CALIFORNIA
PROVIDER PARTICIPATION AGREEMENT
FEE-FOR-SERVICE DIRECT NETWORK TEMPLATE

This Provider Participation Agreement ("Agreement") is made and entered into by and between the Provider identified on the signature page of this Agreement ("Provider"), and Health Net of California, Inc. on behalf of itself and its subsidiaries and affiliates (collectively, "Health Net"). This Agreement is effective July 01, 2022.

RECITALS

A. Whereas, Provider has the legal authority to enter into this Agreement, and to deliver or arrange for the delivery of Contracted Services;

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

C. Whereas, Provider's primary consideration shall be the quality of the health care services rendered to Beneficiaries, pursuant to Title 10 CCR 2240.4;

D. Whereas, The parties desire to enter into this Agreement to arrange for Provider to participate in one or more of Health Net's networks of Participating Providers that render Contracted Services to Beneficiaries of various Benefit Programs;

E. Whereas, on January 1, 2022, DHCS will replace the Health Homes Program and Whole Person Care pilots with the Enhanced Care Management (ECM) benefit;

F. Whereas, to prepare for the implementation of DHCS's ECM benefit, Health Net is engaging with community-based providers to provide a whole-person approach to care that addresses clinical and non-clinical circumstances of high-need Medi-Cal Beneficiaries;

G. Whereas, DHCS's ECM benefit is an integrated service delivery system for populations with complex, chronic conditions and intended to improve outcomes by reducing fragmented care and promoting patient-centered care.

AGREEMENT

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

I. DEFINITIONS

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

1.1 Allowable Charges. Allowable Charges is defined as Provider's billed charges for Contracted Services.

1.2 Beneficiary. A person who is properly enrolled in and eligible to receive Covered Services under a Benefit Program at the time Covered Services are rendered**.** The parties acknowledge that the term 'member' may be used by Health Net in certain related materials, such as Benefit Program documents covering various products,

marketing materials, and Health Net Policies. For reference purposes, the term Beneficiary includes the term 'member' wherever used.

1.3 Benefit Program. The group agreement, evidence of coverage, certificate of insurance, summary plan description or similar documents in effect at the time Covered Services are rendered for lines of business offered through Health Net. The Benefit Programs in which Provider participates and terms and conditions such as payment rates relating to such Benefit Programs, are set forth in the Addenda to this Agreement.

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

1.5 Complete Claim. A Complete Claim means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides reasonably relevant information as defined by applicable State or federal statutes and regulations, and which is submitted to Health Net or a Payor by Provider for payment of Contracted Services that may be processed by Health Net or a Payor without obtaining additional information from Provider or from a third party.

1.6 Contracted Services. Covered Services that are (i) those services which Provider is licensed to provide and which Provider customarily provides to its patients, and (ii) to be provided to a Beneficiary under the terms of the applicable Benefit Program in effect at the time such services are rendered or as required by State or federal law, and (iii) compensated in accordance with this Agreement except as otherwise may be required by State or federal law.

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

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

1.9 Covered Services. The health care services, equipment and supplies that are covered as determined by the Benefit Program and by applicable State and federal law and regulations, including without limitation decisions issued as a result of independent medical review conducted under applicable State or federal law.

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

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

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

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

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

Certain Benefit Plans require adherence to the federal and government program standard for defining and Emergency, which defines an Emergency as : a medical condition manifesting itself by acute symptoms of sufficient severity

(including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the patient's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

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

1.14 Facility(ies). All service locations owned, operated, leased, or subcontracted by Provider at which Contracted Services are provided under this Agreement. Provider's service locations as of the date this Agreement is executed by the parties are listed on an exhibit to this Agreement.

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

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

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

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

1.19 Payor. Any public or private entity contracted with Health Net which provides, administers, funds, insures or is responsible for paying Participating Providers for Covered Services rendered to Beneficiaries under a Benefit Program, including self-funded health plans.

1.20 PPG. A participating physician group that has entered into an agreement with Health Net to deliver or arrange for the delivery of certain Covered Services to Beneficiaries.

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

1.22 Prior Authorization. The written or electronically issued prior approval by Health Net or its designee for the provision of Covered Services which may be required under a Benefit Program or a Health Net Policy.

1.23 Professional Provider. The physicians, allied health professionals and other health care providers who contract with Provider, or are employed by Provider, and who have been accepted by Health Net to provide Contracted Services to Beneficiaries under the terms and conditions of this Agreement, and billed through Provider's federal tax identification number and/or national provider identifier. Professional Providers covered by this Agreement as of the date this Agreement is executed by the parties are listed on an exhibit to this Agreement.

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

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

1.26 State. The State of California.

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

II. DUTIES OF PROVIDER

2.1 General Obligations. Provider agrees on behalf of itself, and each of its Facilities and Professional Providers, as applicable, that during the term of this Agreement and any renewal terms, each of them is:

2.1.1 licensed without restriction or limitation by the State to provide Contracted Services to the extent required by the State;

2.1.2 operating and providing Contracted Services in compliance with applicable local, State, and federal laws, rules, regulations and legal standards of care;

2.1.3 delivering Contracted Services to Beneficiaries in the same manner and with the same availability, as services are delivered to other patients;

2.1.4 maintaining such physical plant, equipment, patient service personnel and allied health personnel as may be necessary to provide Contracted Services;

2.1.5 available to Beneficiaries twenty-four (24) hours per day, seven (7) days per week on an Emergency basis.

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

A) Provider is not accepting new patients, or
B) Provider had previously not accepted new patients, but is currently accepting new patients.

2.1.7 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Provider agrees to: i) cooperate with Quality Management and Improvement ("QI")

activities; ii) maintain the confidentiality of Member information and records pursuant to this Agreement; and iii) allow Health Net to use Provider's performance data.

2.2 Provision of Services. Provider agrees to render Contracted Services to Beneficiaries of Benefit Programs under the terms and conditions of this Agreement. Notwithstanding the foregoing, Provider understands and agrees that Health Net or a Payor does not have an obligation under this Agreement to assign or refer to Provider any minimum amount of Beneficiaries. Health Net has not represented or guaranteed to Provider that any Beneficiaries shall receive Covered Services from Provider or that Provider shall participate in all networks of Participating Providers offered by or through Health Net.

Provider acknowledges that Health Net or a Payor shall not be liable for, nor will exercise control or direction over, the manner or method by which Provider, Facilities, and/or Professional Providers render any Covered Services to Beneficiaries under this Agreement.

2.3 Verification of Eligibility. Except in an Emergency, Provider shall verify the eligibility of Beneficiaries using Health Net's telephonically or electronically available system before providing Contracted Services, in compliance with the timeframes and procedures set forth in Health Net Policies.

2.4 Non-Discrimination. Provider shall not discriminate against any Beneficiary in the provision of Contracted Services hereunder, whether on the basis of the Beneficiary's coverage under a Benefit Program, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, source of payment, utilization of medical or mental health or substance use disorder services or supplies, equipment, pharmaceuticals or supplies, health status (including without limitation, Beneficiaries who are, were, or may be victims of domestic violence, or have or may have conditions that are caused by domestic violence), genetic information, or other unlawful basis including, without limitation, the filing by such Beneficiary of any complaint, grievance or legal action against Provider, Health Net or Payor. Provider agrees to make reasonable accommodations for Beneficiaries with disabilities or handicaps, including but not limited to, providing such auxiliary aides and services to Beneficiaries as are reasonable, necessary and appropriate for the proper rendering of Contracted Services at the Provider's expense.

2.5 Professional Providers and Facilities. The following provisions apply when Provider utilizes Professional Providers or Facilities to deliver Contracted Services to Beneficiaries:

2.5.1 Provider binds its Facilities and Professional Providers, if any, covered by this Agreement, to the terms and conditions of this Agreement, to the extent Contracted Services and/or contractual provisions are performed by, or apply to, such Facilities and Professional Providers;

2.5.2 No new or satellite facility shall be added to this Agreement, or be allowed to deliver Covered Services under this Agreement until Health Net has approved such Facility. Health Net reserves the right to deny participation under this Agreement to any new or satellite facility without any obligation to provide a right to appeal except as may be required by applicable State and federal law.

2.5.3 In the event Provider desires to add a new Participating Provider, Provider shall notify Health Net in writing as soon as possible but no later than sixty (60) days before such proposed addition is to become effective with Health Net. Provider agrees that no new Professional Provider shall be added to this Agreement, or be allowed to render Covered Services under this Agreement, unless and until Health Net has approved the addition of such Professional Provider. Health Net reserves the right to deny participation under this Agreement to any proposed new Participating Provider without any obligation to provide a right to appeal except as may be required under State or federal law.

Provider additionally shall comply with the terms of Section 2.6 hereof with respect to its Facilities and Professional Providers, to the extent Facilities are not owned, and/or Professional Providers are not employed, by Provider.

2.6 Subcontracting. The following requirements shall survive termination of this Agreement with respect to Contracted Services rendered during the term of the Agreement and apply when Contracted Services are provided by a subcontractor, such as a reference laboratory:

2.6.1 Provider shall furnish Health Net with copies of its subcontracts within ten (10) days of Health Net's written request

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

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

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

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

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

2.6.7 In the event that any of Provider's subcontracts fail to comply with the requirements set forth herein, Health Net or Payor shall not be required to recognize the existence or validity of the subcontract with respect to Beneficiaries, Benefit Programs and/or Covered Services. Health Net or a Payor shall further have the right, but not the obligation, to directly pay subcontractors submitting claims for Contracted Services, and to recoup any compensation otherwise due by Health Net or a Payor to Provider pursuant to the terms and conditions of this Agreement. Provider shall indemnify and hold harmless Health Net or a Payor for all such payments and related costs.

2.7 Participating Providers. Except in an Emergency, as otherwise permitted in the applicable Benefit Program Requirements, or as otherwise required by applicable federal or State law, if Provider refers a Beneficiary for Covered Services, Provider shall refer Beneficiary only to Participating Providers and Provider shall coordinate such referrals with Health Net or its designee to facilitate the utilization of the most appropriate Participating Provider based upon the Medical Necessary level of care required for the Beneficiary.

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

2.9 Prior Authorization and Referrals. When either Prior Authorization and/or a Referral is required for the rendition of a health care service, the receipt of the required Prior Authorization and/or the required Referral, each being separate and distinct requirements, is a prerequisite to payment of Complete Claims for Covered Services in addition to confirming eligibility prior to delivering service as required by this Agreement and Health Net Policies. Health Net (or its designee as applicable) may rescind or modify its Prior Authorization, in a manner consistent with Health Net Policies, based on variety of factors, including but not limited to the eligibility of

the Beneficiary and whether the rendered service is a Covered Service. However, when Health Net or its designee issues a Prior Authorization for a specific service under a Benefit Program regulated by the California Department of Managed Health Care or the California Department of Insurance, Health Net (or its designee as applicable) shall not rescind or modify its Prior Authorization after Provider has rendered the specified and authorized service in good faith and pursuant to the terms of the Prior Authorization for any reason, including, but not limited to, Health Net's subsequent rescission, cancellation, or modification of the Beneficiary's contract or Health Net's subsequent determination that it did not make an accurate determination of the Beneficiary's eligibility; provided, however that this section shall not be construed to expand or alter benefits available to a Beneficiary under such Benefit Program.

2.10 Notification. Provider shall notify Health Net or a Payor and the appropriate PCP or PPG as applicable, as soon as possible, but no later than 24 hours or by the next business day after a Beneficiary is admitted to a Facility.

2.11 Credentialing Program. Provider shall submit to Health Net or its designee any applicable Credentials Application, which meets minimum requirements of Health Net. Provider or any Professional Provider or subcontractor shall not begin performing Provider's obligations under this Agreement, until Provider and/or Professional Provider and/or Facility has satisfied applicable credentialing or re-credentialing requirements, if any.

2.12 Insurance. Provider shall maintain insurance in amounts and types as required by Health Net Policies. Provider agrees to provide Health Net with a Certificate of Insurance from Provider's insurance carrier or other mutually agreeable written evidence of such insurance coverage within three (3) days of such request by Health Net. Provider also agrees to notify Health Net in writing at least thirty (30) days prior to any termination, cancellation or material modification of any policy for all or any portion of the coverage required herein.

2.13 Trade names, Trademarks, Directories. Provider shall not use or display the trade names, trademarks, or other identifying information of Health Net without Health Net's prior written approval of both form and content, which approval shall not be unreasonably withheld. However, this provision shall not prohibit Provider from posting a reasonable notice on its website or in its Facilities listing by name those insurance carriers that are accepted by Provider so long as the notice lists each name in substantially similar format. Provider shall supply all printed materials and other information requested by Health Net in connection with the production of provider directories within seven (7) days of Health Net's request. Provider agrees that Health Net may list the name, address, telephone number and other factual information of Provider, each Facility and Professional Provider, and of Provider's subcontractors and their facilities in its provider directories, marketing and informational materials, and electronic media.

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

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

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

2.17 Federal Lobbying Restriction. Health Net is obligated under 31 U.S.C. § 1352 to obtain certain information from subcontractors engaged to fulfill part or all of Health Net's obligations under its health maintenance contracts with state and local governments, the proceeds of which are funded by federal grants or federal appropriations. To that end, Provider certifies and agrees as follows:

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

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

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

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

III. DUTIES OF HEALTH NET

3.1 Payment. Health Net shall, or Health Net shall require Payor to, make payment to Provider for Contracted Services in accordance with Article IV and the applicable addenda, schedules and exhibits of this Agreement.

3.2 Health Net Policies. Health Net Policies are set forth in references and forms available to Provider through the Provider Section of Health Net's website at "https://providerlibrary.healthnetcalifornia.com" or by other means which Health Net will communicate to Provider periodically. Health Net Policies in existence as of the effective date of this Agreement are hereby incorporated into this Agreement by reference. Notwithstanding the foregoing and/or any other provision of this Agreement, the parties agree that a formal amendment to this Agreement shall not be required to effectuate modifications to Health Net Policies. Modifications to Health Net Policies may be made periodically as determined by Health Net in accordance with the procedures set forth in applicable State law (including without limitation the California Health Care Providers' Bill of Rights). Such modifications shall be deemed incorporated in this Agreement as of the effective date of such modification unless otherwise mutually agreed by the parties in writing at the time of the modification in accordance with applicable State law (including without limitation the California Health Care Providers' Bill of Rights).

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

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

3.5 Access To This Agreement.

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

3.5.2 Access by Payors. To the extent Health Net allows a self-funded Payor to access this Agreement, Health Net has obligated such self-funded Payor to fund a claims payment account in a sufficient and timely manner to pay claims for services provided by health care providers like Provider. In the event a self-funded Payor accessing this Agreement fails to sufficiently and timely fund a claims payment account to the material detriment of Provider, Provider may terminate this Agreement as to such self-funded Payor in accordance with Section 5.3 hereof, and, notwithstanding the provisions of Section 4.6 of this Agreement, take legal action against the self-funded Payor and/or Beneficiary as may be permitted by law. Additional information regarding Payors and conditions for accessing this Agreement is set forth in Addendum A of this Agreement.

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

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

4.1 Payment Rates. Health Net shall pay (or shall require Payor to pay), and Provider shall accept as payment in full for Contracted Services, the rates payable by Health Net or Payor under the terms and conditions of this Agreement (including the payment conditions, chargemaster and other provisions set forth in the applicable addenda, schedules and exhibits to this Agreement), less Copayments, Coinsurance and Deductibles payable by Beneficiaries in accordance with the applicable Benefit Program or as otherwise permitted by the section of this Agreement covering Third Party Lien Recoveries. Any overpayment, inaccurate payment or other payment error made by Health Net or Payor shall not be deemed or construed or otherwise operate to change the payment terms or rates provided for under this Agreement.

4.2 Billing and Payment.

4.2.1 Billing. Provider shall submit to Health Net/Payor, via Health Net's/Payor's electronic claims submission program or hardcopy as determined by Health Net/Payor, Complete Claims within one hundred eighty (180) days after Provider renders Contracted Services unless Provider demonstrates good cause pursuant to applicable State law. Where Health Net and/or Payor is the secondary payor under Coordination of Benefits, Provider shall submit Complete Claims for Covered Services accompanied by the explanation of benefits (EOB) or explanation of payment (EOP) from the primary payor to Health Net or a Payor within one hundred eighty (180) days of the date of the EOB/EOP. If Provider fails to comply with the timely claims submission/filing requirements set forth herein, Health Net shall have no obligation to pay for such claims, and Provider shall be prohibited from billing the Beneficiary as set forth in Section 4.6 hereof.

Provider agrees that Health Net or a Payor shall have the right to determine the accuracy of all Complete Claims submitted to it prior to payment, including verification of diagnostic codes, DRG assignment, and whether Provider has delivered the Covered Service in good faith and pursuant to the terms of an applicable Prior Authorization.

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

4.2.3 Appeals. In addition to the dispute resolution and arbitration rights described in Section 7.5 and Section 7.6 herein, Provider may dispute any Health Net action that adjusts, denies, or contests a claim, billing practice, or other contractual provision so long as Provider submits a written dispute to the Health Net Provider Appeals Unit. Unless Provider demonstrates good cause pursuant to applicable State or federal law, Health Net or Payor shall not grant Provider reconsideration or appeal of a claims payment for Covered Services that exceed three hundred sixty five (365) days of Health Net's action or in the case of inaction, within three hundred sixty five (365) days after the time for contesting or denying claims (as defined in applicable State or federal law) has expired. Appeals shall be submitted by Provider in accordance with the procedures, and to the address for Health Net's Provider Appeals Unit, listed in Health Net Policies. If Provider fails to comply with the timely appeals submission/filing requirements set forth herein, Health Net shall have no obligation to pay for such claims except as otherwise required by applicable State and federal law, and Provider shall be prohibited from billing the Beneficiary as set forth in Section 4.6 hereof. Provider and Health Net agree to comply with all timeliness and procedural requirements for submitting and responding to disputes submitted to Health Net's Provider Appeals Unit as set forth in Health Net Policies.

4.3 Recoupment of Overpayments; Right of Offset.

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

4.3.2 In the event Health Net determines that it has overpaid a claim, either in connection with an audit or otherwise, Health Net shall notify Provider in writing through a separate overpayment notice clearly identifying the claim, the name of the Beneficiary, the date of service and explanation of the basis upon which Health Net or Payor believes the amount paid on the claim was in excess of the amount due, including any interest and penalties that may be due on the claim. Such overpayment notice shall be issued within (i) three hundred sixty-five (365) days of the date of payment on the overpaid amount for claims arising from Benefit Programs regulated by the California Department of Managed Health Care or the California Department of Insurance, or within (ii) three (3) years from the date of payment on the overpaid amount for claims arising from

other types of Benefit Programs that are not regulated by the California Department of Managed Health Care or the California Department of Insurance, or (iii) at any time, in the event of fraud and/or misrepresentation. Such notice shall be sent to Provider's address of record with Health Net for the receipt of claim related correspondence and payments unless Provider informs Health Net in writing of an alternative address to which such notices are to be sent at least thirty (30) days in advance of the address change.

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

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

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

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

4.4 Eligibility. The parties acknowledge that verification of eligibility by Health Net is based on information available to Health Net from its customers on the date Provider seeks verification. Health Net shall use reasonable efforts to discourage its customers from retroactively canceling or adding Beneficiaries to a Benefit Program and encourage its customers to timely and accurately provide eligibility information. In the event Contracted Services are provided to an individual who is not a Beneficiary, based on an erroneous or delayed enrollment/eligibility list the following shall apply: (i) when the individual is enrolled in a substitute or replacement health care service or insurance plan which is obligated under applicable law to make payment to Provider for services delivered to the individual, Provider shall seek payment from the substitute or replacement carrier; and (ii) when the individual does not have substitute or replacement coverage, Health Net shall pay Provider for Contracted Services delivered to the individual by Provider prior to the time Provider received notice of that individual's ineligibility pursuant to the terms and conditions of this Agreement**,** provided, however**,** for those Benefit Programs that are not regulated by the California Department of Managed Health Care or the California Department of Insurance, as an additional prerequisite for payment pursuant to this Section 4.4(ii), Provider shall submit to Health Net evidence that Provider has unsuccessfully sought payment through two billing cycles for all or a portion of such charges from the patient or the person having legal responsibility for the patient, or from the entity having financial responsibility for such payment. In the event Health Net pays Provider pursuant to this Section 4.4, Provider shall have no further right and shall not attempt to collect any additional payment from the individual for said services (except for applicable Copayments, Coinsurance and Deductibles) and Provider hereby assigns and transfers all legal rights of collection and Coordination of Benefits for services to Health Net.

4.5 Collection of Copayments, Coinsurance and Deductibles. Provider shall collect all Copayments, Coinsurance and Deductibles due from Beneficiaries, and shall not waive or fail to pursue such

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

4.6 Beneficiary Held Harmless. Provider agrees that in no event, including, but not limited to, non-payment by Health Net or a Payor, insolvency of Health Net or a Payor, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries or persons acting on their behalf other than Health Net or a Payor for Contracted Services provided pursuant to this Agreement except for Copayments, Coinsurance, Deductibles, Excluded Services or permitted third party liens under this Agreement and as permitted under Section 3.5.2 hereof. This provision shall not prohibit collection of Copayments, Coinsurance or Deductibles or Excluded Services or permitted third party liens under this Agreement made in accordance with applicable Benefit Program Requirements. Provider agrees that: (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Beneficiaries; and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Beneficiaries or persons acting on their behalf**.** Provider agrees to (iii) address any and all concerns it has with claims payment through Health Net's provider appeal process pursuant to Health Net Policies and (iv) give the Beneficiary and Health Net confirmation that Provider has rescinded the collection notice and taken any other actions necessary to clear the Beneficiary's credit record of the collection matter.

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

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

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

4.10 Reciprocity. Provider agrees that Health Net may allow the payment rates set forth in this Agreement to be used by Participating Providers and PPGs who may periodically be responsible for compensating Provider for Covered Services rendered by Provider to a Beneficiary.

V. TERM AND TERMINATION

5.1 Term. The term of this Agreement shall commence on the Effective Date and shall continue for a period of one (1) year thereafter (the "Initial Term"). Either party may terminate this Agreement effective as of the end of the Initial Term by providing at least one hundred twenty (120) days prior written notice to the other party. This Agreement shall automatically renew for successive one (1) year periods (the "Renewal Terms").

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

5.3 Termination Due to Material Breach. In the event either party believes the other party has committed a material breach of this Agreement, the non-breaching party shall send the other party a written Notice Of Breach and Demand to Cure ("Notice"). Without limiting either party's other termination rights under this Article V, in the event that either party fails to cure a material breach of this Agreement within thirty (30) days of receipt of the Notice from the other party (the "Cure Period"), the non-defaulting party may terminate this Agreement by providing the defaulting party thirty (30) days prior written notice of termination. The non-defaulting party may exercise this termination option, if at all; within thirty (30) days of the date the Cure Period expires. If the breach is cured within the Cure Period, or if the breach is one, which cannot reasonably be corrected within the Cure Period, and the defaulting party is making substantial and diligent progress toward correction during the Cure Period to the reasonable satisfaction of the non-defaulting party, this Agreement shall remain in full force and effect. The provisions of this Section 5.3 shall not apply to Health Net claims payment timeliness issues which are governed by Article IV of this Agreement, unless and until the parties have completed the dispute resolution process set forth in Sections 7.5 and 7.6 of this Agreement, and the dispute relates to habitual, chronic and material claims payment timeliness issues. In the event a Payor fails in its obligations under the terms of this Agreement to make Complete Claim payments to Provider when due, Provider may terminate the specific delinquent Payor without terminating this Agreement in its entirety, but only after all of the following conditions have been met: (i) Payor has failed to make a payment to Provider within the applicable time frame set forth in this Agreement; (ii) Provider provides written notice to Payor that such payment has not been made; (iii) Payor fails to remit payment to Provider within ten (10) days following Payor's receipt of Provider's written notice; (iv) Provider has made a good-faith attempt to meet with Health Net and Payor to resolve the payment issue(s).

5.4 Termination Upon Notice. Either party may terminate this Agreement during a Renewal Term for any reason or no reason upon one hundred twenty (120) days prior written notice to the other party. In the event that either party provides the other party with such notice, and following Health Net's completion of any applicable regulatory filing requirements, Health Net may, at its option, begin to transition Beneficiaries under this Agreement to another Participating Provider.

5.5 Information to Beneficiaries. The parties each agree not to disparage the other in any information supplied by either party to Beneficiaries or other third parties in connection with any expiration, termination or non-renewal of this Agreement. Health Net shall assume sole responsibility for notifying Beneficiaries, and Health Net may commence transferring Beneficiaries to alternate providers, prior to the effective date of any expiration, termination or non-renewal of this Agreement in accordance with State and federal law. If Beneficiaries seek services or Participating Providers order tests or seek services from Provider after the effective date of any expiration, termination or non-renewal, Provider shall inform such Beneficiaries and Participating Providers only that Provider no longer has an agreement with Health Net to render Covered Services and shall direct them to Health Net's customer service department. Provider shall not otherwise initiate communications with Beneficiaries or other

third parties, verbally or in writing, concerning the expiration, termination or non-renewal of this Agreement and Provider's participation in Health Net's Participating Provider network, unless the parties have agreed in writing to the content of such communications in the context of a mutually agreed communication plan. Nothing in this provision is intended nor shall it be construed to prohibit or restrict Provider, Professional Provider, or other Participating Providers from (i) disclosing to any Beneficiary information regarding treatment options available, the risks, benefits and alternatives thereto, or (ii) disclosing to any Beneficiary the decision or process of Health Net or a Payor to Prior Authorize or deny benefits under a Benefit Program, or (iii) posting a reasonable notice on Provider's website or in Provider's Facilities listing by name those insurance carriers that are accepted by Provider, provided that the notice lists each name in substantially similar format. The terms of this Section 5.5 shall survive termination of this Agreement.

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

VI. RECORDS, AUDITS AND REGULATORY REQUIREMENTS

6.1 Medical and Other Records. Provider shall prepare and maintain Records in accordance with the general standards applicable to such Record-keeping and in compliance with all applicable federal and State confidentiality and privacy laws. Provider shall maintain such Records for at least ten (10) years after the rendition of Contracted Services, and Records of a minor child shall be kept for at least three (3) years after the minor has reached the age of eighteen (18), but in no event less than ten (10) years after the rendition of Contracted Services. Additionally, Provider shall maintain such Records as may be necessary and reasonably requested by Health Net to comply with applicable federal and State law, and accrediting agency reporting requirements, rules and regulations. Provider shall comply with and require Professional Providers to comply with all confidentiality and Beneficiary records accuracy requirements. Provider's Records shall be and remain the property of Provider.

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

6.3 Access to Records and Audits by Health Net. Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit Health Net or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, in order to audit, inspect, review, perform chart reviews, and duplicate such Records unless Provider agrees to a remote audit of such records. If performed on site, access to Records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least thirty (30) business days prior written notice by Health Net or its designated representative, but not more than sixty (60) days following such written notice. Provider shall attend an exit interview upon completion of the audit for the purpose of obtaining a mutually agreed upon reconciliation of the

initial audit findings. Such exit interview shall be conducted at a mutually agreeable time at Provider's place of business in this State during normal business hours upon at least ten (10) days prior written notice by Health Net or its designated representative, but not more than thirty (30) days following such written notice. In the event Provider fails to attend the scheduled exit interview, Provider shall be deemed to have accepted the audit findings. If the audit was performed remotely, such exit interview shall consist of Health Net or its designated representative sharing its audit findings with Provider via written or electronic communications as determined by Health Net. Provider shall be allowed ten (10) days to contest the audit results. If not contested within ten (10) days then Provider shall be deemed to have accepted the audit findings. Provider may be reimbursed reasonable fees associated with the retrieval of Provider's Records and or duplication and preparation of requested Provider Records pursuant to applicable State law, including California Health and Safety code Section 123110. Audit findings relating to any audit of claims shall include adjustment for late charges, overcharges and undercharges. Any such adjustments shall be the net amounts as reflected in the audit findings. Any payments owed by one party to the other as the result of an audit shall be paid within thirty (30) days of the exit interview for such audit.

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

6.5 Regulatory Compliance. Each party agrees to comply with all applicable local, State, and federal laws, rules and regulations, now or hereafter in effect, regarding the performance of the party's obligations hereunder, including without limitation, laws or regulations governing Beneficiary confidentiality, privacy, appeal and dispute resolution procedures to the extent that they directly or indirectly affect Provider, a Beneficiary, Health Net, or Payor, and bear upon the subject matter of this Agreement. If Health Net is sanctioned by any Regulatory Agency for non-compliance that is caused by Provider, Provider shall compensate Health Net for amounts tied to this sanction incurred by Health Net including Health Net's costs of defense and fees.

VII. GENERAL PROVISIONS

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

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

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

7.4 Confidentiality. The Parties each agree that, unless disclosure is required by state or federal law, they shall hold Beneficiary health information and all confidential or proprietary information or trade secrets of each other, in trust and confidence. The Parties each agree that, unless disclosure is required by state or federal law, they shall keep strictly confidential all customized, non-template terms and rates set forth in this Agreement (including without limitation all addenda, exhibits, and any past or future amendments to this Agreement). The Parties further agree that in the event a disclosure is required by state or federal law, they shall disclose only the specific information mandated by such law in order to comply with the applicable legal requirements. Notwithstanding the

foregoing, the Parties acknowledge and agree that this provision does not preclude disclosure by Health Net to Beneficiaries, customers, Regulatory Agencies and exchanges of certain financial terms of this Agreement, including without limitation detailed information contained in the Explanation of Benefits, Records under the conditions set forth in Article VI of this Agreement, and/or information regarding the method of compensation used by Health Net with respect to Health Net's Participating Provider networks, e.g., fee-for-service, capitation, shared risk pool, DRG or per diem. Health Net, Payors and Provider agree that such information shall be used only for the purposes contemplated herein, and not for any other purpose. Health Net, Payors and Provider agree that nothing in this Agreement shall be construed as a limitation of (i) Provider's rights or obligations to discuss with the Beneficiaries matters pertaining to the Beneficiaries' health regardless of Benefit Program coverage options or (ii) Health Net's rights or obligations with respect to subcontractors, including without limitation delegated providers, or (iii) disclosures to counsel or a consultant of a party for the purpose of monitoring regulatory compliance or rendering legal advice pertaining only to this Agreement or disclosures to internal or independent auditors of a party for audit purposes pertaining to this Agreement, provided that in either case the counsel or consultant agrees in writing to comply with the provisions of this Section 7.4 and agrees that the terms of this Agreement may not be disclosed to any other person or entity or used in any manner whatsoever in connection with any other agreement involving Health Net. The terms of this Section 7.4 shall survive termination of this Agreement.

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

7.5 Provider Dispute Resolution Procedure. The parties agree to use the dispute resolution process set forth in this Section 7.5, and binding arbitration as described in Section 7.6, as the final steps in resolving any Dispute. The parties each understand and agree that any and all Health Net internal appeals processes (including without limitation as set forth in Section 4.2.3 hereof) must be properly pursued and exhausted before engaging in the dispute resolution process set forth in this Section 7.5.

(i) Meet and Confer Process:

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

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

(ii) Voluntary Mediation:

If the parties are unable to resolve any Dispute through the meet and confer process set forth above, and desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, a joint request for such services may be made to the American Arbitration Association ("AAA"), or the Judicial

Arbitration and Mediation Services ("JAMS") prior to submitting a Dispute to arbitration, or the parties may initiate such other procedures as they may mutually agree upon.

7.6 Non-Binding Arbitration . If the parties are unable to resolve a Dispute through the dispute resolution process set forth in Section 7.5, the parties agree that such Dispute may be submitted for non-binding arbitration, upon the motion of either party, under the appropriate rules of the AAA or JAMS, as agreed by the parties. The parties each understand and agree that the exhaustion of any Health Net internal appeals processes and the Meet and Confer Process set forth in Section 7.5(a) hereof are conditions precedent to non-binding arbitration under this Section 7.6. Notwithstanding the foregoing, nothing contained herein is intended to require arbitration of disputes alleging medical malpractice between a Beneficiary and Provider or to Disputes between the parties alleging breaches of confidentiality of Beneficiary information, trade secret or intellectual property obligations. The arbitration shall be conducted in San Francisco, California or Los Angeles, California. The written demand shall contain a detailed statement of the matter and facts and include copies of all available related documents supporting the demand. Except as provided below, arbitration must be initiated within one year after the date the Dispute arose by submitting a written notice to the other party.

Notwithstanding the foregoing, if the Dispute involves allegation(s) that Health Net failed to pay or paid a Complete Claim incorrectly under this Agreement, the parties agree that an arbitration shall be filed within one (1) year after the date of Health Net's notice of its final determination on Provider's internal appeal, if any, on such Complete Claim.

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

All such arbitration proceedings shall be administered by the AAA or JAMS, as agreed by the parties; however, the arbitrator shall be bound by applicable State and federal law and shall issue a written opinion setting forth findings of fact and conclusions of law. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. The arbitrator shall have no authority to make material errors of law or to award punitive damages or to add to, modify, or refuse to enforce any agreements between the parties. The arbitrator shall make findings of fact and conclusions of law and shall have no authority to make any award which could not have been made by a court of law. The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of the entry of judgment on the award. The parties recognize and agree that theirs is an ongoing business relationship, which may lead to sensitive issues with respect to the exchange of information related to any Dispute. The parties agree, therefore, to enter into such protective orders (including without limitation creating a category of discovery documents "for attorney's eyes only" to the extent feasible given the nature of the evidence and the Dispute). All discovery information shall be used solely and exclusively for non-binding arbitration of the Dispute between the parties and may not be used for any other purpose. After the arbitration process has concluded, each party shall return or destroy all documents obtained from the other party during the course of the arbitration that are subject to a protective order, and within thirty (30) days of such date shall provide to the other party an officer's certificate signed under penalty of perjury indicating that all such information has been returned or destroyed.

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

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

7.8 Governing Law. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern. Health Net is subject to the requirements of various local, State, and federal

laws, rules and regulations including, but not limited to, the requirements of Chapter 2.2 of Division 2 of the California Health & Safety Code (the Knox-Keene Health Care Service Plan Act) and of Chapters 1 and 2, of Division 1 of Title 28 of the California Code of Regulations ("C.C.R.") and Title 10 of the C.C.R as well as the California Insurance Code. Any provision required to be in this Agreement by any of the above shall bind Provider and Health Net whether or not expressly set forth herein.

7.9 Indemnification.

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

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

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

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

7.11 No Third Party Beneficiary. Nothing in this Agreement is intended to, or shall be deemed or construed to, create any rights or remedies in any third party, including a Beneficiary. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to increase the rights of any such Beneficiary or the duties or responsibilities of Provider or Health Net or Payor with respect to such Beneficiaries.

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

Health Net:

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

Valentina T. .Shabanian
Regional Health Plan Officer
Health Net of California, Inc.
101 N. Brand Ave, Suite 1500
Glendale, CA 91203

Provider: See Provider Mailing Address in Exhibit I, Listing of Facilities

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

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

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

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

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

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

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

IN WITNESS WHEREOF, the parties have executed this Agreement.

NEVADA COUNTY BEHAVIORAL HEALTH DEPARTMENT	**HEALTH NET OF CALIFORNIA, INC.**
Signature	Health Net Signature
Sue Hoek Print Name	Valentina T. Shabanian Print Name
Chair of the Nevada County Board of Supervisors Title	Regional Health Plan Officer Title
Group Name (If Applicable)	Date
94-6000526 Tax Identification Number	
Date	

EXHIBIT I
LIST OF FACILITIES

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

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

Please enter individual information if sole provider.

Nevada County Behavioral Health_____
Provider Name (use Group name if applicable)

94-6000526_____
Provider / Group Tax Identification Number

1982620399_____
Primary / Group NPI Number

Primary Location		
Address:	STREET: 500 Crown Point Circle	SUITE: 120
	CITY: Grass Valley STATE: CA	ZIP CODE: 95945
Telephone #: (530) 265-1437	Fax #:	

Remit Address		
Address:	STREET:	SUITE:
	CITY: STATE:	ZIP CODE:
Telephone #:	Fax #:	

Mailing Address		
Address:	STREET: 500 Crown Point Circle	SUITE: 120
	CITY: Grass Valley STATE: CA	ZIP CODE: 95945
Telephone #: (530) 265-1437	Fax #:	

Note: Please attach a list of additional locations on a separate sheet of paper if required.

ADDENDUM A

MEDI-CAL BENEFIT PROGRAM

Provider understands that Health Net Community Solutions, Inc. ("HNCS"), and California Health and Wellness Plan ("CH&W"), are each affiliates of Health Net and Health Net of California, Inc, and agrees that the obligations of Health Net, set forth in this Addendum, shall be the obligations of HNCS and/or CH&W, insofar as the obligations arise out of Covered Services provided to Medi-Cal Beneficiaries enrolled in or otherwise assigned to either or each of HNCS and CH&W. As used in this Addendum, the term 'Health Net" refers to both or each of HNCS and CH&W, as shall be applicable. Health Net has one or more Medi-Cal prepaid health plan agreements with the California Department of Health Care Services ("DHCS"). For the purposes of this Addendum, Health Net's Medi-Cal agreements with the DHCS and any subcontracts with Medi-Cal prepaid health plans, are hereinafter collectively referred to as the "Medi-Cal Agreement". Health Net has agreed, under the Medi-Cal Agreement, to provide medical services covered under California's Medi-Cal Program, including Provider risk services, to Medi-Cal HMO Beneficiaries enrolled in or otherwise assigned to Health Net, on a prepaid basis. The provisions of the Addendum are required to appear in all subcontracts under the Medi-Cal Agreement by the terms of the Medi-Cal Agreement and by Medi-Cal law and may not be altered. When required under Medi-Cal law, the Agreement shall be effective upon approval by DHCS in writing or operation of law where DHCS has acknowledged receipt of the Agreement and failed to approve or disapprove within sixty (60) calendar days.

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

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

A. COMPENSATION PROVISIONS.

1. Compensation. Provider shall arrange and provide Contracted Services, set forth under Exhibit A-1, to Health Net Medi-Cal HMO Beneficiaries covered under this Addendum on a fee-for-service basis. As compensation for providing such Contracted Services, Provider shall be paid in accordance with the rates set forth on Exhibit A-1. Such compensation shall be paid within forty-five (45) working days of receipt of a complete and accurate claim for Covered Services rendered to a Medi-Cal HMO Beneficiary.

Notwithstanding anything to the contrary contained in this Agreement, if Provider is decertified, suspended and/or terminated by the California Department of Health Care Services ("DHCS"), or other governmental agencies ("DHCS Notice"), Provider acknowledges that it will not be eligible to receive reimbursement for Contracted Services following the date of the DHCS Notice and Health Net will have no liability to pay Provider under this Agreement upon receipt of the DHCS Notice.

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

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

B. GENERAL PROVISIONS

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

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

a) The terms and conditions of this Addendum and the Agreement.

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

c) Health Net Medi-Cal policies and procedures and physician bulletins.

d) DHCS Medi-Cal Managed Care Division (MMCD) Policy Letters.

e) All laws applicable to Provider and Health Net.

f) Health Net's Utilization Care Management Program and Quality Improvement Program.

g) Standards requiring services to be provided in the same manner, and with the same availability, as services are rendered to other patients.

h) No less than the minimum clinical quality of care and performance standards that are professionally recognized and/or adopted, accepted or established by Health Net.

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

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

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

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

7. Medi-Cal HMO Beneficiaries and State Held Harmless. Provider agrees that in no event, including, but not limited to, non-payment by Health Net, the insolvency of Health Net, or breach of the Agreement, shall Provider or a subcontractor of Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Medi-Cal HMO Beneficiaries, the State of California, or persons other than Health Net acting on their behalf for services provided pursuant to the Agreement. Provider agrees: (1) this provision shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Medi-Cal HMO Beneficiaries; and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Medi-Cal HMO Beneficiaries or persons acting on their behalf. Any modification, addition, or deletion of or to the provisions of this clause shall be effective on a date no earlier than fifteen (15) days after the DHCS has received written notice of such proposed change and has approved such change. [22 CCR § 53250(e)(6)].

8. No Surcharges and No Copayments. Provider shall not charge a Medi-Cal HMO Beneficiary any fee, surcharge or Copayment for health care services rendered pursuant to the Agreement except when explicitly allowed by the Medi-Cal Benefit Program, for covered services rendered pursuant to the Agreement. In addition, Provider shall not collect a sales, use or other applicable tax from Medi-Cal HMO Beneficiaries for the sale or delivery of medical services. If Health Net receives notice of any additional charge, Provider shall fully cooperate with Health Net to investigate such allegations, and shall promptly refund any payment deemed improper by Health Net to the party who made the payment. [Knox-Keene Act and Medi-Cal Agreement].

9. Grievances and Appeals. Provider agrees to work with Health Net to resolve all grievances and appeals relating to the provision of services to Medi-Cal HMO Beneficiaries in accordance with the Health Net Medi-Cal grievance and appeal procedures.

10. Provider Patient Relationship. Provider shall be solely responsible, without interference from Health Net or its agent, for providing Hospital Services to Medi-Cal HMO Beneficiaries, and shall have the right to object to treating any individual who makes onerous the relationship between Provider and Medi-Cal HMO Beneficiary. In the event of a breakdown in such relationship, Health Net shall make reasonable efforts to assign the

Medi-Cal HMO Beneficiary to another Participating Provider. If reassignment is unsuccessful, a request may be filed with the DHCS to permit termination of services to such Medi-Cal HMO Beneficiary. Approval from the DHCS must be obtained before Provider terminates services to such Medi-Cal HMO Beneficiary.

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

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

13. Notice. Provider acknowledges that Health Net shall notify the DHCS in the event this Agreement is amended or terminated. Notice to DHCS is considered given when properly addressed and deposited with the United States Postal Service as first class registered mail, postage attached. [Knox-Keene Act and Medi-Cal Agreement].

14. Reports: Provider shall provide Health Net, within the time requested by Health Net, with all such reports and information as Health Net may require to allow to meet the reporting requirements under the Medi-Cal Agreement or any applicable law, [22 CCR 53250(c)(5)].

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

16. Third Party Tort Liability. Provider shall make no claim for recovery for health care services rendered to a Medi-Cal HMO Beneficiary when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance, including workers' compensation awards and uninsured motorist coverage. Within five (5) days of discovery, Provider shall notify Health Net of cases in which an action by the Medi-Cal HMO Beneficiary involving the tort or workers' compensation liability of a third party could result in a recovery by the Medi-Cal HMO Beneficiary. Provider shall promptly provide: (1) all information requested by

Health Net in connection with the provision of health care services to a Medi-Cal HMO Beneficiary who may have an action for recovery from any such third party; (2) copies of all requests by subpoena from attorneys, insurers or Medi-Cal HMO Beneficiaries for copies of bills, invoices or claims for health care services; and (3) copies of all documents released as a result of such requests. Provider shall ensure that its subcontractors comply with the requirements of this provision.

17. Amendments.

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

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

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

19. Transfer of Care Upon Termination of the Agreement. Provider shall, pursuant to the requirements of the Medi-Cal Agreement, assist in the orderly transfer of care of all Medi-Cal HMO Beneficiaries under the care of Provider in the event of the termination of the Agreement.

20. Assignment and Delegation. Assignment or delegation of the Agreement shall be void unless prior written approval is obtained from the DHCS, in the instances where approval by the DHCS is required.

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

22. Cultural and Linguistic Services. Provider shall: (1) not require or encourage Beneficiaries to utilize family Beneficiaries or friends as interpreters; (2) record the language needs of Beneficiaries in the medical

record; and (3) document Beneficiary requests or refusals of interpreter services in the Beneficiary's medical record. Provider shall arrange interpreter services for Beneficiaries either through telephone language services or face-to-face interpreters. Provider is encouraged to directly make these interpretive services available. However, upon request, Health Net's Member Services Department is available to provide certain interpretive assistance to facilitate communications.

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

24. CHDP (Children's Health and Disability Prevention) Program. Health Net requires that all providers of CHDP services be certified by the CHDP Program and adhere to the CHDP Program requirements.

25. CCS (California Children's Services). Provider is responsible for timely referral of children with potential CCS eligible conditions. Failure to appropriately refer will result in Provider assuming financial responsibility for any related charges.

26. CPSP (Comprehensive Perinatal Services Program). Provider is required to refer members to DHCS-certified CPSP providers to ensure that all pregnant women have access to care in accordance with DHCS requirements.

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

The Sensitive Services are as follows:

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

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

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

29.1 Family planning services;

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

29.3 Confidential HIV testing and counseling;

29.4 Immunizations;

29.5 Child Health and Disability Prevention Program;

29.6 California Children Services;

29.7 Maternal and Child Health;

29.8 Refugee assessments;

29.9 Tuberculosis Direct Observed Therapy;

29.10 Women, Infants, and Children Supplemental Food Program;

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

Provider shall, in accordance with the terms and conditions of the public health agreements with the local health departments and Health Net's related policies and procedures, be responsible for the coordination and arrangement of the public health services for its assigned Beneficiaries. The services specified in Sections 29.1 through 29.5 above require reimbursement to the applicable local health department. The services specified in Sections 29.6 through 29.11 above do not require reimbursement to the applicable local health department. [Medi-Cal Agreement]

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

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

32. Prospective Requirements. Health Net shall inform Provider of prospective requirements added by DHCS to the agreement between Health Net and DHCS, before the effective date of such requirements. Provider agrees to comply with any changes to such requirements within thirty (30) days of the effect of said requirements from DHCS, unless DHCS instructs otherwise and to the extent possible.

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

34. Coordination of Care. To the extent that Provider is responsible for the coordination of care for Members, Health Net shall share with Provider any utilization data that DHCS has provided to Health Net to use for the purpose of Member care coordination.

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

EXHIBIT A-1

ENHANCED CARE MANAGEMENT

In consideration, Provider agrees to accept reimbursement as set forth in this Exhibit. For the purposes of this Exhibit only, Provider shall be referred to as ECM Provider.

I. DEFINITIONS

1.1 Assigned Member. An eligible Health Net Medi-Cal Beneficiaries who meets one or more of the ECM Populations of Focus for the ECM benefit and are assigned to an ECM Provider for assessment.

1.2 Community Supports (CS). Community Supports (CS) services are medically appropriate and cost-effective alternatives to services covered under the Medi-Cal State Plan. CS services include, but are not limited to, housing transition navigation services, housing deposits, respite services, nursing facility transition, personal care and homemaker services, medically tailored meals, and asthma remediation.

1.3 CS Provider. A contracted provider of DHCS-authorized CS services. CS Providers are community-based entities with experience and expertise providing one (1) or more of the CS services authorized by DHCS to individuals with complex physical, behavioral, developmental and social needs.

1.4 Dual Eligible. Dual Eligible means a Medi-Cal Beneficiary who is enrolled with Medicare Parts A and B as identified in the eligibility file Health Net receives from the State or directly from CMS.

1.5 ECM Provider. A provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

1.6 Engagement List. A list of Assigned Members to each ECM Provider for assessment.

1.7 Enhanced Care Management (ECM). A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.

1.8 Enrolled Member. An Assigned Member who has accepted ECM services and is authorized by Health Net to receive ECM services from an ECM Provider.

1.8 Lead Care Manager. An Enrolled Member's designated care manager for ECM, who works for the ECM Provider (except in circumstances under which the Lead Care Manager could be on staff with Health Net, as described in the DHCS-MCPECM and CS Contract, Section 4: ECM Provider Capacity). The Lead Care Manager operates as part of the Enrolled Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any CS services. To the extent an Enrolled Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Enrolled Member and non-duplication of services.

1.9 Population of Focus. The following populations have been defined by DHCS to be a Population of Focus: Adult Individuals and families experiencing homelessness; high utilizers; adults with Serious Mental Illness (SMI); Substance Use Disorder (SUD); incarcerated persons and persons transitioning to the community; persons at risk for institutionalization; persons eligible for Long Term Care (LTC); nursing facility residents transitioning to the community; children/youth up to age 21 that are high utilizers; persons with Serious Emotional Disturbance (SED), identified to be at clinical High Risk (CHR) for psychosis or experiencing a first episode of psychosis; persons enrolled with CCS/CCS Whole Child Model (WCM) with additional needs beyond CCS, involved in child welfare (including those with a history of involvement; persons in foster care up to age 26); or as otherwise defined or revised by DHCS.

II. ENHANCED CARE MANAGEMENT CORE REQUIREMENTS AND SERVICES

2.1 **ECM Provider Experience and Qualifications**. ECM Provider shall:

2.1.1 Be experienced in serving the ECM Population(s) of Focus it will serve;

2.1.2 Have experience and expertise with the services it will provide;

2.1.3 Comply with all applicable state and federal laws and regulations and all ECM benefit requirements in the DHCS MCP ECM and CS Contract associated guidance;

2.1.4 Have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Enrolled Members to critical appointments when necessary;

2.1.5 Be able to communicate to Enrolled Members in culturally and linguistically appropriate and accessible ways;

2.1.6 Have formal arrangements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including CS Providers, to coordinate care as appropriate to each Enrolled Member;

2.1.7 Use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social services, and administrative data and information from other entities to support the management and maintenance of an Enrolled Member's care plan that can be shared with other Providers and organizations involved in each Enrolled Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Enrolled Member goals and goal attainment status; develop and assign care team tasks; define and support Enrolled Member care coordination and care management needs; gather information from other sources to identify Enrolled Member needs and support care team coordination and communication and support notifications regarding Enrolled Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

2.2 **Medicaid Enrollment/Vetting for ECM Providers.**

2.2.1 ECM Provider shall enroll as a Medi-Cal provider, pursuant to relevant DHCS All Plan Letters, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.

2.2.2 If APL 19-004 does not apply to ECM Provider, ECM Provider must comply with Health Net's vetting process, which may extend to individuals employed by or delivering services on behalf of ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.

2.2.3 ECM Provider shall participate in and comply with all Health Net Policies requirements as it relates to Medicaid Enrollment and Vetting for ECM Providers. ECM Provider acknowledges that it has had the opportunity to review the Health Net Policies.

2.3 **Identifying Members for ECM.** ECM Provider is encouraged to identify potential eligible Health Net Medi-Cal Beneficiaries who would benefit from ECM and send a request to Health Net to determine if the Health Net Medi-Cal Beneficiary is eligible.

2.4 **Member Assignment to an ECM Provider.**

2.4.1 Health Net shall provide an Engagement List to ECM Provider as soon as possible, but in any event no later than ten business days after ECM referral.

2.4.2 ECM Provider shall immediately accept all Assigned Members on the Engagement List, unless ECM Provider is at its pre-determined capacity.

2.4.3 ECM Provider shall immediately alert Health Net if it does not have the capacity to accept an Assigned Member.

2.4.4 ECM Provider will assess the Assigned Member to determine the appropriate needs of the Assigned Member, and enroll the Assigned Member.

2.4.5 ECM Provider will notify Health Net of the Enrolled Member and the effective date of enrollment into ECM .

2.4.6 Upon enrollment, ECM Provider shall ensure each Enrolled Member has a Lead Care Manager who interacts directly with the Enrolled Member and/or their family member(s),

guardian, caregiver, and/or authorized support person(s),as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any CS, and other servicesthat address social determinants of health (SDOH) needs, regardless of setting.

2.4.7 ECM Provider shall conduct a comprehensive assessment that identifies the Enrolled Member's physical, mental health, substance use, palliative, trauma-informed care, and social service needs. ECM Provider shall start an Enrolled Member's assessment within 30 days of the Enrolled Members enrollment in ECM and complete the assessment within 60 days of the Enrolled Member's enrollment in ECM.

2.4.8 ECM Provider shall advise the Enrolled Member on the process for changing ECM Providers, which is permitted at any time.

2.4.8.2 ECM Provider shall notify Health Net if an Enrolled Member wishes to change ECM Providers.

2.4.8.3 Health Net shall implement any requested ECM Provider changes within thirty days.

2.5 ECM Provider Staffing. At all times, ECM Provider shall have adequate staff to ensure its ability to carry out responsibilities for each Enrolled Member consistent with this Exhibit, the DHCS-MCP ECM CS Contract, and any other related DHCS guidance.

2.6 ECM Provider Outreach and Member Enrollment.

2.6.1 ECM Provider shall be responsible for conducting outreach to each Assigned Member on the Engagement List and enrolling each Assigned Member into ECM in accordance with Health Net Policies.

2.6.2 ECM Provider shall prioritize outreach of Assigned Members based on the highest level of risk and need for ECM.

2.6.3 ECM Provider shall conduct outreach primarily through in-person interaction where members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the Enrolled Member's consent.

2.6.3.1 ECM Provider shall use the following modalities, as appropriate, and as authorized by the Enrolled Member, if in-person modalities are unsuccessful or to reflect an Enrolled Member's stated contact preferences:

2.6.3.1.1 Mail
2.6.3.1.2 Email
2.6.3.1.3 Texts
2.6.3.1.4 Telephone calls
2.6.3.1.5 Telehealth

2.6.4 ECM Provider shall comply with non-discrimination requirements set forth in State and Federal law and this Agreement.

2.7 Initiating Delivery of ECM.

2.7.1 ECM Provider shall obtain, document and manage Enrolled Member authorization for the sharing of Personally Identifiable Information between Health Net ECM, CS, and other Providers involved in the provision of Enrolled Member care to the extent required by federal law.

2.7.2 Enrolled Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law.

2.7.3 When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Enrolled Member authorization for such data sharing back to Health Net.

2.7.4 ECM Provider shall notify Health Net to discontinue ECM under the following circumstances:

2.7.4.1 The Enrolled Member has met their care plan goals for ECM;

2.7.4.2 The Enrolled Member is ready to transition to a lower level of care;

2.7.4.3 The Enrolled Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or

2.7.4.4 ECM Provider has not had any contact with the Enrolled Member despite multiple attempts.

2.7.5 When ECM is discontinued, or will be discontinued, Health Net is responsible for sending a Notice of Action (NOA) notifying the Enrolled Member of the discontinuation of the ECM benefit and ensuring the Enrolled Member is informed of their right to appeal and the appeals process. ECM Provider shall communicate to the Enrolled Member other benefits or programs that may be available to the Enrolled Member, as applicable (e.g., Complex Care Management, Basic Care Management).

2.8 <u>Comprehensive Transitional Care.</u>

2.8.1 ECM Provider shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members enrolled in managed care. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate.

2.8.1.1 If ECM Provider subcontracts with other entities to administer ECM functions, ECM Provider shall ensure the subcontractors are bound to the terms and conditions set forth herein and the DHCS-MCP ECM CS Contract.

2.8.2 To the extent Health Net offers CS or other coordinated services, ECM Provider shall:

2.8.2.1 Ensure each Enrolled Member has a Lead Care Manager;

2.8.2.2 Coordinate across all sources of care management in the event that an Enrolled Member is receiving care management from multiple sources;

2.8.2.3 Alert Health Net to ensure non-duplication of services in the event that an Enrolled Member is receiving care management or duplication of services from multiple sources; and

2.8.2.4 Follow Health Net's instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

2.8.3 ECM Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the ECM Provider), behavioral health providers, Specialists, dental providers, providers of services for LTSS and other associated entities, such as CS Providers, as appropriate, to coordinate Enrolled Member care.

2.8.4 ECM Provider shall provide all core service components of ECM to each Enrolled Member, in compliance with Health Net Policies as follows:

2.8.4.1 Outreach and Engagement of Health Net Medi-Cal Beneficiaries into ECM.

2.8.4.2 Comprehensive assessment and care management plan, which shall include, but is not limited to:

2.8.4.2.1 Engaging with each Enrolled Member .

2.8.4.1.2 Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Enrolled Member health status and gaps in care, and may be needed to inform the development of an individualized care plan.

2.8.4.1.3 Developing a comprehensive, individualized, person-centered care plan by working with the Enrolled Member and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;

2.8.4.1.4 Incorporating into the Enrolled Member's care plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing;

2.8.4.1.5 Ensuring the care plan is reassessed at a frequency appropriate for the Enrolled Member's individual progress or changes in needs and/or as identified in the Care Management plan; and

2.8.4.5.6 Ensuring the Care Management Plan is reviewed, maintained and updated under appropriate clinical oversight.

2.8.4.2 Enhanced Coordination of Care, which shall include, but is not limited to:

2.8.4.2.1 Organizing patient care activities, as laid out in the Care Management Plan, sharing information with those involved as part of the Enrolled Member's multi-disciplinary care team, and implementing activities identified in the Enrolled Member's Care Management Plan;

2.8.4.2.2 Maintaining regular contact with all providers that are identified as being a part of the Enrolled Member's multi-disciplinary care team;

2.8.4.2.3 Ensuring care is continuous and integrated among all service providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services including housing, as needed;

2.8.4.2.4 Engaging the Enrolled Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Enrolled Member engagement in treatment;

2.8.4.2.5 Communicating the Enrolled Member's needs and preferences timely to the Enrolled Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and

2.8.4.2.6 Ensuring regular contact with the Enrolled Member and their family member(s), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

2.8.4.3 Health Promotion, which shall adhere to federal care coordination and continuity of care requirements (42 CFR 438.208(b)) and shall include, but is not limited to:

2.8.4.3.1 Working with Enrolled Members to identify and build on success and potential family and/or support networks;

2.8.4.3.2 Providing services to encourage and support Enrolled Members to make lifestyle choices based on healthy behavior, with the goal of supporting Enrolled Members' ability to successfully monitor and manage their health; and

2.8.4.3.3 Supporting Enrolled Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

2.8.4.4 Comprehensive Transitional Care, which shall include, but is not limited to:

2.8.4.4.1 Developing strategies to reduce avoidable Enrolled Member admissions and readmissions;

2.8.4.4.2 For Enrolled Members who are experiencing, or who are likely to experience a care transition:

i. Developing and regularly updating a transition of care plan;

ii. Evaluating medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;

iii. Tracking admission and/or discharge to or from an emergency department , hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center, and communicating with the appropriate care team members;

iv. Coordinating medication review/reconciliation; and

v. Providing adherence support and referral to appropriate services.

2.8.4.5 Member and Family Support, which shall include, but are not limited to:

2.8.4.5.1 Documenting an Enrolled Member's designated family member(s), AR, guardian, caregiver, and/or authorized support person(s), and ensuring all appropriate authorizations are in place to ensure effective communication among ECM Provider, the Enrolled Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), and Health Net, as applicable;

2.8.4.5.2 Activities to ensure the Enrolled Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Enrolled Member's condition(s) with the overall goal

of improving the Enrolled Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State and local privacy and confidentiality laws;

2.8.4.5.3 Ensuring ECM Provider serves as the primary point of contact for the Enrolled Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s);

2.8.4.5.4 Identifying support needed for the Enrolled Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Enrolled Member's condition and assist them in accessing needed support services;

2.8.4.5.5 Providing for appropriate education of the Enrolled Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) about care instructions for the Enrolled Member; and

2.8.4.5.6 Ensuring that the Enrolled Member has a copy of their care plan and information about how to request updates.

2.8.4.6 Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:

2.8.4.6.1 Determining appropriate services to meet the needs of Enrolled Members, including services that address SDOH needs, including housing, and services offered by Health Net as CS services; and

2.8.4.6.2 Coordinating and referring Enrolled Members to available community resources and following up with Enrolled Members to ensure services were rendered (i.e., "closed loop referrals").

2.9 Training. ECM Provider shall participate in all mandatory, provider-focused ECM trainings and technical assistance provided by Health Net, including in-person sessions, webinars, and/or calls.

2.10 Data Sharing to Support ECM.

2.10.1 Health Net will provide to ECM Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable:

2.10.1.1 Enrolled Member files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;

2.10.1.2 Encounter and/or claims data;

2.10.1.3 Physical, behavioral, administrative and SDOH data (e.g., Homeless Management Information System (HMIS data)) for all Enrolled Members; and

2.10.1.4 Reports of performance on quality measures and/or metrics, as requested.

2.10.1.5 Engagement List to aid ECM Provider with prioritizing outreach to Assigned Members based on highest level of risk and need for ECM services.

2.10.1.6 Additional reports and/or guidance as identified by Health Net or DHCS.

2.11 Quality and Oversight.

2.11.1 ECM Provider acknowledges Health Net will conduct oversight of its participation in ECM to ensure the quality of services provided and ongoing compliance with benefit requirements, which may include audits and/or corrective actions.

2.11.2 ECM Provider shall respond to all Health Net requests for information and documentation to permit ongoing monitoring of ECM.

2.12 Enhanced Care Management Benefit Costs. In order to monitor the impact of the benefit and effectiveness of the intervention in improving health outcomes from Enrolled Member and reducing overall health care costs, upon request from Health Net, ECM Provider shall provide ECMs Provider's cost data as requested by Health Net or DHCS to monitor the impact of the benefit and effectiveness of the intervention in improving health outcomes from Enrolled Member and reducing overall health care costs.

III. ECM CLAIMS, PAYMENT AND REIMBURSEMENT

3.1 Claims Submission and Reporting.

3.1.1 ECM Provider shall submit claims for the provision of ECM-related services to Health Net using the national standard specifications and code sets to be defined by DHCS.

3.1.1.1 For all ECM services rendered to Enrolled Members, including those Enrolled Members with multiple ECM services rendered in the same calendar month for the same ECM service, ECM Provider shall submit to Health Net, via Health Net's electronic claims submission program or hardcopy as determined by Health Net.

3.1.2 In the event ECM Provider is unable to submit claims to Health Net for ECM-related services using the national standard specifications and DHCS-defined code sets, ECM Provider shall submit an invoice to Health Net with a minimum set of data elements (to be defined by DHCS) necessary for Health Net to convert the invoice to an encounter for submission to DHCS.

3.2 Payment for ECM.

3.2.1 Health Net shall pay ECM Provider for the provision of ECM services in accordance with the rates established in this Exhibit.

3.2.2 Health Net shall pay ECM Provider at the applicable payment rate in Table 1 limited to only once per calendar month for each Enrolled Member. However, ECM Provider shall submit one (1) Complete Claim for all ECM services, when rendered, for each calendar month for each Enrolled Member as authorized by Health Net, and ECM Provider understand and agrees that Health Net shall have no obligation to pay ECM Provider claims more than once per calendar month for each Enrolled Member.

3.2.3 Health Net shall pay 90 percent of all clean claims within 30 days of date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the date Health Net receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

3.2.4 ECM Provider will provide outreach engagement to all Assigned Members under this Exhibit. ECM Provider shall submit a Complete Claim for each outreach, and EMC Provider agrees to accept the payment rate in Table 2 as payment in full from Health Net.

3.3 Reimbursement for ECM Services. The following Healthcare Common Procedure Coding System (HCPCS) codes must be used for ECM services. The HCPCS code and modifier combined define the service as ECM. For example, HCPCS code G9008 by itself does not define the service as an ECM service. HCPCS code G9008 must be reported with a modifier U1 for the care coordination service to be defined and categorized as an ECM service. If an ECM service is provided through telehealth, an additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy. ECM Provider shall accept the payment in full as listed in Tables 1 and 2 below from Health Net for ECM services provided to Enrolled Members assigned to Provider.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
G9008	ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services	U1	Used by Managed Care with HCPCS code G9008 to indicate Enhanced Care Management services
G9008	ECM Phone/Telehealth: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1, GQ	Used by Managed Care with HCPCS code G9008 to indicate Enhanced Care Management services
G9012	ECM In-Person: Provided by Non-Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U2	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
G9012	ECM Phone/Telehealth: Provided by Non-Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U2, GQ	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services

ECM Provider shall accept the payments listed in Table 1 below as payment in full from Health Net for authorized ECM services rendered by ECM Provider to Enrolled Members assigned to ECM Provider.

Table 1 – ECM RATES

	Non-Dual Eligible	Dual Eligible
County	**Rate**	
Nevada County	$ 400.00	$ 280.00

ECM Provider shall be paid at rates listed in Table 2 below for conducting outreach to Assigned Members in accordance with section 2.6 of this Exhibit. ECM Provider shall receive one (1) outreach payment for each Assigned Member.

Table 2 – OUTREACH RATE

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description	Rates
G9012	Outreach	U8	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services	$105.00

3.3 Adjustment to Payment Rates. ECM Provider understands and agrees that the State of California may adjust ECM related Medi-Cal payments to Health Net.

a. If the State of California adjusts such payments to Health Net and such adjustment impacts any services in ECM that are part of this Exhibit, Health Net shall use best efforts to give ECM Provider sixty (60) days' notice of its right to adjust rate amounts under this Exhibit in a proportional manner to Health Net's payments and effective as of the date the State of California adjusted the payments to Health Net.

b. In the event ECM Provider declines the rate adjustment, ECM Provider shall notify Health Net in writing at least thirty (30) days prior to the date the rate adjustment will be made of their intent to decline the adjustment and terminate this Exhibit. Health Net may, at its option, immediately begin to transition Enrolled Members to another ECM Provider.

c. In the event of a retroactive reduction, ECM Provider shall reimburse Health Net the amount owed based on the State of California's adjustment effective date and rate amounts within thirty (30) business days from the date Health Net notifies ECM Provider.

d. After the Initial Term, Health Net reserves the right to annually adjust ECM Provider's rates based on the review of ECM Provider's Complete Encounters, ECM costs, and ECM Provider's ability to effectively provide ECM care to meet specific Enrolled Member needs.

EXHIBIT A-2

DISCLOSURE FORM

(Required by California Welfare and Institutions Code Section 14452)

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency;

1) the identity of all owners with a control interest of five (5) percent or greater,
2) certain business transactions as described in 42 CFR 455.105, and
3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity.

If there are any changes to the information disclosed in this form, an updated form should be completed and submitted to Health Net Community Solutions, Inc. within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity		
Name of Individual, Group Practice, or Disclosing Entity		
DBA Name		
Federal Tax Identification Number	NPI	CAQH Number

Section I

Please list the name, title address, date of birth, and Social Security Number for each individual having an ownership or control interest in this provider of five (5) percent or greater.

Please list the name, Tax Identification Number, business address or each organization, corporation, or entity having an ownership or control interest of five (5) percent or greater. (42 CFR 455.104) Please attach a separate sheet if necessary.

Name of individual or entity	DOB	Address	SSN (for individual) or TIN (for entity)

Section II

Are any of the individuals listed in Section one related to each other?

- ☐ Yes
- ☐ No

If yes, list the individual's name above who are related to each other (spouse, sibling, parent, child). 42 CFR 455.104

Name	Relationship

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of five (5) percent or more?

- ☐ Yes
- ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of five (5) percent or more. 42 CFR 455.104

Name of individual or entity	DOB	Address	SSN (for individual) or TIN (for entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program?

- ☐ Yes
- ☐ No

If yes, list those persons below. 42 CFR 455.106

Name and Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more of than $25,000 or any significant business transactions with any subcontractors?

- ☐ Yes
- ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve (12) month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past five (5) year period. 42 CFR 455.105

Name of Supplier or Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information) as a Disclosing Entity?

- ☐ Yes
- ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date or birth, Address, Social, Security Number, and percent of interest.

Name and Title	DOB	Address	SSN	% of Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

_____ _____

Signature Title (indicate if authorized Agent)

_____ _____

Name (please print) Date

ADDENDUM B

BUSINESS ASSOCIATE ADDENDUM

A. This Addendum contemplates that Provider (hereinafter in this Addendum, "Business Associate") will provide a service to, or perform a function on behalf of Health Net, as more fully set forth in the Agreement, and in connection therewith, which is limited to claims processing, and/or Utilization Management, and/or credentialing, as more specifically set forth in the Agreement and/or delegation agreement , as applicable, Business Associate may use or disclose Protected Health Information including Electronic Protected Health Information ("ePHI") (collectively "PHI"), that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and certain privacy and security regulations found at 45 CFR Parts 160 through 164 ("HIPAA Regulations"), as they may be amended from time to time; the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"); and the Final Omnibus HIPAA/HITECH Rules (78 Fed. Reg. 5566 (Jan. 25, 2013)) (the "Final Regulations"). HIPAA, the HIPAA Regulations, the HITECH Act, and the Final Regulations are collectively referred to in this Addendum as the "HIPAA Requirements."

B. Protected Health Information *("PHI")* and Electronic Protected Health Information *("ePHI")* shall have the meaning given to such terms at 45 C.F.R. § 160.103.

C. Any entity which creates, uses, maintains, discloses or receives PHI from or *on behalf of Health Net* is a business associate, as defined in the HIPAA Requirements at 45 C.F.R. § 160.103; in addition, any entity (including an agent) that creates, receives, maintains, or transmits PHI *on behalf of a business associate* is now also considered a business associate under 45 C.F.R. §160.103 (and all such entities shall be referred to in this Addendum as "Subcontractors").

D. Pursuant to the HIPAA Requirements, all business associates of Health Net (and all Subcontractors of business associates) must agree in writing to certain mandatory provisions regarding the safeguarding, use and disclosure of PHI; and

E. The purpose of this Addendum is to satisfy the requirements of the HIPAA Requirements, including, but not limited to, business associate contract requirements set forth at 45 C.F.R. § 164.308(b)(1) and § 164.314(a) and § 164.504(e), as they may be amended from time to time.

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

1. Definitions. Unless otherwise provided in this Business Associate Addendum, other capitalized terms have the same meaning as set forth in the HIPAA Requirements.

2. Scope of Safeguards, Use and Disclosure of Protected Health Information. Except as otherwise limited in this Business Associate Addendum, Business Associate shall safeguard, use and disclose PHI solely to provide the services, or perform the functions, described in the Agreement, provided that such use or disclosure would not violate the HIPAA Requirements if so used or disclosed by Health Net. Business Associate, to the full extent applicable, shall ensure that its directors, officers, and employees shall:

(a) Not use or further disclose PHI other than as permitted or required by this Business Associate Addendum or as Required By Law;

(b) Implement appropriate administrative, physical and technical safeguards to protect the confidentiality and integrity of the PHI that Business Associate creates, receives, maintains or transmits on behalf of Health Net and to prevent use or disclosure of PHI other than as provided by this Business Associate Addendum;

(c) Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a safeguard, use or disclosure of PHI by Business Associate in violation of the requirements of this Business Associate Addendum;

(d) Report promptly to Health Net's designated Privacy Officer at privacy@healthnet.com any use or disclosure of PHI not provided for by this Business Associate Addendum of which Business Associate becomes aware;

(e) Require Subcontractors to whom Business Associate provides PHI received from, or created or received by Business Associate on behalf of, Health Net, to agree in writing to the same safeguards, restrictions and conditions that apply to Business Associate with respect to such PHI under this Business Associate Addendum and notify Subcontractors that they will incur liability under their agreement and under the HIPAA Requirements for non-compliance;

(f) Provide to Health Net in the form and format specified by Health Net (or, as directed by Health Net, to an Individual), and in the time and manner reasonably designated by Health Net, but in any event no later than 10 calendar days after written request by Health Net, any information necessary to allow Health Net to respond timely to a request by an Individual for a copy of the Individual's PHI pursuant to 45 C.F.R. § 164.524;

(g) Maintain for a period of six (6) years all Designated Record Sets relating to PHI received from, or created or received by Business Associate on behalf of, Health Net;

(h) Maintain for a period of six (6) years records of all disclosures of PHI, other than for the purpose(s) set forth in this Business Associate Addendum, including the date, name of recipient, description of PHI disclosed and purpose of disclosure;

(i) Provide to Health Net or, as directed by Health Net, to an Individual, in the time and manner reasonably designated by Health Net, but in any event no later than 10 calendar days after written request by Health Net, any necessary information collected in accordance with Section 2(H) of this Business Associate Addendum in order to allow Health Net to respond timely to a request by an Individual for an accounting of the disclosures of the Individual's PHI pursuant to 45 C.F.R. § 164.528;

(j) Make any amendments to PHI that Health Net directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of Health Net or an Individual in the time and manner designated by Health Net;

(k) Make reasonable efforts to implement any restriction of the use or disclosure of PHI that Health Net has agreed to as described under Section 4(c) of this Business Associate Addendum;

(l) Business Associate shall use appropriate administrative, physical, and technical safeguards to prevent improper use or disclosure of PHI in any form or media. As required by 45 C.F.R. Part 164, Subpart C with respect to ePHI, develop, implement, maintain, use and comply with administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that Business Associate creates, receives, maintains, or transmits on behalf of Health Net as required by 45 CFR Part 164, Subpart C;

(m) Additionally, as required by 45 CFR Part 164, Subpart C, with respect to ePHI, ensure that any Subcontractor, to whom Business Associate provides PHI, agrees, in writing, to develop, implement maintain, use and comply with reasonable and appropriate safeguards to protect the ePHI. Business Associate shall implement and comply with (and ensure that its Subcontractors implement and comply with) the administrative safeguards set forth at 45 C.F.R. 164.308, the physical safeguards set forth at 45 C.F.R. 310, the technical safeguards set forth at 45 C.F.R. 164.312, and the policies and procedures set forth at 45 C.F.R. 164.316 to reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI and ePHI that it accesses, uses, creates, maintain, transmits and/or discloses on behalf of Health Net. Business Associate acknowledges the foregoing safeguards, policies and procedures requirements shall apply to Business Associate and Business Associate's Subcontractors in the same manner that such requirements apply to Health Net;

(n) To disclose to its Subcontractors or other authorized third parties, only (i) the information contained in a "limited data set," as such term is defined at 45 C.F.R. 164.514(e)(2), or, (ii) if needed by Business Associate or its Subcontractors or other authorized third parties, the minimum necessary data to accomplish the intended purpose of such requests or disclosures. In all cases, Business Associate shall request and disclose PHI only in a manner that is consistent with guidance issued by the Secretary from time to time;

(o) Additionally, as required by 45 CFR Part 164, Subpart C, with respect to ePHI, report to Health Net any Security Incident (whether at Business Associate or at a Subcontractor) of which Business Associate becomes aware;

(p) Make Business Associate's internal practices, books, and records relating to the safeguards, use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Health Net available to Health Net or, at the request of Health Net, to the Department of Health and Human Services ("DHHS"), in a time and manner designated by Health Net or DHHS, for purposes of determining Health Net's compliance with the HIPAA Requirements; provided that, in all events, Business Associate shall immediately notify Health Net upon receipt by Business Associate of any request received from DHHS relating to Health Net's compliance with the HIPAA Requirements and shall provide Health Net with copies of any materials provided to DHHS;

(q) Business Associate agrees that with respect to any and all PHI received from Health Net or created or received by Business Associate on behalf of Health Net that Business Associate maintains, or which is maintained by any Subcontractor of Business Associate, in any form (collectively for this Section referred to as "Health Net PHI") and no longer needed to perform services under the Agreement, or, at any time upon Health Net's written request, Business Associate will return or destroy all Health Net PHI, and shall retain no copies of such Health Net PHI; provided that if such return or destruction is not feasible or contrary to the record retention requirements of the Agreement or applicable law, Business Associate shall extend the protections of the Agreement to the Health Net PHI and limit further uses and disclosures to those purposes that make the return or destruction of the Health Net PHI infeasible or that require Business Associate to retain PHI. A senior officer of Business Associate shall certify in writing to Health Net that all PHI has been returned or destroyed as provided above and that Business Associate retains no copies of PHI in any form;

(r) Allow Health Net, upon reasonable notice, to inspect Business Associate's policies, procedures and practices with respect to compliance with the terms of this Business Associate Addendum; provided, however, that Health Net has no duty to inspect and its decision not to inspect does not relieve Business Associate of its compliance responsibility;

(s) To the extent that Business Associate carries out one or more of Health Net's obligations under the HIPAA Requirements, Business Associate must comply with all requirements of the HIPAA Requirements that would be applicable to Health Net;

(t) Business Associate must honor all restrictions consistent with 45 C.F.R. §164.522 that Health Net or the Individual makes the Business Associate aware of, including the Individual's right to restrict certain disclosures of protected health information to a health plan where the individual pays out of pocket in full for the healthcare item or service, in accordance with the HIPAA Requirements; and

(u) Except as provided for in this Business Associate Addendum, in the event Business Associate receives an access, amendment, accounting of disclosure, or other similar request directly from an Individual, Business Associate shall provide Health Net with written notice of such request within five (5) business days of such request. If applicable, within five (5) business days of notice to Business Associate by Health Net of a request for an accounting of disclosures, access or amendment request, Business Associate shall make available the PHI to Health Net as required for Health Net to comply with 45 C.F.R. §164.528; provide Access consistent with the requirements of 45 C.F.R. §164.524; and/or, provide an accounting consistent with the requirements of 45 C.F.R. §164.528. If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable Health Net to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. §17935(e).

3. Reporting of Breaches.

(a) In addition to the obligations set forth elsewhere in this Business Associate Addendum, Business Associate agrees that, except as specifically provided in subsection (c), Business Associate agrees to report to Health Net's Privacy Officer at privacy@healthnet.com any Breach of Unsecured PHI, including any Breach of Unsecured PHI involving Business Associate's Subcontractors, the same business day after Discovery of a Breach. More specifically, as provided for in 45 C.F.R. § 164.102, Business Associate recognizes and agrees that any acquisition, access, use or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule (Subpart E of 45 C.F.R. Part

164) is presumed to be a Breach. As such, Business Associate shall (i) notify Health Net of any non-permitted acquisition, access, use or disclosure of PHI, and (ii) assist Health Net in performing (or at Health Net's direction, perform) a risk assessment to determine if there is a low probability that the PHI has been compromised. Such notice shall include the identification of each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate, to have been, accessed, acquired, or disclosed in connection with such Breach. Notifications should be sent to privacy@healthnet.com. In addition, Business Associate shall provide any additional information reasonably requested by Health Net for purposes of investigating and responding to the Breach.

(b) In the case of a Breach of Unsecured PHI (whether by Business Associate or Business Associate's Subcontractor), Business Associate agrees to provide Health Net with information to enable it to assess whether there is a low probability that the data involving protected health information has been compromised and to cooperate with Health Net in meeting any other obligations under the HIPAA Requirements and other applicable security breach notification laws. The information must include information regarding the following factors: the nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification; the unauthorized person(s) who used the protected health information or to whom the disclosure was made; whether the protected health information was actually acquired or viewed; and, the extent to which the risk to the protected health information has been mitigated.

(c) Additional Responsibilities in the Event of Breach. Business Associate shall take prompt steps to limit or avoid the recurrence of any Breach and take any other action pertaining to such unauthorized access or disclosure required by applicable federal and state laws and regulations. Business Associate shall comply with this provision regardless of any actions taken by Health Net. Business Associate further agrees to mitigate, to the extent practicable, any harmful effect that becomes known to Business Associate of a Breach or a use or disclosure of PHI by Business Associate in violation of the requirements of this Business Associate Addendum.

4. Obligations of Health Net. To assist Business Associate in the proper use and disclosure of PHI, Health Net shall:

(a) Provide Business Associate with the notice of privacy practices that Health Net produces in accordance with 45 C.F.R. § 164.520, as well as any changes to such notice;

(b) Provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures;

(c) Notify Business Associate of any restriction on the use or disclosure of PHI that Health Net has agreed to in accordance with 45 C.F.R. § 164.522; and

(d) Not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Requirements if the PHI were to be so used or disclosed by Health Net.

5. Standard Transactions. To the extent Business Associate conducts Standard Transaction(s) on behalf of Health Net, Business Associate shall, without limitation, comply with the HIPAA Regulations, "Administrative Requirements for Transactions," 45 C.F.R. § 162.100 et seq., and shall not: (a) Change the definition, data condition or use of a data element or segment in a standard; (b) Add any data elements or segments to the maximum defined data set; (c) Use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) Change the meaning or intent of the standard's implementation specifications.

6. Termination for Breach.

(a) Health Net and Business Associate each shall have the right to terminate the Agreement upon written notice to the other if either Party determines that the other Party has breached a material term of the provisions of this Business Associate Addendum; provided that Health Net's remedies under this Business Associate Addendum and the section(s) of the Agreement related to termination, if any, shall be cumulative.

(b) As an alternative to the preceding paragraph, either Party may choose to provide the other Party with ten (10) days written notice of the existence of an alleged material breach, and afford the Party in breach the opportunity to cure such alleged material breach. The Party receiving such breach notice must cure such breach to the satisfaction of the non-breaching Party or the non-breaching Party may declare a material breach in accordance with Section 6(a) above. If termination of this Business Associate Addendum or the Agreement is not feasible, Health Net shall report the problem to the Secretary of U.S. Health and Human Services.

7. Future Confidentiality of PHI. Upon the expiration or earlier termination of the Agreement, for any reason and only upon written request by Health Net, Business Associate shall return or destroy all PHI received from Health Net, or created or received by Business Associate on behalf of Health Net that Business Associate still maintains and retain no copies of such PHI; provided that if such return or destruction of PHI is infeasible, Business Associate shall provide to Health Net notification of the conditions that make return or destruction infeasible and shall extend the protections of this Business Associate Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. Business Associate agrees that if applicable state law requires the retention of Health Net PHI for a specified time period, Business Associate shall postpone destruction of such Health Net PHI in compliance with applicable state law.

8. Survival of Terms. The obligations of Business Associate under Sections 2(f), 2(g), 2(h), 2(i), 2(p), 2(q) and 3 of this Business Associate Addendum shall survive the termination or expiration of the Agreement.

9. Injunctive Relief. Business Associate agrees that the remedies at law for any breach by it of the terms of this Business Associate Addendum shall be inadequate and that monetary damages resulting from such breach are not readily measured. Accordingly, in the event of a breach or threatened breach by Business Associate of the terms of this Business Associate Addendum, Health Net shall be entitled to immediate injunctive relief. Nothing herein shall prohibit Health Net from pursuing any other remedies available to it for such breach, and Health Net's rights under this Business Associate Addendum and the sections of the Agreement related to injunctive relief, if any, shall be cumulative.

10. Amendment of Addendum. In the event of a material change in the HIPAA Requirements or state law affecting safeguards or the use or disclosure of PHI, or amendments for new or changed Standard Transactions or Identifiers, Health Net may amend this Business Associate Addendum and the Agreement as necessary to comply with the change in the law or regulation and such amendment shall become effective sixty (60) days after receipt by Business Associate. Health Net's rights and remedies under this Business Associate Addendum and the section(s) of the Agreement related to amendments, if any, shall be cumulative.

11. Notice of Investigation or Lawsuit and Indemnification. Business Associate shall notify Health Net immediately upon receipt of notice of an investigation or of a lawsuit filed against Business Associate related to or arising from the use or disclosure of PHI by Business Associate or a Business Associate Subcontractor pursuant to this Business Associate Addendum. Any indemnification provision in the Agreement shall apply to Business Associate's and Health Net's use and disclosure of PHI pursuant to this Business Associate Addendum; provided, however, that the limits of liability and limits on consequential type damages, if any, provided in the Agreement shall not apply in the event of a breach of this Business Associate Addendum or with respect to Business Associate's obligations for indemnification.

12. Confidentiality. Notwithstanding the foregoing, PHI shall not be included within the definition of "confidential information" in the section(s) of the current Agreement related to protection of confidential information, if any, as Business Associate's obligations with respect to PHI are set forth in this Business Associate Addendum.

13. State Law Requirements. To the extent that State law is more stringent than the HIPAA Requirements, any safeguard, use or disclosure of PHI by Business Associate shall be made in accordance with State law.

14. Interpretation. Any ambiguity in this Business Associate Addendum shall be resolved in favor of a meaning that permits Health Net to comply with the HIPAA Requirements.

15. Effective Date. This Business Associate Addendum shall be effective on the effective date of the Agreement.