (1) Office Site listed in this Agreement and Provider cease to operate its medical practice at said Office Site, then Plan, in its sole and absolute discretion, may immediately terminate this Agreement as provided in Section 15.3

3.2 Provider shall provide to Plan Members those Covered Medical Services set forth in Attachment B.

3.3 Provider shall comply with the Referral Procedures (provided by Plan) in effect at the time of referral and shall not directly or indirectly engage in self-referral or any other method of referral not specifically authorized by the Referral Procedure in effect. Should a Provider fail or refuse to comply with the Referral Procedures, Plan may, in addition to any other right or remedy under this Agreement, deny payment for any claim rising from this non-compliance from any amount owed to Provider. Any denied payments under this provision may not be billed to the Member.

3.4 Provider shall not admit a Plan Member to a Plan Hospital (or any hospital) on a non-emergency basis without first receiving the prior written authorization of the Plan's Medical Director or his/her designated agent.

3.5 Provider shall provide Covered Medical Services to Plan Members with the standard of care, skill and diligence consistence with professionally recognized standards of care customarily used in the community in which such services are rendered.

3.6 Provider shall provide Covered Medical Services to Plan Members in the same manner and in accordance with the same standards, and with the same time availability as he or she provides or arranges for the provision of Covered Medical Services and other services and supplies to all of his or her other recipients of Covered Medical Services consistent with existing medical ethical/legal requirements for providing continuity of care to any patient. Provider shall not discriminate against any Plan Member on the basis of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or mental or physical handicap.

3.7 Subject to the provisions of this Article III, Provider will determine the method, details, and means of performing Covered Medical Services pursuant to this Agreement.

3.8 Provider shall cooperate and consult with a Member's Primary Care Physician, other Plan Physician and Plan, in the monitoring, coordination and management of the Plan Member's overall health care.

3.9 Provider may, at Provider's sole cost and expense, employ such nonprofessional assistants or employees, as Provider deems necessary to perform Covered Medical Services in Provider's office. Plan may not control, direct, or supervise Provider's assistants or employees in the performance of Covered Medical Services.

3.10 Nothing in this Agreement shall be construed to restrict Provider from entering into other contracts or agreements to provide health care services to other health care delivery plans, patients, or employer groups. Plan and Provider acknowledge and agree that Provider does not render professional medical services exclusively on behalf of himself or herself or for another individual, group, organization, or governmental agency, subject to the following limitations:

(a) Provider may provide professional medical services to persons or entities other than Plan provided that such activities do not hinder or conflict with Provider's ability to perform his or her duties and obligations under this Agreement.

(b) All professional medical services rendered by Provider on behalf of himself or herself, or for another individual, group, organization, or governmental agency, shall be rendered exclusively outside of services to Plan Members. Provider shall neither represent nor imply in any way to the recipient thereof that such services are being rendered by or on behalf of Plan.

(c) All professional medical services rendered by Provider outside the scope of this Agreement shall not be covered by Plan's policy of professional liability insurance. Furthermore, Provider shall defend, indemnify and shall further hold harmless Plan, its shareholders, directors, officers, physicians, agents and employees from and against all claims, damages, losses and expenses, including costs and attorney's fees, incurred by reason of liability imposed upon Plan for damages sustained by any person or persons because of the alleged negligence or the medical malpractice of Provider while rendering services outside the scope of this Agreement.

(d) Provider shall be responsible for providing his or her own professional liability insurance coverage for any professional medical services rendered within or outside the scope of this Agreement.

3.11 Provider shall comply with all aspects of Plan's credentialing and re-credentialing policies and procedures.

3.12 Provider shall comply with all of the rules and regulations of Plan and Plan Sponsors and recognizes that such provisions may be amended from time to time. Provider agrees to cooperate with all applicable federal, state or municipal statutes, ordinances, or regulations, all applicable rules and regulations of the Medical Board of California and the ethical standards of the American and California Medical Association.

3.13 Provider agrees to cooperate with all administrative policies and procedures which Plan may adopt, and abide by the claims processing, authorization, Utilization Management, Quality Management, appeal, peer review and audit policies and procedures of Plan and Plan Sponsors, and to comply with all final determinations rendered pursuant to such policies and procedures. Provider may appeal adverse determinations in accordance with the procedures established by Plan.

3.14 Claims for Provider Services rendered to Plan Members shall be submitted by Provider to Plan on the Plan's approved claim form. On such claim forms, Provider shall use appropriate diagnosis and procedure codes to identify services rendered to Plan Members as defined by Current Procedural Terminology (CPT-4) and/or HCPCS and International Classification of Diseases (ICD-10-CM) or subsequent editions or as otherwise designated by Plan. All claims forms must be submitted to the Plan within the standard time frames in accordance to the applicable Medi-Cal and Medicare programs and no later than ninety (90) days for Commercial claims from the date of service. Failure to submit claims forms within the required time frame may result in non-payment or reduced payment of such claim(s) at the sole discretion of the Plan.

3.15 Clinc shall ensure that each of its Physicians (whether the physician is an employee or contractor of Provider) maintains a current license to practice medicine in the State of California and authorization to prescribe and administer controlled substances. Clinic shall notify Plan promptly of any modification, suspension, or revocation of any Physician's license or authorization to prescribe or to administer controlled substances. Clinic shall also ensure there is a "transfer" agreement with Plans capped hospital to ensure capped hospitals hospitalists can treat members assigned to clinic. Clinic shall further notify the Plan promptly concerning any restriction, suspension, denial, impairment, revocation, termination, or non-renewal of Provider's Physicians' medical staff privileges at any hospital. Clinic has provided a copy of the following certification and qualification for each Provider's Physicians:

(1) Physician's effective California license to provide the medical services required herein;

(2) Physician's current certificate issued by the United States Drug Enforcement Administration (DEA);
(3) Physician's current Board Certification or Board Eligibility certificate, where applicable;
(4) Physician's current malpractice insurance certificate, where applicable;
(5) List of required continuing medical education completed by Physician during the past two (2) years; and
(6) Certificate of Residency

Prior to rendering services hereunder to any Plan Member, Provider shall require each of its Physicians to complete the Provider Application, and submit the completed applications to Plan for approval. Upon Plan request, Provider shall furnish Plan with additional evidence indicating that all of Provider's Physicians licenses, certificates and qualifications are then existing, valid and full force and effect. Provider shall notify Plan in writing no less than thirty (30) days in advance of any addition or deletion of Provider's Physicians.

3.16 Provider shall ensure that the Health Professionals employed by or under contract with Provider shall be appropriately licensed to provide health care services in the State of California, have met and continue to meet all applicable federal, state or municipal status, ordinance or regulations and Plan standards of care and shall submit evidence of such licensure to Plan upon request.

3.17 Provider shall provide Emergency Services when Medically Necessary and shall not be required to have received Authorization for Emergency Services from Plan. Provider shall notify Plan no later than the following business day after a Plan Member receives Emergency Services.

3.18 Provider shall comply with drug formularies and policies regarding the prescription of generic or lowest cost alternative brand name pharmaceutical proposed by Plan or Plan Sponsors, subject to generally accepted medical and surgical practices and standards prevailing in the professional community. If for medical reasons, Provider believes a generic equivalent should not be dispensed, such physician agrees to obtain prior authorization from the Medical Director of Plan or Plan Sponsors or his/her agent. Provider acknowledges the authority of Plan or Plan Sponsors'-contracting pharmacists to substitute generics for brand name drugs, as specified in Section 4073 of the California Business and Professions Code, unless otherwise indicated

3.19 Provider understands that Plan will place certain obligations upon Provider regarding the quality of care received by Plan Members and that Plan or Plan Sponsors in certain instances will have the right to oversee and review the quality of care administered to Plan Members. Provider agrees to cooperate with Plan Medical Directors or the Plan Sponsors' Medical Directors in the Medical Directors' review of the quality of care administered to Plan Members.

3.20 Provider will supply all necessary office personnel, equipment, instruments and supplies required to perform Covered Medical Services and which are usual and customary for a medical practice in Provider's specialty in the community.

3.21 During the entire term of this Agreement, Provider shall maintain his/her professional competence and skills commensurate with the medical standards of the community, and as required by law, by attending and participating in approved continuing education courses.

3.22 Provider agrees to ensure that he or she complies with the obligation of Providers hereunder including, without limitation, the obligations of Articles V, VI, VII and VIII, Section 11.3., Exhibit G and Exhibit H, Regulatory Requirements.

3.23 If Provider is a professional corporation (or medical group partnership), Provider shall obligate, in writing, each of its physician shareholder(s) or partners and/or employee(s) who is to perform services hereunder to comply with all of the obligations of Provider hereunder.

3.24 Unless otherwise agreed to by the Plan's Governing Board, Provider agrees to coordinate with Plan or Plans for proper determination of Coordination of Benefits and Third Party Liability and to bill and collect from other payers those charge for which the other payers are responsible. Provider shall report all collections received in accordance with this Section 3.24 to Plan.

3.25 Provider shall maintain all licenses required by law to operate the facilities and all certifications necessary for Providers to participate in the Medicare and Medi-Cal programs. Provider agrees to notify Plan promptly in the event any action is taken against any such license or certification.

3.26 Provider agrees to abide with all terms and conditions set forth in any and all regulations promulgated by all Federal agencies affecting HMO participation in the Medicare Risk program and promulgated by all Federal and State agencies affecting HMO participation in the Medi-Cal program. State regulations are further described and incorporated by reference in the attached Exhibit H. This shall include adherence to the enforceable provisions as set forth in the HIPAA of 1996. All terms and conditions of an HMO Participation Agreement shall pertain and apply to Medicare-Risk Program Participation and to Medi-Cal Program participation. The Governing Body of the Plan shall develop and promulgate standards against which individual Provider performance shall be measured, and with which Provider must conform, to qualify as Medicare-Risk Program provider and as a Medi-Cal Program provider. Such standards shall include utilization, quality of care, patient service, and cost performance. Providers participating in the Medicare Risk Program or in the Medi-Cal Program may be suspended or terminated by the Governing Body and/or Quality Management of Plan if Provider performance does not conform to such standards as determined from time to time by the Governing Body.

3.27 Provider Notice to Plan Sponsor, Including Health Net. In the event Provider a) ceases to accept new Plan Member, or b) if it had previously not accepted new patients and now is accepting new Plan Member, Provider shall notify the Plan Sponsor within five business days of such event. Notwithstanding the above, the parties acknowledge that for general acute care hospitals, sub-sections 1367.27 (l) (3) and (l) (4) of the Provider Directory Law shall not apply.

a. Provider shall notify the Plan Sponsor in writing, thirty (30) days in advance, of any changes to federal tax identification numbers and/or national provider identifier numbers that may apply.
b. Provider will notify the Plan Sponsor of changes to their demographic data by completing the Online Profile Form and/or providing an affirmative response to the Plan Sponsor's Outreach Program, as described in Plan Sponsor's Policies, through the online interface.
c. Provider shall participate in and comply with all the Plan Sponsor Policies in effect on the effective date of this Agreement, and as modified periodically by the Plan Sponsor.
d. Plan Sponsor will maintain the online interface that is located on their website. Provider will notify the Plan Sponsor of changes to their demographic data by completing the Online Profile Form and/or providing an affirmative response to the Plan Sponsor's Outreach Program, through the online interface.
e. The Plan Sponsor is required to contact provider groups, hospitals and ancillary providers annually, to validate the accuracy of the information for each provider listed in the Plan Sponsor's provider directories. For the purposes of Section 1367.27 the Plan Sponsor considers Provider to be a provider subject to these requirements.

3.28 Member Assistance. In the event a Member or potential Member contacts Provider seeking Covered Services and Provider is not accepting new Members to provide Covered Services, Provider shall direct such Member or potential Member (i) to the Plan Sponsor for additional assistance in finding a Provider and (ii) to the DMHC to report any inaccuracy with the Provider Directory provided to such Member by the Plan Sponsor.

3.29 Continuation of Compliance. Plan retains the right to require Provider to provide information to Plan and/or Plan Sponsor that is required by Plan to satisfy the requirements of the Provider Directory Law.

3.30 Termination. Plan may terminate the Agreement for cause in the event Provider repeatedly fails to update the information required to be in the Provider Directory; provided, however, that Plan shall give Provider written notice of its failure to comply with the Provider Directory Law and Provider shall be given a reasonable opportunity to cure any deficiency (no less than ten business days) before the Agreement may be terminated.

3.31 Provider contracts with subcontracted providers. Provider acknowledges that in the event it subcontracts with providers, such subcontracts must comply with all terms and conditions of this Agreement, including without limitation all regulatory requirements, including compliance with the Provider Directory Law.

ARTICLE IV
COMPENSATION

4.1 As compensation for providing Covered Medical Services to Plan Members, Plan shall pay Provider the rates set forth in Attachment C for any fee-for-service claim which may be payable to Providers by Plan within thirty (30) calendar days for Medi-Cal claims and no later than forty-five (45) working days or less for Commercial or Medicare claims in accordance with applicable provisions of the Acts and Regulations after receipt by Plan of a complete and accurate claim for payment for Covered Medical Services rendered hereunder in accordance with the provisions hereof.

4.2 Provider shall obtain necessary Authorization for Plan Member hospital admissions and shall not bill, or attempt to collect from a Plan Member for services rendered, including where the Plan fails to pay for such services, and services that are determined not to be Medically Necessary or not to be Covered Medical Services, unless Provider advised Plan Member prior to the rendering of those services that the services were not covered and of Plan Member's obligation to pay therefore, and Plan Member agreed in writing to be financially responsible for such services. Plan may request signed Agreement documents from Physician and/or Plan hospital for Plan records.

4.3 Provider agrees to accept Compensation paid for covered medical services hereunder, as payment in full. Provider agrees that whether or not there is any unresolved dispute for payment, pursuant to the applicable regulatory guidelines of AB1455, under no circumstances shall Provider, directly or indirectly, make any charge or claim or maintain any action of law against any Plan Member for Covered Medical Services, and that this provision shall survive termination of this Agreement whether by rescission or otherwise. No surcharge to any Plan Member other than applicable co-payments will be permitted. A surcharge shall, for purposes of this Agreement be deemed to be any additional fee not provided for in Plan Member contract and Evidence of Coverage provided by the Plan Sponsors. Provider may bill and collect from Plan Members all charges for non-Covered Medical Services provided to Plan Members in accordance with the preceding Section 4.2. However, should any conclusive overpayment by Plan be made against any claim submitted by Provider, Plan shall notify Provider and shall offset any undisputed overpayment to amounts payable processed against current claim(s), pursuant to Exhibit I, until such overpayment is offset in full.

4.4 Provider agrees that in no event, including but not limited to non-payment by Plan's breach of this Agreement, shall any Plan Member be liable for any sum owed by Plan and, neither Provider nor its agent, trustee, assignee, or any subcontractor who render Covered Medical Services to Plan Members pursuant to this agreement shall bill, charge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any action of law or have any other person acting on a Plan Member's behalf to collect sums owed by the Plan. If Plan receives notice of any surcharge upon a Plan Member, it shall take appropriate action, including but not limited to, terminating this Agreement for cause and requiring that Provider provide the Plan Member with an immediate refund of such surcharge.

4.5 The obligations set forth in this Article IV shall survive termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of Plan Members, and the provisions of this Article IV shall supersede

any oral or written agreement to the contrary now existing or hereafter entered into between Provider and any Plan Member or persons acting on his or her behalf.

ARTICLE V
QUALITY MANAGEMENT PROGRAM

5.1 A Quality Management Program shall be established by Plan to review the quality of Covered Services furnished by Provider to Plan Members, to be made available to Provider prior to providing services to Members and to be included as Attachment A.

ARTICLE VI
UTILIZATION MANAGEMENT PROGRAM

6.1 A Utilization Management Program shall be established by Plan to review the medical necessity of Covered Medical Services furnished by Provider to Plan Members, to be made available to Provider prior to providing services to Members and to be included as Attachment A. The express purpose of the Utilization Management Program shall be to ensure the delivery of medically necessary Covered Healthcare Services. Such program will be established by Plan, in its sole and absolute discretion, and will be in addition to any concurrent or retrospective review and any utilization management program required by the conditions or provisions. Provider shall comply with, and subject to Provider's rights of appeal, shall be bound by such utilization management program. Provider shall implement any change required by Plan regarding a Provider procedure or problem identified by the Utilization Management Program. If requested, Provider shall serve on the Utilization Review Committee of such program, without compensation, in accordance with the procedures established by Plan. Failure to comply with the requirements of this Section 6.1 may be deemed by Plan to be a material breach of this Agreement and may, at Plan's option, be grounds for immediate termination of this Agreement by Plan. Provider agrees that decisions of the Plan's designated Utilization Review Committee may be used to deny Provider payment for those Covered Medical Services provided to a Plan Member which are determined to be medically unnecessary or for which Provider failed to receive prior written consent to treat a Plan Member.

6.2 Provider agrees to provide to Plan all patient encounter and HEDIS (Healthcare Effectiveness Data and Information Set) data, including utilization and cost data, required to enable Plan to meet all quality improvement goals and governmental regulatory requirements imposed on Plan, and such other data as required.

ARTICLE VII
REGULATORY COMPLIANCE

7.1 This Agreement is subject to all requirements imposed by federal and state law, and municipal and county ordinances, as amended, and all regulations issued pursuant thereto. This includes the provisions of Chapter 2.2 of Division 2 of the California Health and Safety Code, the Knox-Keene Health Care Service Plan Act of 1975, Chapters 7 and 8, Part 3, Division 9 of the Welfare and Institutions Code, Part 6.2 of Division 2 of the California Insurance Code, Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations, Chapter 5.8 of Title 10 of the California Code of Regulations, Chapter 3 of Title 22 of the California Code of Regulations; and Subchapter 13, Chapter 4, Part 1, Title 17 of the California Code of Regulations, and the Sections 160 – 164 of the HIPAA of 1996 pertaining to privacy, PHI and security, collectively called "Acts and Regulations", and any provision required to be in this Agreement by any of the above Acts and Regulations, as amended, shall bind the parties whether or not provided in this Agreement. Provider further agrees to abide by and comply with all the regulatory requirements set forth in the attached Exhibit G, Regulatory Requirements.

7.2 Provider agrees to permit Plan, Plan Sponsors, the DMHC, the DHS, the comptroller General of the United States, the Local Initiative or their authorized representatives, if applicable, to inspect, examine or copy at all reasonable times upon demand, all facilities, books, records and papers relating to the provision of Covered Medical Services rendered by Provider under this Agreement, to cost thereof, to the amount of any payment received therefore from Plan Members, or from others on such Plan Members' behalf and to the financial condition of Provider.

7.3 Provider agrees to maintain, in a form in accordance with the general standards applicable to such book or record keeping at Provider's place of business or at such other mutually agreeable location in California, the books, records and other papers provided for herein for at least ten (10) years from the date of the close of the Plan's fiscal year in which this Agreement is in effect, and that such obligation shall not terminate upon termination of this Agreement, whether by rescission or otherwise.

7.4 Attachment E contains the names of all of the officers and directors of Provider, of all the stockholders owning more than (10%) of the issued and outstanding stock of Provider. Provider shall promptly notify Plan of any change in the information contained on Attachment E.

7.5 Provider agrees to maintain, provide to Plan, and, upon request, make available to the DMHC, copies of all subcontracts for the provision of Covered Medical Services and to ensure that all such subcontracts are in writing, comply with Act and Regulations, and require that the subcontractor:

(1) Makes all applicable books and records available at all reasonable times for Inspection, examination, or copying by Plan.

(2) Retain such books and records for a term of at least ten (10) years from the close of plan fiscal year in which the subcontract is in effect.

7.6 Provider agrees to notify Plan in the event any agreement with a subcontractor for the provision of Covered Medical Services provided is amended or terminated.

7.7 Provider agrees to hold harmless both the State of California and Plan Members in the event Plan cannot or will not pay for covered medical services provided to Plan Members hereunder.

ARTICLE VIII
ACCESS TO AND CONFIDENTIALITY OF MEDICAL RECORDS

8.1 Provider shall maintain for each Plan Member receiving Provider Covered Medical Services pursuant to this Agreement, a single standard medical record in such form and containing such information as may be required by applicable federal and state laws and HIPAA regulations. The medical record shall contain, at a minimum, medical charts, prescription orders, diagnoses for which medications were administered or prescribed, documentation of orders for laboratory, radiological, EKG, hearing, vision, and other tests and results of such tests and other documentation sufficient to disclose the quality, quantity, appropriateness, and timeliness of Covered Medical Services performed or ordered under this Agreement. Each Plan Member's medical record shall be legible and maintained in detail consistent with good medical and professional practice that permits effective internal and external peer review and/or medical audit and facilitates an adequate system of follow-up.

8.2 Provider shall safeguard the confidentiality of Plan Member information according to applicable federal and state laws and HIPAA regulations, and shall take the usual precautions to prevent the unauthorized disclosure of PHI.

8.3 Duly authorized representatives of Plan, Plan Sponsors, and federal, state and local governments as well as HIPAA enforcement agency, shall have access to Plan Members' records and shall be allowed to make notes and copies, subject to all applicable state and federal laws and regulations relating to the confidentiality of patient medical records.

8.4 Consistent with laws relating to the confidentiality of patient medical records, Provider shall make the medical records of Plan Members available to other Plan providers to assure continuity of care for Plan Members.

8.5 Provider shall ensure that all employed or contracting Physicians and Health Professionals comply with the records maintenance, PHI, access and confidentiality provisions of this Agreement, as though each such professional was the Provider for the purpose of this Agreement.

8.6 Provider hereby authorizes Plan to release to duly authorized representatives of Plan, Plan Sponsors, and federal, state and local governments, as well as HIPAA enforcement agency, subject to all applicable state and federal laws relating to the confidentiality of patient medical records, any and all information, records, summaries of records and statistical reports specific to Provider without receiving Provider's prior written consent. Provider hereby releases Plan, its employees and/or its authorized agents from any and all liability and expense that are incurred by Provider due to any action taken by Plan pursuant to this section 8.6.

ARTICLE IX
ADVERTISING AND PUBLICITY

9.1 Plan and Provider each reserves the right to use and control the use of its name and all symbols, trademarks and service marks presently existing or later established by it. Neither Plan nor Provider shall use the other party's name, symbols, trademarks or services marks in advertising or promotional materials or otherwise (with the exception of the use of Provider's and/or Provider's employee or contracting physician's name, address, phone number, type of practice and willingness to accept new patients in standard provider listings developed by Plan's Plan Sponsors without the prior written consent of that party and shall cease any such usage immediately upon written notice of the party or on termination of this Agreement, whichever is sooner.

ARTICLE X
RELATIONSHIP OF THE PARTIES

10.1 None of the provisions of this Agreement is intended to create nor shall any be deemed or construed to create, any relationship between Plan and Provider (or any Physician of Health Professional) other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither Plan nor Provider, nor any of its representative partners, contractors, employees, agents or representatives shall be construed to be the contractors, partners, employees, agents or representatives of the other. As independent contracting parties, Plan and Provider maintain separate and independent management, and each has full, unrestricted authority and responsibility regarding its organization and structure. Provider understands and agrees that:

(a) Plan will not withhold on behalf of Provider any sum for income tax, unemployment insurance, social security or other withholding pursuant to any law or requirement of any governmental body relating to Provider, including contributions to government mandated employment-related insurance and similar programs, or make available to Provider any benefits afforded to employees of Plan, except as required by law;

(b) All of such payments, withholdings and benefits, if any, are the sole responsibility of Provider and;

(c) In the event of any claim by any person or entity, including any governmental agency, for any of the items described in Section 10.1(a), above, Provider agrees, on demand, to indemnify, defend, and hold Plan and its representatives,

successors-interest, assigns, agents, and employees, and each of them, free and harmless from and against any and all debts, liabilities, obligations, losses, damages, costs or expenses (including but not limited to attorney's fees), liens, or encumbrances accruing, based upon or arising out of any such claim with respect to any of the items discussed in Section 10.1(a), above, including any interest or penalty obligation related thereto.

10.2 Nothing in this Agreement, express or implied, is intended or shall be construed to confer upon any person, firm or corporation other than the parties hereto and their respective successors or assignees, any remedy or claim under or by reason of this Agreement or any term, covenant or conditions hereof, as third party beneficiaries or otherwise, and all of the terms, covenants and conditions hereof shall be for the sole and exclusive benefit of the parties hereof and their successors and assignees.

ARTICLE XI
LIABILITY, INDEMNITY AND INSURANCE

11.1 Neither Plan nor Provider, nor any of its respective agents or employees shall be liable to third parties for any act or omission of the other party.

11.2 Provider agree to indemnify, defend and hold harmless Plan, Plan Members, and their agents, contractors and employees from any and all liability, loss, damage, cause of action, claim and expense of any kind, including costs and attorneys' fees, which results from the negligent or willful performance or nonperformance by the Provider or its agents, contractors, or employees of the duties and obligations of Provider under this Agreement.

11.3 Provider, at its sole expense, agrees to maintain a policy of self-insurance or professional liability insurance of not less than one million ($1,000,000) per claim and three million annual aggregate ($3,000,000) to insure Provider and its agents, servants and employees against any and all lost, liability or damage arising from its duties and obligations under this Agreement. In addition, Provider, at its sole expense, agrees to maintain a policy of self-insurance or policies of insurance of not less than one million ($1,000,000) per claim and three million ($3,000,000) covering Providers principle place of business to insure Provider against any and all 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 the operation of a motor vehicle for business purposes by Provider, or Provider's agents, servants or employees. Provider further agrees to purchase such other available insurance as shall be necessary to insure Provider and its agents, servants or employees against any and all damages arising from its duties and obligations under this Agreement. All such policies shall be purchased from licensed insurance companies permitted to conduct business in the State of California. Provider shall make Plan an additional named insured on such policies. Provider shall also provide, at its sole expense, Workers' Compensation benefits for its agents, servants and employees as required by California law.

11.4 Provider shall provide Plan with written evidence that the policies of insurance required under Section 11.3 are in full force and effect, and are valid and existing in accordance with the provisions of this Agreement. In addition, Provider shall provide Plan within a minimum of thirty (30) days prior written notice in the event any of the policies set forth in Section 11.3 is cancelled or changed. (Sample form in Attachment D).

11.5 If the professional liability insurance procured by Provider pursuant to Section 11.3 is on a "claim made" rather than "occurrence" form, Provider, upon termination of this Agreement, shall either obtain extended reporting malpractice insurance coverage ("tail" coverage) in a form acceptable to Plan with liability limits equal to those most recently in effect prior to the date of termination, or enter into such other arrangements as shall reasonably assure Plan of the maintenance of coverage applicable to the claims arising during the period in which this Agreement as in effect for a period of not less than seven (7) years after the date of termination.

11.6 Provider shall advise Plan of each professional liability claim filed against Provider and/or a Provider agent, servant, or employee and each settlement of a professional liability claim entered into by Provider and/or a Provider agent, servant or employee within fifteen (15) days following said filing or settlement.

ARTICLE XII
PLAN MEMBER COMPLAINTS AND DISPUTES

12.1 If Provider receives any complaint regarding Provider in connection with Agreement, Provider agrees to notify Plan or Plan Sponsor within five (5) working days of all details of such complaint. In the event that Plan receives any complaint regarding Provider, Plan or Plan Sponsor will notify Provider within five (5) working days of receipt thereof.

12.2 A Plan Member Grievance Policy and Protection has been established by the Plan Sponsors in their sole and absolute discretion. Provider agrees to cooperate with Plan and Plan Sponsor in the investigation and resolution of Plan Member complaints and grievances under the Plan Sponsor Member Grievances Policy and Procedure.

12.3 In the event any complaint or grievance of a Plan Member cannot be settled through the Plan Sponsor's initial procedures, the matter may be submitted to Plan Sponsor for administrative review Provider agrees to cooperate and, when necessary, participate in any such administrative hearing proceedings. The administrative hearing results shall be final and binding on all parties.

ARTICLE XIII
DISPUTE RESOLUTION

13.1 Plan shall continue with its responsibilities under this Agreement during any dispute. If a dispute arises out of or relating to this Agreement, or the breach of the Agreement, and if the dispute cannot be settled through negotiation, then the Parties agree first to try in good faith to settle the dispute by non-binding mediation, to be held in Tulare County, California, before resorting to litigation or some other dispute resolution procedure, unless the Parties mutually agree otherwise. The Parties must mutually select the mediator, but in case of disagreement, then the Parties will select the mediator by lot from among two nominations provided by each Party. The Parties will split equally all costs and fees required by the mediator; otherwise each Party will bear its own costs of mediation. If mediation fails to resolve the dispute within 30 days, then either Party may pursue litigation to resolve the dispute.

13.2 Any grievance related to contracting, UM and claims settlement practices shall be deferred to the Claims Settlement Practices & Dispute Resolution Mechanism and timelines policy ("Policy") as provided for by Plan Sponsors. Provider shall submit such formal disputes and grievances in the medium(s) and to the address(es) as identified in the Policy.

ARTICLE XIV
UNFORESEEN CIRCUMSTANCES

14.1 For so long as any natural disaster, war, riot, civil insurrection, epidemic, other emergency or other event not within the control of Provider results in the facilities or personnel of Provider being unavailable to provide or arrange for the provision of Covered Medical Services, Provider shall only be required to make a good faith effort to provide such services, taking into account the impact of the event.

ARTICLE XV
TERM AND TERMINATION OF AGREEMENT

15.1 The initial term of this Agreement shall commence as of the later of either a) the effective date of termination of the Plan's contract with the IPA through which Provider currently provides Covered Medical Services to Plan Members, or b) on the date of signature to this Agreement between Plan and Provider, and shall continue for a period of one year. Thereafter, the Agreement will automatically renew for successive one-year terms, without the necessity of notice of action by either party; provided, however, that this Agreement may be terminated as provided below.

15.2 After the initial term, this Agreement may be terminated without cause by either party giving the other party ninety (90) day's prior written notice of such termination.

15.3 For cause termination may be effected for breach of this Agreement or default in the performance of any provision herein, if such breach or default is not corrected to the reasonable satisfaction of the non-breaching / non-defaulting party within thirty (30) days of receipt of written notice from the non-breaching / non-defaulting party specifying the breach of default. Such notice shall clearly remain in effect until the effective date of termination. Notwithstanding the above, this Agreement may be immediately terminated for cause in the event of the following circumstances;

(1) Provider's license to provide services in the State of California is modified, suspended or revoked; or
(2) Provider's certificate issued by the United State Drug Enforcement Agency ("DEA") authorizing Provider to prescribe and administer controlled substances is modified, suspended or revoked; or
(3) Provider's medical staff privileges at any hospital are restricted, suspended, denied, impaired, revoked, terminated or not renewed; or
(4) Provider fails to maintain insurance in at least the minimum amount specified in Section 11.3 of this Agreement; or
(5) Provider fails to comply with Plan Quality Management Program, as specified in Section 5.1 of this Agreement; or
(6) Provider fails to comply with Plan Utilization Management Program, as specified in Section 6.1 of this Agreement; or
(7) There is one (1) Office Site listed in this Agreement and Provider ceases to operate its medical practice at said Office Site; or
(8) Plan, Plan Sponsors or Local Initiative determines that the health, safety or welfare of Plan Members is jeopardized by the Provider continuing to provide Covered Health Care Services under this Agreement.

15.4 In the event of termination of this Agreement, upon request, Provider shall make available to Plan, or its designated representative, at no charge, any or all records, whether medical or financial, related to the Provider's performance under this Agreement.

15.5 Except as otherwise required by law, Provider agrees that any Plan decision to terminate this Agreement pursuant to this Article XV shall be final. Except as otherwise required by law, Provider further agrees that it shall have no right(s) to appeal the decision of the Plan through any formal or informal administrative hearing or review process nor shall he or she have any other due process right to appeal a Plan decision to terminate this Agreement

15.6 Upon termination of this Agreement, Provider shall continue to provide Covered Medical Services to Plan Members, who are receiving Covered Medical Services at the time of termination, who retain eligibility under the terms and conditions of their benefits Agreement, or by operation law until the Covered Medical Services being rendered to the Plan Members are completed, or until Plan or Plan Sponsor makes reasonable and medically appropriate arrangements for the provision of such services by another Plan Provider, and notify Provider that such arrangements have been made. Provider shall continue to

provide Covered Medical Services under such circumstances at the compensation rates then in effect for this Agreement. Additionally, Plan shall remain obligated to pay, and shall pay Provider for Covered Medical Services rendered prior to the effective date of termination hereof, in accordance with the provision of Section 4.1.

15.7 Notwithstanding any other provision of this Agreement, in the event that a Plan Sponsor notifies Plan that said Plan Sponsor wishes to remove Provider or any Provider employee or contractor from the Plan or Plan Sponsors' roster of participating physicians/providers, Plan shall have the right toterminate Provider's and/or such Provider employee's or contractor's participation in said Plan.

ARTICLE XVI
TRADE SECRETS AND NON-SOLICITATION

16.1 (a) Except when required by law, including under the Ralph M. Brown Act and the California Public Records Act, Provider agrees to keep confidential and to not disclose the professional and business practices, trade secrets or privileged information of Plan, and to keep such knowledge confidential in Provider's dealings with any medical group, clinic, hospital, health care facility, IPA, or other medical practice for which Provider may either work or have contact with during the term of this Agreement (and any subsequent term of this Agreement) and for a period of three (3) years after this Agreement terminates. Further, Provider agrees that it shall not use or disclose to any person or entity (except for the benefit of Plan) information obtained by Provider during the period of its relationship with Plan as to Plan contracts (including managed care contracts), medical records, business methods, financial statements, or any other trade secret, confidential or proprietary information with respect to Plan, including but not limited to, information concerning customers, third-party payers, patients or patient groups of Plan with whom the Provider dealt or of whom Provider became aware during the term of this Agreement.

(b) During the term of this Agreement (and any subsequent term of this Agreement) and for a period of three (3) years after the effective date of termination of this Agreement, Provider shall not directly or indirectly engage in the practice of solicitation of Plan Members or any employer of said Plan Members without Plan's prior written consent. For purposes of this Agreement, solicitation shall mean any action by Provider that Plan may reasonably interpret to be designed to persuade a Plan Member to discontinue his or her relationship with Plan, to disenroll from Plan or Plan Sponsor, or to encourage a Plan Member to receive health care from Provider on a different form of compensation. A breach of this Section 16.1(b) during any of this Agreement shall be grounds for immediate termination of this Agreement.

(c) Provider hereby represents, warrants and covenants to Plan that (i) the execution, delivery and performance of this Agreement by Provider do not and shall not conflict with, breach, violate or cause a default under any contract, agreement, instrument, order, judgment or decree to which Provider is a party or by which he is bound, (ii) Provider is not a party to or bound by any exclusivity, non-compete agreement, non-solicitation agreement or confidentiality agreement with any other Person that would interfere with, impair or prevent the performance by Provider of this Agreement, (iii) Provider shall not use or disclose any confidential information or trade secrets of any third party in connection with the performance of his duties hereunder, and (iv) this Agreement constitutes the valid and binding obligation of Provider, enforceable against Provider in accordance with its terms. Provider shall indemnify, defend and hold harmless Plan and its agents, contractors and employees from and against any and all liability, loss, damage, cause of action, claim and expense of any kind, including costs and attorneys' fees, arising out of or relating to a breach by Provider of the foregoing representations, warranties and covenants

ARTICLE XVII
HIPAA REQUIREMENTS

17.1 The parties acknowledge that:

a) Pursuant to this Agreement, they will use or disclose Protected Health Information which includes Electronic Protected Health Information ("PHI", "EPHI" or "IIHI") that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and certain regulations, including the Security Rule found at Title 45, Code of Federal Regulations (CFR), Sections 160 through 164 ("HIPAA Regulations"), and is not limited to, subsequent amendments;

b) Plan, and Plan Sponsor are Covered Entities as that term is defined in the HIPAA Regulations, and Provider creates or receives PHI/EPHI or IIHI from or on behalf of Plan, Plan Sponsors and may be construed, therefore, as Business Associates, as defined in the in the HIPAA Regulations;

c) Pursuant to§164.504(e) of the HIPAA Regulations, as it may be amended from time-to-time, Business Associates of Plan must agree in writing to certain mandatory provisions regarding the safeguarding, use and disclosure of PHI/EPHI or IIHI;

17.2 Definitions pertaining to this Article XVII are as follows. Unless otherwise provided herein, capitalized terms are ascribed the same meaning as set forth in the HIPAA Regulations.

a) **"Availability"** means the property that data or information is not made available or disclosed to unauthorized persons or processes.

b) **"Business Associate"** shall have the meaning given to such term under the HIPAA Regulations, including, but not limited to, Title 45 CFR Section 160.103.

c) **"Confidentiality"** means the property that data or information is not made available or disclosed to unauthorized persons or processes.

d) **"Designated Record Set"** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, Section 164.501.

e) **"Individually Identifiable Health Information" or "IIHI"** shall mean information as it relates to the individual's health, healthcare, or payment for healthcare in any form, written, spoken, faxed and electronic and, such that is defined in a standard transaction as stipulated by HIPAA that can serve to identify an individual;

f) **"Integrity"** means the property that data or information have not been altered or destroyed in an unauthorized manner.

g) **"Parties"** shall mean Plan and Provider.

h) **"Privacy Rule" and "Security Rule"** shall mean the HIPAA Regulation that is codified at Title 45 CFR Parts 160 to 164, as it pertains to use and disclosure.

i) **"Protected Health Information"** or **"Electronic Protected Health Information" ("PHI" or "EPHI)** means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual, or; the past, present or future payment for the provision of health care to an individual; and, (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to, Title 45 CFR Section 164.501. For the purpose of this Addendum, the acronym PHI and EPHI may also refer to IIHI.

j) **"Security Incident"** means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

j) **"Security Rule"** means the Security Standards for the Protection of EPHI, set forth at 45 CFR Parts 160 through 164.

k) **"Treatment, Payment or Operational purposes" or "TPO"** shall pertain to the related performance of reasonable industry standard management and administration within the organization.

17.3. Scope of Use and Disclosure of PHI/EPHI OR IIHI. Except as otherwise limited in this Amendment:

a) Provider shall use and disclose PHI solely to provide the services, or to perform the functions, described in the Agreement, provided that such use or disclosure would not violate the HIPAA Regulations if so used or disclosed by Provider and recipient entities;

b) Provider may use or disclose PHI or IIHI for the TPO of Provider or to provide Data Aggregation services to Plan, Plan Sponsor;

c) Provider may use or disclose certain PHI provided the protected individual gives written consent and/or authorization that is limited to the scope and purpose of such use or disclosure;

d) Provider shall not request, use or release more than the minimum amount of PHI/EPHI necessary to accomplish the purpose of the use or disclosure as required to satisfy its obligations so long as such use and/or disclosure would not violate the Privacy Rule.

17.4 Obligations of Provider. In connection with its use and disclosure of PHI/EPHI and IIHI, Provider shall:

a) Not use or disclose PHI or IIHI other than as permitted or required by the Agreement or as Required by Law;

b) Use reasonable and appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by Article XVII;

c) Mitigate, to the extent practicable, any harmful effect that is known to Provider of a use or disclosure of PHI by Provider in violation of the requirements of this Article XVII;

d) Report to Plan any use or disclosure of the PHI or IIHI not provided for by this Article XVII of which Provider becomes aware;

e) Require contractors or agents to whom Provider provides PHI or IIHI created or received by Provider on behalf of Plan to agree to the same restrictions and conditions that apply to Provider with respect to such PHI under this Article XVII;

f) Provide access, at the request of Plan to PHI or IIHI in a Designated Record Set, to Plan or, as agreed by Provider, to an Individual in order to meet the requirements under §164.524 of the HIPAA Regulations;

g) Make any amendment(s) to PHI or IIHI in a Designated Record Set that the Plan directs or agrees to, pursuant to §164.526 of the HIPAA Regulations at the request of Plan in the time and manner proscribed;

h) Make internal practices, books, and records, including policies and procedures and PHI or IIHI, relating to the use and disclosure of PHI or IIHI created or received by Provider on behalf of Plan, available to the Plan, Plan Sponsors, the HSS Office for Civil Rights or its delegated HIPAA enforcement agency, if requested, in a time and manner designated by the regulatory agency, for the purpose of determining the parties' compliance with the HIPAA Regulations;

i) Maintain for a period of seven (7) years an accounting of all disclosures of PHI or IIHI that are required to be maintained under §164.528 of the HIPAA Regulations. Such accounting will include the date of the disclosure, the name of the recipient, a description of PHI or IIHI disclosed and the purpose of the disclosure. This interval requirement of this section shall survive the terms of Article XV;

j) Provide to Plan, in a timely manner, information collected in accordance with this Section 17.4, to permit Plan to respond to a request by an oversight entity for an accounting of disclosures of PHI or IIHI in accordance with §164.528 of the HIPAA Regulations;

k) Make reasonable efforts to implement any restriction to the use or disclosure of PHI or IIHI that Plan has agreed to pursuant to Section 17.5.
l) With respect to EPHI, implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that Provider creates, receives, maintains, or transmits on behalf of Plan as required by 45 CFR Part 164, Subpart C.
m) With respect to EPHI, ensure that any agent, including a subcontractor, to whom Provider provides EPHI, agrees to implement reasonable and appropriate safeguards to protect the EPHI.
n) With respect to EPHI, report to Plan any Security Incident of which Provider becomes aware.

17.5 Obligations of Plan

a) Use appropriate safeguards to maintain and ensure the confidentiality, privacy and security of PHI or IIHI transmitted to Plan pursuant to this Agreement, in accordance with the standards and requirements of the Privacy Rule, until such PHI or IIHI is received by Provider;
b) Provide Provider with the notice of privacy practices that Plan and Plan Sponsors produces in accordance with §164.520 of the HIPAA Regulations;
e) Promptly notifies Provider of any change in, or revocation of, permission by Individual to use or disclose PHI or IIHI, to the extent that such changes may affect Provider 's use or disclosure of PHI;
f) Promptly notify Provider of any restriction to the use or disclosure of PHI that Plan has agreed to in accordance with §164.522 of the HIPAA Regulations, to the extent that such restriction may affect Provider 's use or disclosure of PHI;
g) Not request Provider to use or disclose PHI or IIHI in any manner that would not be permissible under the HIPAA Regulations if done, by Plan, unless such disclosure is necessary for the purposes of Data Aggregation or TPO activities of Provider under the Agreement.

17.6 Plan shall notify Provider of any change to regulations that may affect normal operations and shall make any amendment to this Agreement from time to time, as required by newly promulgated provisions.

ARTICLE XVIII
GENERAL PROVISIONS

18.1 Assignment

This Agreement shall be binding upon, and shall inure to the benefit of, the parties to it, and their respective heirs, legal representatives, successors and assigns. Notwithstanding the foregoing, Provider shall not assign this Agreement without first obtaining the written consent of Plan. Assignment or delegation of this Agreement by Provider shall be void unless prior written approval of such assignment or delegation is obtained from Plan.

18.2 Notices

Any notice required to be given pursuant to this Agreement shall be made in writing and shall be sent personally delivered or by certified mail, return receipt requested, postage prepaid, to the other party as follows:

Adventist Health Plan, Inc.
ONE Adventist Health Way
Post Office Box 619002
Roseville, CA 95661-9002
Attention: Vice President Plan Operations

Provider:
County of Tulare

5957 S Mooney Blvd

Visalia, CA 93277

Attn: Fiscal Operations

Notices delivered personally shall be deemed communicated upon actual receipt. Mailed notices shall be deemed communicated as of the date shown as date of delivery upon the United States Postal Service return receipt thereof, three (3) days after mailing. Either party may at any time change its address for notification purposes by mailing or delivering a notice as required herein above stating the change and setting forth the address. The new address shall be effective on the tenth (10th) day following the date such notice is received, unless a subsequent date of effectiveness is specified in said notice.

18.3 Documentation

Plan shall provide Provider with a copy of any document required by a Plan Sponsor which has been approved by Plan 's Board of Directors and which requires the signature of Provider and/or a Provider employee or contractor.

18.4 Treatment Alternatives: Plan encourages open Provider-Member communication regarding appropriate treatment alternatives. Plan promotes open discussion between Provider and Plan Members regarding Medically Necessary or appropriate patient care, regardless of Covered Services limitations. Provider is free to communicate any and all treatment options to Plan Members regardless of benefit coverage limitations.

18.5 Severability
If any provision of this Agreement is held by a court of competent jurisdiction or applicable state or federal law and their implementing regulations to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force and effect, subject to Section 18.6.

18.6 Effect of Severable Provision
In the effect that a provision of this Agreement is rendered invalid or unenforceable or declared null and void, as provided in Section 18.5 above, and its removal has the effect of materially altering the obligations of either party in such a manner as, in the judgement of the affected, (1) will cause serious financial hardship to such party; or (2) will cause such party to act in violation of its corporate articles or bylaws, the party so affected shall have the right to terminate this Agreement upon thirty(30) days prior written notice to the other party. The provisions of Article XV shall apply to such termination.

18.7 Confidentiality
The terms of this Agreement and in particular the provisions regarding Compensation, are confidential and shall not be disclosed by Provider except as necessary to the performance of this Agreement or as required by law, including under the Ralph M. Brown Act and the California Public Records Act.

18.9 Waiver
The waiver of any provision, or of the breach of any provision, of this Agreement must be set forth specifically in writing and signed by waiving party. Any such waiver shall not operate or be deemed to be a waiver of any prior or future breach of such provision or of any other provision.

18.10 Entire Agreement
This Agreement, together with the attachments, supersedes any and all agreements, promises, negotiations or representations, either written or oral, between the parties hereto with respect to the subject matter contained herein and contain all of the covenants and Agreements between the parties with respect to the rendering of covered medical services by Provider. Each party to this Agreement acknowledges that no representations, inducements, promises, or Agreements, oral or otherwise, have been made by either party, or anyone acting on behalf of either party, that are not embodied herein, and that no other Agreement, statement, or promise not contained in this Agreement shall be valid or binding. Except as otherwise provided herein, any effective modification must be in writing and signed by both parties.

18.11 Amendment
This Agreement may only be amended by the mutual written consent of the parties except as set forth below.

18.12 THIS SECTION WAS DELETED AND IS INTENTIONALLY BLANK

18.13 Headings
The headings of articles and sections contained in this agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

18.14 Conflict of Interest
Provider warrants that no part of the Compensation provided herein shall be paid directly or indirectly to any officer or employee of the Plan as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to Provider in connection with any services contemplated or performed relative to this Agreement. Provider certifies that no member of or delegate of Congress, the General Accounting Office, DHHS (including the Health Care Financing Administration or current Administration), or any other Federal agency has or will benefit financially or materially from this Agreement.

18.15 Governing Law
This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of California.

ARTICLE XIX
CONDITION PRECEDENT

This Agreement is conditioned upon Plan receiving all necessary licenses, certifications and/or approvals from the DMHC and CMS.

THE PARTIES, having read and considered the above provisions, indicate their agreement by their authorized signatures below.

ADVENTIST HEALTH PLAN, INC.

Date: 7/30/2020 By Andrea Kofl

Print Name Andrea Kofl

Title President, Central Valley Network

Date: 7/30/2020 By Bill Wing

Print Name Bill Wing

Title President, Adventist Health

[Pursuant to Corporations Code section 313, County policy requires that contracts with a **Corporation** be signed by both (1) the chairman of the Board of Directors, the president or any vice-president (or another officer having general, operational responsibilities), and (2) the secretary, any assistant secretary, the chief financial officer, or any assistant treasurer (or another officer having recordkeeping or financial responsibilities), unless the contract is accompanied by a certified copy of a resolution of the corporation's Board of Directors authorizing the execution of the contract. Similarly, pursuant to California Corporations Code section 17703.01, County policy requires that contracts with a **Limited Liability Company** be signed by at least two managers, unless the contract is accompanied by a certified copy of the articles of organization stating that the LLC is managed by only one manager.]

COUNTY OF TULARE

Date: ____________ By ____________
Chairman, Board of Supervisors

ATTEST: JASON T. BRITT
County Administrative Officer/Clerk of the Board of Supervisors of the County of Tulare

By ____________
Deputy Clerk

Approved as to Form
County Counsel

By Allison K. Pierce 8/18/20
Deputy
Matter # 20191984

EXHIBIT I

DOWNSTREAM PROVIDER NOTICE

AB1455 CLAIMS SETTLEMENT PRACTICES & DISPUTE RESOLUTION MECHANISM

As required by Assembly Bill 1455, the DMHC has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products it regulates. This information notice is intended to inform Provider of its rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for commercial HMO, POS, and, where applicable, PPO products and other applicable lines of business, **with the exception of Medicare Advantage line of business,** where Plan is delegated to perform claims payment and provider dispute resolution processes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

I. Claim Submission Instructions

A. Sending Claims to Plan. Claims for services provided to Plan Members assigned to Provider must be sent to the following:

Via Mail:	PO Box 572734 Tarzana, Ca 91357
Via Physical Delivery:	6400 Canoga Ave #163 Woodland Hills, Ca 91367
Via Clearinghouse:	MPM38

B. Calling Plan Regarding Claims. For claim filing requirements or status inquiries, you may contact Plan by calling: (800) 514-6834 ext. 408

C. Claim Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by Plan:

i. *Submission of a Clean Claim within industry standard timelines per line of business with commercial claims not to exceed 90 calendar days;*

ii. *Submission of information and documentation upon request by Plan subject to Title 28 CCR 1300.71(a) (10)*

D. Claim Receipt Verification. For verification of claim receipt by Plan, please do the following:
Contact the Claims Supervisor at: (800) 514-6834 ext. 408

II. Claims Dispute Resolution Process for Contracted Providers

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to Plan , appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider's name; provider's identification number, provider's contact information, and:

i. If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Plan to a contracted provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;

ii. If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and,

iii. If the contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

B. Sending a Contracted Provider Dispute to Plan. Contracted provider disputes submitted to Plan must include the information listed in Section II.A., above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of the Provider Dispute Resolution Officer at the following:

Via Mail:	ONE Adventist Health Way Roseville, Ca 95661

C. (Left blank intentionally)

D. Acknowledgment of Contracted Provider Disputes. Plan will acknowledge receipt of all contracted provider disputes as follows:

i. Electronic (computerized format not currently available) contracted provider disputes will be acknowledged by Plan within two (2) Working Days of the Date of Receipt by Plan

ii. Paper contracted provider disputes will be acknowledged by Plan within fifteen (15) Working Days of the Date of Receipt by Plan

F. Contact Plan Regarding Contracted Provider Disputes. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to Plan at: ONE Adventist Health Way Roseville, Ca 95661

F. Instructions for Filing Substantially Similar Contracted Provider Disputes. Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format

i. Sort provider disputes by similar issue

ii. Provide cover sheet for each batch

iii. Number each cover sheet

iv. Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheet

G. Time Period for Resolution and Written Determination of Contracted Provider Dispute. Plan will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Working Days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute.

H. Past Due Payments. If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, Plan will pay any outstanding monies determined to be due, and any applicable interest and penalties required by law or regulation, within five (5) Working Days of the issuance of the written determination.

III. Dispute Resolution Process for Non-Contracted Providers

A. Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider's written notice to Plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information, and:

i. If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Plan to provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect;

ii If the non-contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

B. Dispute Resolution Process. The dispute resolution process for non-contracted Providers is the same as the process for contracted Providers as set forth in sections II.B, II.C, II.D, II.E, II.F, II.G, and II.H above.

IV.Claim Overpayments

A. Notice of Overpayment of a Claim. If Plan determines that it has overpaid a claim, Plan will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the Date of Service(s) and a clear explanation of the basis upon which Plan believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

B. Contested Notice. If the provider contests Plan's notice of overpayment of a claim, the provider, within 30 Working Days of the receipt of the notice of overpayment of a claim, must send written notice to Plan stating the basis upon which the provider believes that the claim was not overpaid. Plan will process the contested notice in accordance with Plan's contracted provider dispute resolution process described in Section II above.

C. No Contest. If the provider does not contest Plan's notice of overpayment of a claim, the provider must reimburse Plan within thirty (30) Working Days of the provider's receipt of the notice of overpayment of a claim.

D. Offsets to payments. Plan may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse Plan within the timeframe set forth in Section IV.C., above, and/or (ii) Plan's contract with the provider specifically authorizes Plan to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, Plan will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim(s).

V. Effective Date

Pursuant to the terms promulgated under AB1455, this notice will be deemed effective for implementation as of the date of the Agreement between the Plan and Provider, for disputes arising for date(s) of service on or after January 1, 2018.

EXHIBIT II
MEDICARE ADVANTAGE PROGRAM
DOWNSTREAM PROVIDER CONTRACT ADDENDUM

This revised ICE Downstream Provider Contract Addendum (**"Addendum"**) is hereby incorporated into this Agreement and is intended to add contract language required by the Centers for Medicare and Medicaid Services, (**"CMS"**) for participation in the Medicare Advantage (**"MA"**) Program.

WHEREAS, CMS requires that specific terms and conditions be incorporated into subcontracts between a First Tier Entity (Plan)and a Downstream Provider (Provider) to comply with the provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. (Pub. L. 108-73) (MMA).

WHEREAS, Downstream Provider desires to provide services to Medicare beneficiaries who enroll in the Medicare Advantage Program; and

WHEREAS, First Tier Entity desires that Downstream Provider provide services to Medicare beneficiaries who enroll in the Medicare Advantage Program; and

WHEREAS, Downstream Provider agrees to comply with the terms and conditions specified by CMS in the form of this Addendum to the Agreement between Downstream Provider and First Tier Entity;

NOW, THEREFORE, the parties agree as follows:

Article I. DEFINITIONS

1. **"Agreement"** means the agreement between the First Tier Entity and Downstream Provider that specifies the contractual relationship between the First Tier Entity and Downstream Provider for the provision of services to Enrollees.
2. **"Downstream Provider"** means an entity or individual that is contracted by a First Tier Entity to provide services to Enrollees. A Downstream Provider includes, but is not limited to physicians, ancillary providers, and other health care providers.
3. **"First Tier Entity"** means the entity which contracts with a Medicare Advantage Organization, (MAO) to provide services to Enrollees. A First Tier Entity includes but is not limited to medical group, individual practice association ("IPA"), or hospital.
4. **"Centers for Medicare and Medicaid Services" ("CMS")** means the agency within the Department of Health and Human Services that administers the Medicare Program.
5. **"Completion of Audit"** means Completion of Audit by CMS of an MAO, MAO subcontractors or related entities.
6. **"Final Contract Period"** means Final Contract Period between CMS and the MAO with whom the First Tier Entity has entered into an Agreement.
7. **"Industry Collaboration Effort" ("ICE")** is a collaboration of health plans, providers and industry associations working on health care issues.
8. **"Medicare Advantage Organization" ("MAO")** means a Health Plan that has entered into an agreement with the CMS to provide services to Medicare beneficiaries under the Medicare Advantage Program.
9. **"Medicare Advantage" ("MA")** means the program offered by the federal government in which Medicare beneficiaries have several options to receive health care services.
10. **"Member"** means an individual who has enrolled in or elected coverage through an MAO. A Member is also known as an Enrollee.

Article II. OPL 77 REQUIRED PROVISIONS

Operational Policy Letter (OPL) 98.077 (revised) requires the Downstream Provider to comply with the following requirements:

1. Downstream Provider agrees to give the Department of Health and Human Services (HHS), and the General Accounting Office (GAO) or their designees the right to audit, evaluate, inspect books, contracts, medical records, patient care documentation, other records of subcontractors, or related entities for (10) years, or for periods exceeding ten (10) years, from the end of the Final Contract Period or Completion of Audit, whichever is later for reasons specified in the federal regulation, for Members enrolled in a MAO. 42 CFR 422.504 (e)(2)(3)(4)(i)(2).
2. Downstream Provider agrees to comply with all confidentiality and Member record accuracy requirements. 42 CFRs 422.118 and 422.504. (a) (13).
3. Downstream Provider agrees to hold harmless and protect Members from incurring financial liabilities that are the legal obligation of the MAO or First Tier Entity. In no event, including but not limited to, nonpayment or breach of an agreement by the MAO, First Tier Entity, or other intermediary, or the insolvency of the MAO, First Tier Entity, or other intermediary, shall Downstream Provider bill, charge, collect a deposit from or receive other compensation or remuneration from a Member. Downstream Provider shall not take any recourse against the Member, or a person acting on behalf of the Member, for services provided. This provision does not prohibit collection of applicable coinsurance, deductibles, or co-payments, as specified in the MAO Evidence of Coverage. This provision also does not prohibit collection of fees for non-covered services, provided the Member was informed in advance of the cost and elected to have non-covered services rendered. 42 CFRs 422.504(g)(1) and (i)(3)(i).
4. Downstream Provider agrees to perform, if applicable, the functions that are delegated consistent with the First Tier Entity requirements, MAO requirements, and federal regulation. Downstream Provider also agrees to comply with any applicable delegation requirements and regulations between the MAO and First Tier Entity. 42 CFRs 422.504(i)(3)(iii) and 422.504(i)(4).
5. First Tier Entity agrees to pay Downstream Provider promptly according to CMS standards and comply with all payment

provisions of law. 42 CFR 422.520(b).

6. Downstream Provider agrees to comply with CMS reporting requirements as specified in Sec 422.257(c)(d)(1)(4)(encounter data) and Sec 422.516(a)(6)(b) and Sec 422.500(3)(ii) (informational data). 42 CFR 422.504(a)(8).
7. Downstream Provider agrees to comply with CMS accountability provisions, including but not limited to the requirement to comply with Medicare laws, regulations, and CMS instructions, which are more fully documented in the MAO's policies and procedures. 42 CFRs 422.504(i)(3)(ii)(A) and 422.504(i)(4)(v).

Except as provided in this Addendum, all other provisions of the Agreement between Provider and First Tier Entity not inconsistent herein shall remain in full force and effect. This Addendum shall remain in force as a separate but integral addition to such Agreement to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

ATTACHMENT A

QUALITY MANAGEMENT PROGRAM AND UTILIZATION MANAGEMENT PROGRAM

(ATTACHMENTS WILL BE SENT UPON PLAN'S RECEIPT OF EXECUTED AGREEMENT)

ATTACHMENT B

COVERED MEDICAL SERVICES

Check Covered Medical Services Provided by Primary Care Provider

__X__ Family Practice
__X__ General Practice
__X__ Internal Medicine
__X__ Pediatrics
__X__ Obstetrics and Gynecology

Check Covered Medical Services Provided by Specialty Provider

_______Allergy
_______Anesthesiology
X Cardiology
_______Dermatology
X Ear, Nose & Throat (Otolaryngology)
_______Emergency Medicine
X Endocrinology
_______Gastroenterology
_______Geriatrics
X Gynecology
X Infectious Disease
_______Neonatology
X Nephrology
_______Neurology
_______Neurosurgery
X Obstetrics &Gynecology
_______Oncology- Hematology

X Ophthalmology
_______Pathology
X Pediatrics
X Physical/Rehabilitation Medicine
X Podiatry
_______Psychiatry
_______Pulmonary Medicine
_______Radiology
_______Rheumatology
_______Surgery, Colon & Rectal
_______Surgery, General
_______Surgery, Hand
_______Surgery, Neck & Head
_______Surgery, Orthopedic
_______Surgery, Plastic
_______Surgery, Thoracic & Cardiovascular
_______Urology
X Other (list and define below)
Vascular Sugery, Pain Management

ATTACHMENT C

PROVIDER COMPENSATION FEE SCHEDULE

Subject to pre-authorization, eligibility and other Plan Sponsor rules, payment for all covered services for which Plan is the responsible party per Plan Sponsor, for which Provider agrees to accept as payment in full for authorized services, is as follows:

For Medicare, and Medi-Medi HMO Members:
One hundred percent (100) % of the then current Medicare Allowable rate for the area in which services are provided.

For Medi-Cal Members:
Primary Care Services: $10.00Per Member Per Month
Specialty Care Services: One hundred percent (100%) of the then current prevailing Medi-Cal rate for the area in which services are provided as set forth by the Department of Health Care Services
Such rate shall NOT include the Code 18 wrap payments which are part of the Provider's Prospective Payment System rates with the Department of Health Care Services.

Immunizations and Administration: Medi-Cal immunizations are covered as part of the federal Vaccines for Children (**VFC**) program. Administration fees will be included in capitation but all immunizations given must be billed for quality data.

Miscellaneous:

- Unusual and/or necessary services beyond the scope of approved services shall be processed By Report and Subject to Medical Review.
- Adequate supporting documentation will be provided with claim. Sequestration applies to Medicare Advantage only.
- Codes (i.e. supplies or injected material deemed payable, etc.) with no fixed dollar value assigned by Medicare shall be payable at Cost + 5% (invoice required).
- CMS Medicare RBRVS Policy and Procedure, claims submission, processing and payment guidelines shall apply for all service(s) rendered, including but not limited to, multiple procedures, global services, applicable sequestration and applicable modifiers. Standard CPT/ RBRVS/RVU guidelines shall prevail where there is no Medicare applicable policy. Claims payments may also be affected by the California Code of Regulations, Health & Safety Section 1371.39, pertaining to unfair payment and unfair billing practices.
- Provider hereby represents, warrants and covenants to Plan that (i) the execution, delivery and performance of this Agreement by Provider do not and shall not conflict with, breach, violate or cause a default under any contract, agreement, instrument, order, judgment or decree to which Provider is a party or by which he is bound, (ii) Provider is not a party to or bound by any exclusivity, non-compete agreement, non-solicitation agreement or confidentiality agreement with any other Person that would interfere with, impair or prevent the performance by Provider of this Agreement, (iii) Provider shall not use or disclose any confidential information or trade secrets of any third party in connection with the performance of his duties hereunder, except as required by law, including under the Ralph M. Brown Act and the California Public Record Act, and (iv) this Agreement constitutes the valid and binding obligation of Provider enforceable against Provider in accordance with its terms. Provider shall indemnify, defend and hold harmless Plan and its agents, contractors and employees from and against any and all liability, loss, damage, cause of action, claim and expense of any kind, including costs and attorneys' fees, arising out of or relating to a breach by Specialist of the foregoing representations, warranties and covenants.
- For the Medicare Fee Schedule, providers may access the internet website at: http://www.cms.gov
- For the Medi-Cal fee schedule, provider may access the internet website at: https://www.medi-cal.ca.gov

ATTACHMENT C.1

MEDI-CAL INCENTIVES

This Attachment C.2 implements Plan's Medi-Cal Incentive Program for Provider. Through this Incentive Program, Plan may make two types of incentive payments available to Provider for assigned Medi-Cal Members: (1) Pay for Performance ("P4P") Bonus; and (2) Upstream Bonus (each, a "Bonus," and collectively, "Bonuses"). Each Bonus will be based on services rendered within a Base Year, which is a calendar year. To the extent Provider is eligible for and qualifies for a Bonus during a Base Year, Plan will pay such Bonus to Provider in the calendar year immediately following the Base Year.

Eligibility

In order to be eligible for a Bonus ("Eligible"), the following must be met for the entire Base Year:

1. Provider must be a network provider in good standing with Plan;
2. Provider must keep its panel open to accept new members;
3. Provider must meet or exceed the baseline Encounter Data ("ED") submission policy established by Plan and/or Plan Sponsor, as may be amended by Plan and/or Plan Sponsor from time to time.

Pay for Performance (P4P) Bonus

Plan will offer a P4P Bonus designed to improve health and reduce unnecessary health care costs. Plan will send an announcement preceding each Base Year specifying the performance metrics, benchmarks and targets to be considered in calculating an Eligible Provider's P4P Bonus amount. Provider shall be eligible to receive up to a certain per Medi-Cal Member per month within the Base Year as a P4P Bonus. The amount of any Bonus will be calculated based on metrics measured for all Medi-Cal Members assigned to Provider.

Pay for Performance (P4P) Bonus Maximum Rate: $3.50 Per Member Per Month

Consistent with the Provider Agreement, Provider may not limit medically necessary services to members. Members experiencing an emergency medical condition should be referred to their nearest emergency department. Plan will monitor any improper limitations in medically necessary services and may take corrective action against any Provider for any such incidences.

Upstream Bonus

Certain Plan Sponsors may establish incentive programs pursuant to which Plan may receive incentive payments from these Plan Sponsors. These Plan Sponsors may update and change their incentive programs. To the extent that Plan receives such an incentive payment for Medi-Cal Members, Provider may be eligible for an Upstream Bonus based on Plan's determination of Provider's contribution toward the incentive received by Plan from a Plan Sponsor. The determination of whether Provider receives an Upstream Bonus and the calculation of the amount of the Upstream Bonus are fully within the discretion of Plan.

Medi-Cal Regulation

Plan has made reasonable efforts to structure the incentives payable under this Attachment consistent with law and regulation, as known as of the date of this regulation. Plan does not represent or warrant whether the California Department of Health Care Services will exclude these incentive payments, if any, from its supplemental Medi-Cal payment calculation, consistent with 81 Federal Register 27577, as the rules in this area are currently in flux. In the event that the federal or state government sets forth new law or policy that impacts the treatment of these incentives pursuant to 81 Federal Register 27577, Plan reserves the right, without undertaking any obligation, to revise the Incentive Program in order to maximize the likelihood that the incentives under this Attachment will be in addition to the reimbursement levels to Provider specified by the Department of Health Care Services.

Nothing in this attachment constitutes remuneration in return for or to induce the provision or acceptance of business for which payment may be made in whole or in part by a Federal health care program (other than Medi-Cal business covered by this attachment) on a fee-for-service or cost basis.

ATTACHMENT C.2

PRIMARY CARE SERVICES

Provider is paid a monthly Capitation Payment in anticipation of Medically Necessary, Primary Care Services that are expected to be provided by Provider. Provider is expected to provide industry-standard primary care services for Members. Provider is also reimbursed on a fee-for-service basis for providing non-primary care physician services for those services which the Provider is trained and capable to provide.

Services Included in the Capitation Fee

Provider is compensated as described above to provide medically necessary primary care services, including the following:

- Routine office visits
- Office visits for acute chronic care
- Evaluation and Management
- Supplies used in providing the services above
- Initiating and making referrals for Medically Necessary specialty care services.
- 24-hour on-call coverage

Primary care services include but are not limited to the following codes for all services provided and billed by a primary care physician, including Family Medicine, General Practice, Internal Medicine, Pediatrics, and Preventive Medicine. Additional codes may be designated by the Department of Health Care Services or the Centers for Medicare & Medicaid Services as primary care services.

Initial Health Assessment

- 99381-99387, 99391-99397

Visit: New Patient (G0466)

- 92002, 92004, 97802, 99201-99205, 99304-99306, 99324-99328, 99341-99345, 99406, 99407, 99497, G0101, G0102, G0108, G0117-G0118, G0296, G0442, G0443, G0444, G0445, G0446, G0447, G0490, Q0091

Visit: Established Patient (G0467)

- 92012, 92014, 97802, 97803, 99212-99215, 99304-99306, 99307-99310, 99315-99316, 99318, 99334-99337, 99347-99350, 99406, 99407, 99495, 99496, 99497, G0101, G0102, G0108, G0117-G0118, G0270, G0296, G0442, G0443, G0444, G0445, G0446, G0447, G0490, Q0091

Visit: IPPE or AWV (G0468)

- G0402, G0438, G0439

Additional Services

- G0436, G0437

Plan reserves the right to deduct from Provider's Capitation Fee for any expenses incurred due to Provider's non-compliance with the responsibilities described herein.

Services Not Included in the Capitation Fee

Provider is compensated on a fee-for-service basis for providing Medically Necessary, Covered Services to Members who need non-primary care services for which Provider is trained and qualified to provide. Provider shall be reimbursed on a FFS basis based on the Specialty Care Services rate in Attachment C.1.

ATTACHMENT D

INSURANCE COVERAGE FORM

Date: 7-6-2020

To: PRISM
PRINT name of insurance carrier

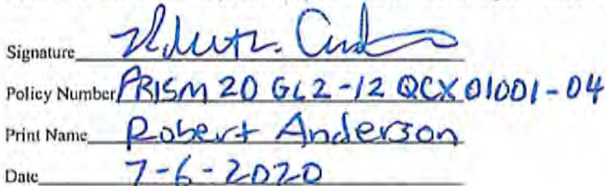
75 Iron Point Circle Ste.200 FOLSOM, CA 95630
PRINT address, city, state, and zip code

Re: Continuous Authorization for Insurance Coverage Information Release

I hereby authorize you to send a Certificate of Insurance, identifying my policy, its effective and expiration dates, policy limits, endorsements and exclusions, if any, to:

Adventist Health Plan, Inc.
ONE Adventist Health Way
Post Office Box 619002
Roseville, CA 95661-9002
Attention: Vice President Plan Operations

Additionally, I authorize and direct you to submit notice of renewals, changes in coverage amounts, and/or cancellations to Adventist Health Plan, Inc. at least thirty (30) days prior to the renewal, change or cancellation date.



Signature ______

Policy Number PRISM 20 GL2-12 QCX 01001-04

Print Name Robert Anderson

Date 7-6-2020

ATTACHMENT E

DISCLOSURE FORM
(Welfare and Institutions Code Section 14452)

____
Provider

The undersigned hereby certifies that the following information regarding __________ (The "Provider") is true and correct as to the date set forth below:

Officers/Directors/General Partners:

____

____

Co-Owner(s):

____

____

Stockholders owning more than ten percent (10%) of the stock of the Provider:

____

Major creditors holding more than five percent (5%) of Provider Debt:

____

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

____

If not already disclosed above, is Provider, either directly or indirectly related to or affiliated with Adventist Health Plan, Inc? Please explain:

____

____

Dated:______________________________

Signature:___________________________

Name:______________________________Title:____________________

ATTACHMENT F

PROVIDER PHYSICIANS

I certify that I am a physician employee or otherwise contractually obligated to Provider to provide specific covered services to Plan Members contracting with Provider. I agree to be bound by the terms and conditions of this Agreement for and on behalf of Provider.

Print Name/Title	Signature / Date	Individual NPI #
Sukhvinder Bhajal, MD		13646270113
Shyam Bhaskar, MD		1194788158
Daniel Boken, MD		1538250808
Jessica Camarena, PA		1518278688
Kai-Lieh Chen, MD		1548384712
Kirk Coverston, MD		1487726915
N. Elise Cyrus, NP		1912567587
Devon Dimond, MD		1134521750
Liliana Gelvez, MD		1205972957
Laurie Hagopian-Dresser, MD		1578513610
Farnoush Karimpour, NP		1902248859
Pawan Kumar, MD		1972541829
Hoang Le, MD		1205075348
Nicholas Lin, MD		1417168998

Henry Ow-Yong, MD		1154435428
Joseph Ruda, MD		1760466395
Harish Shah, MD		1649264060
Naeem Siddiqi, MD		1134190374
Side Xi, MD		1679643688

ATTACHMENT G

CMS MEDICARE ADVANTAGE
REGULATORY REQUIREMENTS

Code of Regulations §	**Description of Requirement.**
Exhibit 422.504(e)(2); 422.504(e)(3); 422.504(i)(2)(ii); 422.504(e)(4)	Provider grants Contracted Health Plan ("Plan"), DHHS, CMS, GAO and their respective designees the right to audit etc. for 10 years or periods exceeding 10 years or completion of an audit, whichever is later.
Exhibit 422.504(a)(3)(iii); 422.118	Provider agrees to comply with all confidentiality and enrollee record accuracy requirements.
Exhibit 422.504(g)(1)(I)	Provider agrees that Enrollees will not be liable for payment of moneys owed by Plan or Provider. Provider agrees, and will require its Participating Providers to agree, not to, under any circumstances bill, charge, collect a deposit from, seek compensation from, seek remuneration from, seek reimbursement from, impose a Surcharge on, bring a collection action at law or in equity against, or have any recourse against an Enrollee or persons acting on behalf of Enrollee (other than Plan), except to the extent that Co-payments are specified in Plan's agreement with CMS or for Non-covered Services.
Exhibit 422.504(i)(3)(iii); 422.504(i)(4).	Provider shall specify the delegation requirements in a written delegation agreement, in manner consistent with federal regulations.
Exhibit 422.520(b).	The financially responsible party shall pay all clean claims for Covered Services, including Covered Services rendered by non-contracted but authorized providers, within the shorter of: the time period required by law; the time period required by Plan's agreement with CMS; or the time period required by subcontract with the provider. The term "complete claim" shall have the meaning given the term in the Medicare regulations (currently at 42 CFR §422.500).
Exhibit 422.516 and 422.310, 422.504(a)(8)	Provider shall comply with reporting requirements by providing Plan at its request with information (while safeguarding confidentiality) with respect to: the cost of care; patterns of utilization; availability, accessibility and acceptability of services; developments in the health status of the members assigned to Provider; fiscal soundness of Provider's operation; significant business transactions; loans to subcontractors and related entities; risk adjustment data; and other data and information as reasonably requested by CMS.

Section 2.01 Section 2.02 Code of Regulations §	Description of Requirement. Subcontractors and Sub-subcontractors must:
Exhibit 422.504(i)(3)(ii) & (4).	Provider agrees that to the extent that any of Plan's activities or responsibilities under its contract with CMS are delegated to Provider or by Provider to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider: (a) Written arrangements must specify delegated activities and reporting responsibilities. (b) Written arrangements must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the Plan determine that such parties have not performed satisfactorily. (c) Written arrangements must specify that the performance of the parties is monitored by the Plan on an ongoing basis. (d) Written arrangements must specify that either: (i) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the Plan; or (ii) The credentialing process will be reviewed and approved by the Plan and the Plan must audit the credentialing process on an ongoing basis. (e) All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and CMS instructions. If the Plan delegates selection of the providers, contractors, or subcontractor to another organization, the Plan's written arrangements with that organization must state that the CMS-contracting Plan retains the right to approve, suspend, or terminate any such arrangement.
Exhibit 422.504(i)(4)(v).	Provider shall comply with applicable Medicare laws, regulations, guidelines and CMS instructions and contractually require contractors and subcontractors to do the same.
Exhibit 422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)	To provide for continuation of enrollee health care benefits, Provider agrees, and will require its contracted or subcontracted Providers, if any, to agree that, notwithstanding any termination of this Agreement or Plan's agreement with CMS, to continue the provision of Covered Services: (i) For all enrollees, for the duration of the contract period for which payments have been made; and (ii) For enrollees who are hospitalized on the date this Agreement or the Plan's agreement with CMS terminates, or, in the event of an insolvency, through date of discharge; and, (iii) For any longer period required by state or federal law, or otherwise specified in this Agreement.
Exhibit 422.110(a)	Provider shall not discriminate against members based on health status, which includes but is not limited to: physical or mental condition, claims experience; utilization of services; medical history; genetic information; evidence of insurability; and disability.
Exhibit 422.112(b); 422.113; 422.100(b)	If capitated for emergency medical services, Provider shall pay for emergency and urgently needed care consistent with Medicare regulations.
Section 2.03 Code of Regulations §	**Description of Requirement. Subcontractors and Sub-subcontractors must:**
Exhibit 422.100(b)(1)(iii)	If capitated for emergency medical services and/or renal dialysis services, Provider shall pay for renal dialysis for those temporarily out of service area, in accordance with Medicare regulations.
Exhibit 422.100(g)(1).	Provider understands that Members have a right to direct access to mammography screening and influenza vaccinations, without authorization from the PCP or from Plan.

Exhibit 422.100(g)(2)	Provider understands that in Plan's Medicare Advantage Program there are no copayments for influenza and pneumococcal vaccines.
Exhibit 422.112(a)(1)	Provider agrees to notify Plan in advance of the loss of any contractors or subcontractors and to advise Plan how that gap in the network will be filled. The Plan's network must be sufficient at all times to provide access to covered services.
Exhibit 422.112(a)(3)	Members have the right to direct access to in-network women's health specialist for routine and preventive services, without prior authorization from Plan or PCP.
Exhibit 422.204; 422.504(i)(4).	A Provider Agreement and any subcontract entered into by Provider may be suspended or terminated or any delegated activity may be revoked, or other remedies may apply, in instances where CMS or the MA organization determine that Provider or one of its Participating Providers, if any, have not performed satisfactorily.
Exhibit . 422.112(a)(7)	If Provider is a physician, physician network (IPA, medical group or clinic), hospital or skilled nursing facility, Provider must make Covered Services available 24 hrs/day, 7 days/week.
Exhibit 422.80(a), (b), (c)	If Provider is asked to assist Plan with any marketing functions, or to distribute marketing or membership materials in the waiting room, Provider shall adhere to CMS marketing provisions.
Exhibit 422.112(a)(8)	Provider shall ensure services are provided in culturally competent manner to all enrollees, including those with limited English proficiency or reading skills and diverse cultural and ethnic backgrounds.
Exhibit 422.112(b)(5).	If Provider is a primary care physician or physician network, Provider must conduct a health assessment of all new enrollees assigned to Provider within 90 days of the effective date of enrollment or verify that Plan has already done so.
Exhibit 422.128(b)(1)(ii)(E)	Provider shall document in a prominent place in medical record if individual has executed Advance Directive.
Exhibit 422.504(a)(3)(iii)	Provider shall provide Covered Services in a manner consistent with professionally-recognized standards of health care.
Section 2.04 Code of Regulations §	**Description of Requirement. Subcontractors and Sub-subcontractors must:**
Exhibit 422.208	Provider understands that all payment and incentive arrangements between the Plan and its providers and Provider and any first tier, & downstream contractors and subcontractors must be specified in the written contract(s) with those entities.
Exhibit 422.504(h)(1)	Provider understands that the moneys used to pay Provider under this Agreement are in whole or in part federal funds. Provider shall also comply with all laws and regulations governing the use of federal funds, including but not limited to criminal laws, anti-kickback laws, the False Claims Act, the Civil Rights Act, the Americans with Disabilities Act and the Age Discrimination.
Exhibit 422.64(a): 422.504(a)(4): 422.504(f)(2)	Provider agrees to disclose to Plan, who will disclose to CMS, all information necessary to: (1) administer & evaluate the program; and (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services.

Exhibit 422.111(e)	Provider shall make good faith effort to notify Plan of the termination of a provider contract or subcontract, at least 75 days prior to the proposed termination date, so that Plan may notify affected members within the time period required by Federal and/or State law.
Exhibit 422.502(a)(8); 422.502(1)(2) & (3)	By submitting claims or encounter data to Plan, Provider will be deemed to have certified the completeness and truthfulness of the claim or data. Plan will be relying to its detriment on that certification when it submits the data to CMS and certifies to that agency the completeness and truthfulness of the aggregated encounter data.
Exhibit 422.202(b); 422.504(a)(5)	Upon request, Provider shall consult with Plan as Plan develops or amends its medical and quality management policies. Provider shall comply with all applicable Plan policies and procedures, including but not limited to those on medical and quality management.
Exhibit 422.504(f)(2)(iv)(A), (B) & (C)	Provider understands that Plan must disclose to CMS certain quality and performance indicators relating to the provision of Plan benefits, including but not limited to Member satisfaction levels, outcomes, compliance with Applicable Requirements, number and type of grievance appeals, dis-enrollment rates for Medicare beneficiaries enrolled in Plan for the previous two years. Performance levels can affect the rate of payment from CMS and Plan's ability to retain its agreement with CMS. Provider shall cooperate with Plan in its efforts to achieve acceptable performance levels and shall take corrective action necessary to raise unacceptable performance levels.
Exhibit 422.204(c)(1)	Plan will notify Provider in writing of the reason for any denial, suspension & termination of the Agreement. Provider shall notify its subcontracting providers, if any, in writing of the reason for any denial, suspension & termination of their subcontracts.
Section 2.05 Code of Regulations §	**Description of Requirement. Subcontractors and Sub-subcontractors must:**
Exhibit 422.204(c)(4)	To promote continuity of care and adequate notice to Members, Provider shall provide at least sixty (60) days notice to its subcontracting providers, if any, before terminating any subcontract without cause.
Exhibit 422.752(a)(8)	Provider shall not employ or contract with, or allow its subcontractors, if any, to employ or contract with, individuals excluded from participation in Medicare under section 1128 or 1128A of the SSA or other federal program. Provider shall notify Plan immediately if it, or any of its employees or subcontractors have been debarred from any federal program.
Exhibit 422.562(a)	Provider shall cooperate with Plan's grievance and appeals committee and shall adhere to appeals/grievance procedures and decisions.

ATTACHMENT H

KNOX-KEENE REQUIREMENTS

The following chart sets forth the requirements of the Knox-Keene Act and its implementing regulations ("Knox-Keene Act"). Plan, Plan Sponsors and Provider are all subject to applicable provisions of the Knox-Keene Act, as amended from time to time. In the event of any inconsistency between this Exhibit and the Knox-Keene Act, or any other term of this Agreement and the Knox-Keene Act, the Knox-Keene Act shall prevail. Throughout this chart, references to Plan include Plan and Plan Sponsors, as applicable.

Subject Area	H&S Code Section	Description
SECTION 1 – GENERAL REQUIREMENTS FOR PROVIDER CONTRACTS		
Fair and Reasonable Contracting	Section 1367(h)	Provider contracts must be fair, reasonable, and consistent with the Act. **See Article VII**
Records	Rule 1300.67.8(b)	**Specific Provision Required:** Provider contracts must include a requirement for providers to maintain records, , provide the Department access to the records, and retain records for at least two years. This survives contract termination by operation of law. **See Section 7.5 and Article VIII**
Confidentiality of provider compensation	Rule 1300.67.8(a)	A written provider contract shall be arranged in a manner that permits confidential treatment of provider pay by the Director. **See Article IV and Attachment C**
Plan's access to provider records	Rule 1300.67.8(c)	The Plan shall have access at reasonable times upon demand to the books, records and papers of the provider. **See Section 7.5 and Article VIII**
Surcharges Prohibited	Rule 1300.67.8(d)	**Specific Provision Required:** A provider contract shall prohibit surcharges for covered services. **See Section 4.4**
Specific incentive to deny, reduce, limit, delay services prohibited	Section 1348.6 1367.62(a)(3)	The contract cannot contain any incentive plan, whether in cash or in kind, with specific payment to induce denial, reduction, limitation or delay of medically necessary and appropriate services.
Enrollee Held Harmless Provision	Section 1379	**Specific Provision Required:** Every contract between a plan and a provider shall be in writing and provide that if the plan fails to pay for health care services as stated in the contract, the enrollee shall not be liable to the provider for any sums owed by the plan. **See Sections 4.2 and 4.4**

Subject Area	H&S Code Section	Description
SECTION 1 – GENERAL REQUIREMENTS FOR PROVIDER CONTRACTS – CON'T		
Language Assistance	Section 1367.4(f) Rule 1300.67.04(e)(4) 1300.67.04(e)(4)(B)	**Specific Provision Required:** The contract shall require compliance with language assistance standards and require providers to provide information necessary to assess compliance. Delegation of any part of the plan's language assistance obligation is a material modification of the provider contract. **Provider must comply with Plan Sponsor requirements.**
Communications to Enrollees	Section 1373.65; Rule 1300.67(b)(1)(l)	**Specific Statutory Language Required:** Plans and providers must include in all written, printed, or electronic communications sent to enrollees re contract termination or block transfer the specific notice and font providing contact info for HMO help Center. **This is the responsibility of Plan Sponsors; Plan and Provider must coordinate in the event of a termination or block transfer.**
Provider Directory Update and Maintenance	Section 1367.27	Provider must notify Plan and Plan Sponsors if Provider is not accepting new patients. Plan and Plan Sponsors must notify the DMHC and update Provider Directories in a timely manner to assure that Members have current information regarding provider access. **See Sections 3.27-3.31**
SECTION 2 – CONTINUITY OF CARE & TERMINATION		
Continuity and Coordination of Care Services Provided by a Terminated or Nonparticipating Provider	Sections 1367 (d) & (j); 1373.96 (b) , (c) & (d)	Plans may include in the contract the obligation that provider groups and its providers ensure for continuity of care and ready referral for needed specialty care. Plans remain ultimately responsible. Upon enrollee request, plans must arrange and pay for a terminated provider [or a non-participating provider for a new enrollee] to continue to provide completion of covered services to an enrollee who has any of the following defined conditions: • Acute Condition • Serious chronic condition • Pregnancy and partum period • Terminal illness • Newborn child (up to 36 months) • Authorized surgery or procedure (within 180 days) Exception: not required if the provider does not agree to continue to provide services. **See Section 15.6**

Subject Area	H&S Code Section	Description
SECTION 2 – CONTINUITY OF CARE & TERMINATION – CON'T		
Payment for Continuous Care Provided by a Terminated or Nonparticipating Provider	Sections 1367(d); 1373.96 (d), (f) & (g)	The Plan may include a provision requiring a terminated provider to accept current contracting rates, terms and conditions. Similarly, a Plan can contract with a nonparticipating provider to provide for continuing care services under the same terms and conditions as participating providers. Absent an agreement, a terminated or nonparticipating provider must be compensated for services in a continuity of care situation at rates and methods of payment similar to those used by the plan or provider group for currently contracting, non-capitated providers who provide similar services and practice in the same or a similar geographic area. If the provider does not agree to comply with current terms/conditions of contracting providers, there is no plan obligation to continue his or her services. **See Section 15.6**
Requirements Regarding the Completion of Covered Services	Section 1373.96(a)-(e), (j)	This section provides the circumstances under which a health plan must arrange for the completion of covered services by a terminated provider [or a non-participating provider for a new enrollee] to enrollees that have specified conditions listed above if (1) the enrollee begins coverage under the health plan while receiving certain services from a non-participating provider, or (2) the enrollee receives certain services from a terminated provider at the time of the contract's termination. Exception: Continuity of care n/a to new enrollee if offered out of network option or option to continue w/previous provider. Limitations: this obligation arises upon request of the enrollee, and is subject to the provider's agreement. See **Section 15.6**
Plan & Delegated Provider	Section 1373.96(g);	A plan that delegates the responsibility of complying with Section 1373.96 to a provider group must ensure that the requirements of Section 1373.96 are met. The plan remains ultimately responsible.
Notice to Enrollees of a Provider Termination and Transfer to a New Provider	Sections 1373.65 (b) (c) & (d)	Termination Notice: Requires a health plan to send written notice to enrollees who are assigned to a terminated provider group or hospital at least 60 days prior to the termination date of a contract between the health plan and a provider group or general acute care hospital. If group has exclusive admitting privileges include enrollees who reside within 15 mile radius of hospital.
	Section 1373.65(f)	Requires a plan and a provider to include in all written, printed, or electronic communications to an enrollee concerning contract termination or block transfer a statement that the enrollee may have the right to keep his or her provider for a designated time period. *Caveat: Enrollee communications are subject to statutory language requirements.*
	Section 1373.65(d)	If an individual provider terminates his or her contract with a provider group that contracts with a health plan, the plan may delegate the enrollee notice requirement but such delegation should address the statutory language requirements.
Notice of Available Providers	Section 1367.26	A Plan must provide to enrollees, upon request, a list of contracting providers within the enrollee or prospective enrollee's general geographic area. The Plan may direct enrollees to Plan website for information. A plan may requires its contracting providers, contracting provider groups, or contracting specialized plans to satisfy these requirements and ensure requirements are met [see subdivision (f)]

Subject Area	H&S Code Section	Description
SECTION 3 – BILLING		
Plan Liable for Covered Services of Terminated Provider (Financial Responsibility)	Rules 1300.67.4(a)(10) & 1300.67.8(e)	**<u>Specific Provision Required</u>** The provider contract shall include a provision that upon termination of the provider contract, the plan is liable for covered services rendered by the provider to an enrollee who retains eligibility and is under the care of the terminated provider from the time of termination until the time services are completed, unless the plan makes reasonable and medically appropriate provision for the assumption of services by another contracting provider. Note: This section refers broadly to a "provider contract." Not limited to acute care hospital or provider group. **See Section 15.6**
Rescission or Modification of Authorization after Services are Provided	Section 1371.8	Authorizations: A plan that authorizes a specific type of treatment shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to the authorization. This requirement does not expand or alter the benefits available to the enrollee or subscriber under a plan.
Prohibition on Provider Balance Billing Note: Plan subject to fine per each provider contract that does not contain required provision. Section 1393.5	Section 1379; Rule 1300.71(g)(4)	**<u>Specific Provision Required.</u>** Every Plan contract with a Provider shall include a provision stating that, except for applicable co-payments and deductibles, a provider shall not invoice or balance bill a plan's enrollee for the difference between the provider's billed charges and the reimbursement paid by the plan (or the plan's capitated provider) for any covered benefit. **See Section 4.4**
Provider Surcharges	Section 1385	Every plan must require all contracting providers to report to the plan in writing all surcharge and co-payment moneys paid by subscribers and enrollees directly to such providers, unless the director expressly approves otherwise.
Provider Surcharges	Rules 1300.67.8(d) & 1300.45	**<u>Specific Provision Required.</u>** Provider contracts shall prohibit surcharges for covered services and provide that whenever the plan receives notice of any such surcharge it shall take appropriate action. **See Section 4.4**
Limitation on Liens and Third Party Recoveries	Civil Code Section 3040	If Third Party Liability is addressed in the contract, recoveries are subject to the monetary limits described in Civil Code § 3040.

Subject Area	H&S Code Section	Description
SECTION 4 – CONTRACT CHANGES		
Material Changes to a Provider Contract	Section 1375.7(b)(1)(A)	A plan must provide at least 45 business days' notice of its intent to change a material term of the contract, and the provider has the right to negotiate and agree to the change, unless the change is necessary to comply with state or federal law or regulations or any accreditation requirements. Provider has the right to terminate the contract if the plan and provider cannot agree to the material change. **See Section 18.11**
Changes to Provider Dispute Resolution Mechanism	Section 1367(h)(1)	A plan must inform its providers upon any change to its provider dispute resolution mechanism.
Material Changes to Documents Incorporated by Reference in the Provider Contract	Section 1375.7(b)(1)(A)	Does not permit a plan to make material changes to a manual, policy or procedure document referenced in the provider contract without giving the provider 45-business days' notice and the opportunity to negotiate and terminate the contract. This may be waived upon mutual agreement of the parties. Note exception, below (change in law, accreditation body).
Material Changes Due to State or Federal Law, or Accreditation Body	Section 1375.7(b)(1)(A)	The plan may change a material term of the contract to comply with federal law or regulations or any accreditation requirements of a private sector accreditation organization. The Plan may provide less than 45-day notice of the change to a material term if the change in the state or federal law or regulations or any accreditation requirements requires a shorter timeframe for compliance. **See Section 18.11**
Notice Prior to Modification of Claims Processing Procedures, Fee Schedules and Claims Payment Procedures	Rule 1300.71(m)	For changes in the Disclosures Made Pursuant to Rule 1300.71(l) [Information for Contracting Providers] and (o) [Fee Schedules], plans and its capitated provider(s) are prohibited from making changes, amendments or modification in the disclosures required by Rule 1300.71(l) and (o) without 45 days notice.
Disclosure of Fee Schedule Factors	Rule 1300.75.4.1(b)	**<u>Specific Provision Required</u>** Every contract involving a risk-sharing arrangement between a plan and an organization shall require the plan to disclose the amount of payment for each and every service to be provided under the contract, including any fee schedules or other factors or units used to determine the fees for all services.
SECTION 5 – CLAIMS		
Reimbursement of claims and Contested Claims	Sections1371 & 1371.35; Rules 1300.71(e)(1) & (g)	Timeframe for reimbursement of claims: A plan shall reimburse claims or any portion of any claim as soon as practical, but no later than 30 working days after receipt of the claim (or 45 working days if the plan is an HMO), unless the claim or portion thereof is contested by the plan. If contesting the claim, the plan must notify the claimant in writing that the claim is contested or denied within 30 working days after receipt of the claim (or 45 working days if the plan is an HMO). These requirements also apply to claims processing organizations, plans or capitated providers that process or pay claims on behalf of the plan.

Subject Area	H&S Code Section	Description
SECTION 5 – CLAIMS – CON'T		
Contesting Claims	Sections 1371 & 1371.35; Rules 1300.71(h)	A plan may contest a claim in writing no later than 30 working days (45 working days if the plan is an HMO). The notice that a claim is being contested must identify the portion of the claim that is contested and the specific reasons for contesting the claim.
Notice of Denial or Modification	Rule 1300.71(h)(3)	A plan's notice of denial/contesting of a claim must identify the individual or entity that was requested to submit information, the specific documents requested, and the reason(s) why the information is necessary to determine payor liability.
Incomplete Claims	Section 1371.35(a)	Notice Requirements: The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim.
Completed Claim, Institutional Provider	Section 1371.35(c) Rule 1300.71(a)(2)	A claim or portion thereof is reasonably contested if the plan has not received a completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim.
Completed Claim, Professional Provider	Section 1371.35(c) Rule 1300.71(a)(2)	A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. **See Attachment C**
Substantiation by Provider Claims	Rule 1300.71(a)(2) & (a)(8)(G); 1300.71(a)(10), and 1300.71(a)(11)	To substantiate the claims payment, the provider does not have to submit more than: a) "Reasonably relevant information" Rule 1300.71(a)(10); b) "Information necessary to determine payer liability" Rule 1300.71(a)(11); and, c) The information detailed in Rule 1300.71(a)(2).
Medical Records	Rule 1300.71(a)(8)(G)	**<u>Specific Provision Prohibited</u>:** The provider contract must not require the provider to submit medical records that are not reasonably relevant to claims payment as defined by Rule 1300.71(a)(10) for the adjudication of a claim on three or more occasions over the course of any three month period.

Subject Area	H&S Code Section	Description
SECTION 5 – CLAIMS – CON'T		
Good Cause Exception	Rule 1300.71(b)(4)	Requires a plan to accept and adjudicate a claim filed beyond the deadline when the provider submits a provider dispute pursuant to Section 1300.71.38 and demonstrates good cause for the delay.
Timeframe for Contesting or Denying Claims	Rule 1300.71(h)	A plan, and a plan's capitated provider, may contest or deny a claim, or portion of a claim, by notifying the provider in writing that the claim is contested or denied within 30 working days after the date of receipt of the claim by the plan (45 days for HMO).
Acknowledgement of Claims Receipt	Rule 1300.71(c)	Requires a plan and the plan's capitated provider to identify and acknowledge the receipt of electronic claim within 2 working days of receipt and a paper claim within 15 working days of receipt.
Acknowledgement Date of Claims Receipt	Rule 1300.71(a)(6)	Date of receipt is the working day when the claim is first delivered, physically or electronically, to the plan's specified claims payment office, post office box, designated claims processor or the responsible capitated provider.
Criteria for Interest and Penalties	Sections 1371 & 1371.35(b); Rules 1300.71.38(g), 1300.71(i) & (k)	Illustrates that a plan pay interest on: a) Uncontested claims not timely paid; b) Frivolous contested claims; c) Claims where the plan supplies late or no notice of the claim being contested or denied; and, d) Payment adjustments made if the provider dispute involves a claim and is determined in whole or in part in favor of the provider.
Amount of Interest and Penalty	Section 1371 Rule 1300.71(i)(1) & (2)	If a plan fails to make timely reimbursement of an uncontested claim, the plan must pay interest to the provider, at the rate of 15% per year, from the date claim should have been paid. However, for claims that involve emergency services and care, the plan shall pay the provider the greater of $15 per year or portion of year on a non prorated basis or 15% interest per annum for the period of time that the payment is late.
Calculation of Interest and Penalty	Rule 1300.71(i) & (j)	Explains how a plan calculates interest and penalty on a late payment. Plan shall pay the provider a $10 penalty when it fails to automatically include the interest due to the provider with a late claim payment.
Timeframe for Interest and Penalty	Rule 1300.71(k)	Interest on late claims or frivolous requests accrues starting from the first calendar day after the expiration of the Time for Reimbursement defined in 1300.71(g).
Required payments after Written Determination	Rule 1300.71.38 (g)	Plan must pay amounts determined to be due, as well as all interest and penalties, within five (5) working days of the issuance of the plan's Written Determination.
Date upon which Interest and Penalty accrues	Rule 1300.71.38(g)	When a provider dispute involving a claim is determined in whole or in part in favor of the provider, accrual of related interest and penalties shall commence on the day following the expiration of the "Time for Reimbursement."

Subject Area	H&S Code Section	Description
SECTION 5 – CLAIMS – CON'T		
Reimbursement of Overpayment of Claims	Section 1371.1; Rule 1300.71(b)(5)	When a plan notifies the provider in writing through a separate notice identifying the overpayment and the amount of the overpayment (the notice must be within 365 days of the date of payment), the provider must reimburse the plan within 30 working days of receipt of the notice, unless the provider contests the overpayment or portion thereof. The provider has 30 working days to contest the overpayment in writing to avoid interest at the rate of 10 percent per year accruing from the first calendar day after the 30-working day period.
Provider Protest of Reimbursement Notice:	Section 1371.1; Rule 1300.71(d)(4)	A provider who contests a reimbursement of an overpaid claim must notify the plan in writing within 30 working days of receipt of the plan's overpayment notice. The notice shall state the basis upon which the provider believes that the claim was not over paid.
Reimbursement Interest:	Section 1371.1	If a provider does not reimburse a plan for an overpaid claim within 30 working days, interest accrues at the rate of 10 percent per annum beginning with the fist calendar day after the 30-working day period.
Prohibited Request for Reimbursement or Reduction of Level of Payment:	Section 1371.2	A plan cannot request reimbursement for overpayment or reduce the level of payment to a provider based solely on the allegation that the provider has contracted with any other licensed health plan.
Overpayment Notice Deadline:	Rule 1300.71(b)(5)	Prohibits a plan from requesting reimbursement for the overpayment of a claim unless the plan sends a written request for reimbursement to the provider within 365 days of the date of payment on the overpaid claim
Requirements for Notice:	Rule 1300.71(d)(3)	A plan's notice of reimbursement to a provider must be in writing, identify the claim, the name of the patient, and the date of service, and explain the basis upon which the plan or the plan's capitated provider believes the amount paid on the claim was in excess of the amount due.
Overpayment Rebuttal	Rule 1300.71(d)(4)	If a provider contests a plan's notice of reimbursement of the overpayment of a claim, the provider shall within 30 working days of the receipt of the notice send written notice to the plan stating the basis for the provider's belief that the claim was not overpaid.
Overpayment Repayment	Rule 1300.71(d)(5)	If a provider does not contest the plan's notice of reimbursement of the overpayment of a claim, the provider shall reimburse the plan or the plan's capitated provider within 30 working days of the receipt of the notice of overpayment
Overpayment and Offsets	Rule 1300.71(b)(5) & (d)(6)	A plan or a plan's capitated provider may offset an overpayment only when (i) the provider fails to reimburse the plan or the plan's capitated provider within 30 working days for an uncontested overpayment or (ii) the provider has entered into a written contract specifically authorizing the plan or the plan's capitated provider to offset an uncontested notice of overpayment of a claim.

Subject Area	H&S Code Section	Description
SECTION 5 – CLAIMS – CON'T		
Explanation of Claim Denial, Contest, and Adjustment	Rules 1300.71(d)(1) & (h)	For each claim that is denied, adjusted or contested a plan shall provide an accurate and clear written explanation of the specific reasons for the action taken by the plan within 30 working days after the date of receipt of the claim by the plan and the plan's capitated provider (45 working days if the plan is an HMO).
Timeframes for Claims Adjudication	Section 1371	Timeframes for the Adjudication of Claims must be no later than 30 working days of receipt of claim (45 days HMO)
Explanation of Claim Denial, Contest, and Adjustment	Section 1371.37	Plan is prohibited from engaging in an unfair payment pattern by delaying the processing of complete claims, reducing the amount of payment or denying complete and accurate claims, repeatedly failing to pay the uncontested portion of a claim within the timeframes noted above, and repeatedly failing to automatically include interest due on claims pursuant to Section 1371.
Request for Additional Claim Information	Section 1371.35(a) & (c) Rule 1300.71(d)(2)	A plan must submit a clear and specific written request to the provider for additional information to make a complete claim. The written notice to a provider must identify, by revenue code, the specific portion of the claim that the plan is contesting, outline the reasonable grounds for contesting each claim and state what information is required of the provider in order for the plan to reconsider the claim. The plan or the plan's capitated provider shall also provide a clear, accurate and written explanation of the necessity for the request. A provider shall submit the additional information the plan needs to a complete claims within 10 working days of receipts. If the plan requires further information than what is sent by the provider, the plan has an additional 15 working days to request the new information.
Reasonably Relevant:	Rule 1300.71(a)(10)	Minimum amount of itemized, accurate, and material information required for a competent claims adjudicator to determine the nature, the cost, and (if applicable) the extent of the plan's or the plan's capitated provider's liability.
Denial for Provider's Failure to Submit Requested Information	Rule 1300.71(d)(2)	Plan must use provider dispute resolution mechanism to handle and resolve a provider dispute when a plan denies a claim because the provider failed to submit information requested.
Requests not Reasonably Relevant	Rule 1300.71(a)(8)	Prohibits practices, policies, and procedures that result in repeated delays in the adjudication and correct reimbursement of provider claims. This includes requests by the plan for information not considered reasonably relevant.
Disclosure of Claims Submission Requirements	Rule 1300.71(l)	At the time of initial contract and on a contracted provider's written request, a plan and the plan's capitated provider shall disclose its "Information for Contracting Providers" including directions regarding the submission, documentation and handling of provider claims and disputes.
Pro Forma Copy:	Rule 1300.71(n)	A plan and a plan's capitated provider must furnish to the Department a pro forma copy of the plan's and the plan's capitated provider's "Information to Contracting Providers" and "Modification to the Information for Contracting Providers" within 7 calendar days of the Department's request.

Subject Area	H&S Code Section	Description
SECTION 5 – CLAIMS – CON'T		
Disclosure of Fee Schedule	Rule 1300.71(o)	A plan and a plan's capitated provider must disclose to a provider initially upon contracting and annually thereafter the complete fee schedule and the detailed payment policies, rules, and non-standard coding methodologies used to adjudicate claims.
Risk Arrangement Disclosure	Rule 1300.75.4.1(b)	Every contract involving a risk-sharing arrangement between a plan and a risk bearing organization shall require the plan to disclose the amount and calculation of payment for each and every service to be provided under the contract. For any proprietary fee schedule, the contract must include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.
Unfair Payment Patterns	Section 1371.37(b), (c) & (d); Rules 1300.71(a)(8), 1300.71(s)(1) & (4) &	A "demonstrable and unjust payment pattern" or "unfair payment pattern" means any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of a provider claim. There are 26 prohibited unjust payment patterns from payers to providers, such as: • The failure to provider a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim; • The inclusion of a contract provision in a provider contract that requires the provider to submit medical records that are not reasonably relevant; • The failure to reimburse at least 95% of complete claims with the correct payment over the course of any three-month period; • The failure to provider the Information for Contracting Providers and Fee Schedule and other required information disclosures over the course of any three-month period; • The failure to provide three (3) or more contracted providers the required notice for Modifications to the Information for Contracting Providers and to the Fee Schedule and other required information over the course of any three-month period.
Department's Authority	Rule 1300.71(s)(1)	The Department may review the plan's and the plan's capitated provider's claims processing system through periodic medical surveys, financial examinations, and the investigation of complaints. The Department's findings of evidence of unjust payment patterns may result in enforcement action by the Department.
	Rule 1300.71(s)(4)	Issues the Director May Consider in Making Unjust Payment Pattern Determination: Documentation or justification for the implementation of the practice, policy or procedure; the aggregate amount of money involved in the cited action or inaction; the number of claims adjudicated by the plan during the time period in question; legitimate industry practice; potential impact of the payment practices on the delivery of health care or on provider practices; the plan's intentions or knowledge of the violation(s); the speed and effectiveness of remedial measures implemented to ameliorate harm to providers or patients or to preclude future violations; and, any previous similar or related enforcement actions involving the plan.

Subject Area	H&S Code Section	Description
SECTION 5 – CLAIMS – CON'T		
Reporting of Unfair Patterns	Section 1371.39	Describes how a complaint may be made to the Office of Provider Oversight (1) by a plan that believes a provider is engaged in unfair billing patterns or (2) by a provider that believes a plan is engaged in unfair payment patterns.
Waiver Prohibited	Section 1300.71(p)	**Specific Provisions Prohibited** The plan and its capitated provider shall not require or allow a provider to waive any right conferred upon the provider for any obligation imposed upon the plan by Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8, and Rules 1300.71, 1300.71.38, 1300.71.4, 1300.77.4. Any contractual provision or other agreement purporting to constitute, create or result in such a waiver is null and void. **See Section 7.8**
SECTION 6 – CONTRACTUAL DISPUTES		
Fast, Fair and Cost-Effective Dispute Resolution Mechanism	Section 1367 (h)(1)	**Specific Provision Required** All Provider Contracts shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan. Provider contracts must also contain provisions requiring the plan to inform its providers upon contracting with the plan, or upon change of these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted. **See Exhibit I**
Dispute Resolution Mechanism - Requirements	Rule 1300.71.38	The dispute resolution mechanism is subject to further regulatory requirements including, but not limited to, notice provisions, time periods for submission of disputes, time periods for acknowledgement, time periods for resolution and written determination, and past due payments. **See Exhibit I**
Definition of Provider Dispute	1300.71.38(a)	Provider Dispute is defined in Rule 1300.71.38(a).
Separate Provider Dispute Resolution mechanisms for contracted and non-contracted providers	Rule 1300.71.38	The plan and the plan's capitated provider that pays claims may maintain separate dispute resolution mechanisms for contracted and non-contracted provider disputes, provided that each mechanism complies with Sections 1367(h), 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.37, 1371.4, and 1371.8.
Notice of Provider Dispute Resolution Mechanism	Section 1367(h)(1); Rule 1300.71.38(b)	A plan shall inform a contracting provider of the provider dispute resolution mechanism at the time the contract is initially executed and upon a change to the contract provisions. When contesting, adjusting, or denying a claim, a plan and a plan's capitated provider that pays claims shall inform the provider of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions for filing a provider dispute.

Subject Area	H&S Code Section	Description
SECTION 6 – CONTRACTUAL DISPUTES – CON'T		
Events Triggering the Dispute Resolution Mechanism	Rule 1300.71(d)(2), (d)(4), (e)(2), (e)(5) & (g)(3)	Subjects: Non-exclusive list of events triggering the provider dispute resolution mechanism include: • Denial by the plan or the plan's capitated provider that pays claims due to provider's failure to furnish requested information; • Contested notice of overpayment; • Provider disputes with a capitated provider delegated to pay claims for the plan; • Non-contracting provider disputes appropriateness of computation of the reasonable and customary value of a service.
Provider Disputes Submitted on behalf of an Enrollee are not part of the Provider Dispute Resolution Mechanism	Rule 1300.71.38(c)(4)	The plan shall resolve any provider dispute submitted on behalf of an enrollee in the plan's consumer grievance process and not in the dispute resolution mechanism. When a provider submits a dispute to a plan on behalf of an enrollee, the submitting provider is deemed to be assisting the enrollee within the meaning of Section 1368.
Time Limits to Dispute Claims, Billing or Unfair Payment Patterns	Rule 1300.71.38(d)(1)	The contract cannot reduce the timeframe or deadline for the receipt of a provider dispute for an individual claim, billing dispute or other unfair payment patterns to less than 365 days from the date of the plan's action/inaction.
Plan Requirement to Acknowledge Receipt of Provider Dispute	Rule 1300.71.38(e)	A plan or a plan's capitated provider that pays claims shall identify and acknowledge a provider's electronic dispute submission within 2 working days of receipt and a paper dispute submission within 15 working days of receipt.
Timeframe for Resolution and Written Determination	Rule 1300.71.38(f)	A plan or a plan's capitated provider that pays claims must resolve a provider dispute and issue a Written Determination within 45 working days after receiving the provider dispute or amended provider dispute. **See Exhibit I**
Past Due Payments	Rule 1300.71.38(g)	If the provider dispute is decided in favor of the provider, in whole or in part, the payment, including all applicable interest and penalties, must be made within 5 working days of the issuance of the Written Determination.
Retaliation Against a Provider by a Plan	Rule 1300.71.38(i)	The plan or the plan's capitated provider that pays claims shall not discriminate or retaliate against a provider because the provider filed a provider dispute. Retaliation includes, but is not limited to, cancelling a provider's contract with the plan.
Dispute Resolution Costs	Rule 1300.71.38(j)	A plan shall not charge a provider for resolving a dispute submitted to its dispute resolution mechanism. A plan has no obligation to reimburse a provider for costs incurred while utilizing the provider dispute resolution mechanism.

Subject Area	H&S Code Section	Description
SECTION 6 – CONTRACTUAL DISPUTES – CON'T		
Non-delegable Duties re Timely Claims Payment	Section 1371	Plans must have appropriate systems for processing provider claims in a timely manner. This timely claims payment requirement is not waived even if a plan delegates claims payment duties to medical groups, IPAs, or other contracting entities.
Acceptance and Adjudication of Claims by Plan's contracted claims processing organization or capitated provider that pays claims.	Rule 1300.71(e)(1)	**Specific Provision Required** A plan's contract with a claims processing organization (CPO) or a capitated provider that pays claims (CP) shall obligate the CPO or CP to accept and adjudicate claims in accordance with Sections: 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.8 and Rules: 1300.71, 1300.4, and 1300.77.4.
Maintenance of Dispute Resolution Process	Rule 1300.71(e)(2)	**Specific Provision Required** The plan's contract with a capitated provider that pays claims shall require the capitated provider that pays claims to establish and maintain a fast, fair, and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with Sections: 1371, 1371.1, 1371.2, 1371.22, 1371.36, 1371.37, 1371.38, 1371.4, 1371.8 and Rules 1300.71, 1300.71.38, 1300.71.4, 1300.77.4.
Department and Provider Access	Rule 1300.71(e)(4)	**Specific Provision Required** The plan's contract with a capitated provider that pays claims (CP) shall require the CP to make available to the Department and the plan all records, notes, and documents regarding the CP's dispute resolution mechanism and resolution of provider disputes.
Provider Claims Involving Medical Necessity/Utilization Review	Rule 1300.71(e)(5)	**Specific Provision Required** The plan's contract with a capitated provider that pays claims (CP) shall provide that any provider who submits a claim dispute involving an issue of medical necessity or utilization review shall have an unconditional right to appeal that claim to the plan's dispute resolution process for a de novo review and resolution for a period of 60 working days from the CP's Date of Determination.
Assumption and Liability for Claims Payment	Rule 1300.71(e)(6)	**Specific Provision Required** The plan's contract with a claims processing organization (CPO) or a capitated provider that pays claims (CP) shall authorize the plan to assume responsibility for the processing and timely reimbursement of provider claims in the event the CPO or CP fails to timely and accurately reimburse claims.
Plan Retained Right and Responsibility to Administer Claims Dispute Resolution	Rule 1300.71(e)(7)	**Specific Provision Required** The plan's contract with a capitated provider that pays claims (CP) shall authorize the plan to assume responsibility for the administration of the CP's dispute resolution mechanism(s) and for the timely resolution of provider disputes if the CP fails to timely resolve provider disputes.
Plan's Retained Liability re Claims Processing	Rule 1300.71(e)(8)	The plan's contract with a claims processing organization or a capitated provider that pays claims shall not relieve the plan of its obligation to comply with Sections 1371, 1371.1, 1371, 2, 1371. 22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, 1371.7, 1371.8 and Rules 1300.71, 38, 1300.71.4 and 1300.77.4.

Subject Area	H&S Code Section	Description
SECTION 6 – CONTRACTUAL DISPUTES – CON'T		
Claims Dispute Mechanism of a Capitated Provider that Pays Claims	Rule 1300.71.38	All plans and their capitated providers that pay claims (CP) shall establish a fast, fair, and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. The plan and the plan's CP may maintain separate dispute resolution mechanisms.

ATTACHMENT I

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

(IRS FORM W-9 ATTACHED)

Each Contracting Entity is required to complete a W-9 form and indicate the appropriate TIN, regardless of operations as Sole Proprietorship, Partnership, Corporation or Medical Group.