blue of california

«General>>Provider Name»

Provider Agreement

Independent Provider Agreement

(All Products)

«General>>Effective Date»

Blue Shield of California
601 12th Street, Oakland, CA 94607

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INDEPENDENT FEE FOR SERVICE PROVIDER AGREEMENT

This INDEPENDENT PROVIDER AGREEMENT (this **"Agreement"**) is entered into between «General>>Provider Legal Name», «General>>Provider Business Type» ("Provider") and California Physicians' Service, dba Blue Shield of California, a California nonprofit corporation, (**"Blue Shield"**) on behalf of itself, and its licensed health plan affiliates. This Agreement shall be effective as of the date of execution by Blue Shield (the "Effective Date").

RECITALS

A. Blue Shield is licensed as a prepaid health care service plan under the Knox-Keene Act of 1975, as amended (the **"Knox-Keene Act"**). Blue Shield and its licensed health care service plan affiliates contract with individuals, associations, employer groups, and governmental entities to provide or to arrange for the provision of covered health care services to Members (as defined herein) enrolled in health plan Benefit Program(s) (as defined herein).

B. Provider is an individual physician duly licensed to practice medicine in the State of California, ("Physician Provider), or an individual non-physician duly licensed in the State of California ("Non-Physician Provider"), a California Medical Foundation, duly organized under California Health & Safety Code section 1206(l), or a California professional medical corporation, the shareholders of which are individuals who are duly licensed to practice medicine in the State of California, or an entity comprised of individuals who are duly licensed to practice in the State of California.

C. Plans and Provider desire that Provider be included as a participating provider in its provider networks to provide certain Covered Services (as defined herein) to its Members.

D. This Agreement is designed for use with a variety of Benefit Programs. Provisions specific to particular Benefit Programs are included in Exhibits to this Agreement.

NOW, THEREFORE, the parties hereto agree as follows:

I. DEFINITIONS

For purposes of this Agreement, the following capitalized terms shall have the meanings ascribed to them below:

1.1 **Authorization/Authorized**: is the approval of Health Plan, or its delegate, for the provision of Covered Services obtained in accordance with, and as further described in, the Provider Manual and this Agreement.

1.2 **Benefit Program**: is a health benefit policy or other health benefit contract or coverage document (a) issued by Health Plan or (b) administered by Health Plan pursuant to a

government contract. Benefits Programs and their designs are subject to change periodically.

1.3 **Blue Shield Provider Allowances:** is the term used to describe the compensation schedules, as further described in the Provider Manual.

1.4 **CMS**: is the Centers for Medicare and Medicaid Services, an agency of the federal government.

1.5 **Commercial Benefit Program:** is a Benefit Program based on a contract between an employer or individual and Health Plan for coverage for health care services.

1.6 **Commercial Member:** is a Member enrolled in a Commercial Benefit Program.

1.7 **Continuity of Care:** are those Covered Services that a qualifying Member is entitled to receive pursuant to California Health and Safety Code Section 1373.96, Completion of Covered Services, and Public Health Service Act, Title XXVII, part D, Sections 2799A-3 and 2799B–8, Continuity of Care (hereinafter Consolidated Appropriations Act, 2021 (CAA), Section 113).

1.8 **Copayment:** is any copayment, deductible, coinsurance, and/or amounts in excess of the maximum benefit for which a Member is financially responsible in connection with the receipt of Covered Services, as specifically described in the Health Services Contract and/or Evidence of Coverage applicable to the Member and in effect as of the date of service. Any other amount which Provider may seek to recover from Members for Covered Services constitutes a surcharge and is prohibited by both this Agreement and the Knox-Keene Act.

1.9 **Covered Services:** are Medically Necessary health care services, supplies and drugs that a Member is entitled to receive pursuant to the Benefit Program applicable to the Member. Except as otherwise provided in the Member's Health Services Contract and Evidence of Coverage, Covered Services must generally be referred and authorized in conformity with Health Plan's utilization management programs.

1.10 **Culturally and Linguistically Appropriate Services or CLAS:** means those services required by Department of Health and Human Services ("DHHS"), Office of Minority Health ("OMH"), Final Report on "National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care" published in the Federal Register, Volume 65, No. 247 of December 22, 2000, as amended AND the DHHS, Office for Civil Rights (OCR), "Policy Guidance on the Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency (LEP)" to be provided by health care plans and providers to Members with limited English proficiency ("LEP"), and DHCS, DMHC, the Local Initiative and Plan-required CLAS services.

1.11 **DHCS:** is the California Department of Health Care Services or any successor agency thereto.

1.12 **DMHC:** is the California Department of Managed Health Care or any successor agency thereto.

1.13 **Emergency Services:** has the meaning set forth in the Member's Evidence of Coverage based on the Member's Benefit Program.

1.14 **Evidence of Coverage:** is the document issued to the Member, pursuant to California law, that describes the benefits, limitations and other features of the Benefit Program in which the Member is enrolled, sometimes referred to as a Member Handbook.

1.15 **Health Plan:** is the applicable licensed health care service plan that can access services under this Agreement as identified in Exhibit A and is either Blue Shield or is affiliated with Blue Shield.

1.16 **Health Plan Provider(s):** are those licensed health care providers, including, without limitation, institutional providers, that have entered into agreements with a Health Plan to provide Covered Services to Members.

1.17 **Health Services Contract:** is the group or individual contract that describes the Benefit Program and the Covered Services to which a Member is entitled, as well as the Member's Copayment obligation.

1.18 **Laws and Regulations:** means any and all laws and regulations of the State of California or of the United States and all orders, instructions and other requirements of any government agency, including, but not limited to, the Medicare Advantage Manual and All Plan Letters issued by DHCS, which are applicable to this Agreement.

1.19 **Local Initiative**: is L.A. Care Health Plan, the duly constituted government agency that is Los Angeles County's locally created health care service plan.

1.20 **Medi-Cal**: is the federal and state funded health care program established by Title XIX of the Social Security Act, as administered in California by DHCS.

1.21 **Medi-Cal Benefit Program**: A Benefit Program based on a contract between DHCS and Health Plan or the Local Initiative for the coverage for health care services.

1.22 **Medi-Cal Member**: is a Member enrolled in a Medi-Cal Benefit Program.

1.23 **Medically Necessary or Medical Necessity**: means, with respect to the provision of medical services, supplies and drugs: (a) required by a Member; (b) provided in accordance with recognized professional medical and surgical practices and standards; (c) appropriate and necessary for the symptoms, diagnosis, or treatment of the Member's medical condition; (d) provided for the diagnosis and direct care and treatment of such medical condition; (e) not furnished primarily for the convenience of the Member, the Member's

family, or the treating provider or other provider; (f) furnished at the most appropriate level that can be provided consistent with generally accepted medical standards of care; and (g) consistent with Blue Shield Medical Policy and Blue Shield Medication Policy.

1.24 **Medicare Advantage Benefit Program**: A Benefit Program based on a contract between CMS and Health Plan to provide eligible Medicare Advantage Members with coverage for health care services.

1.25 **Medicare Advantage Member**: is a Member enrolled in and eligible for a Medicare Advantage Benefit Program.

1.26 **Member:** is an individual who is eligible for and enrolled in a Benefit Program to which this Agreement applies (as identified in Exhibit A) or a health benefit plan of an Other Payor (as defined in Section 9.11 hereof).

1.27 **Plan(s):** means, collectively, Health Plan and the licensed health care service plans affiliated with Health Plan that can access services under this Agreement, as identified in Exhibit A.

1.28 **Provider Appeal:** is Provider's written notice to Health Plan challenging, appealing, or requesting reconsideration of a claim, requesting resolution of billing determinations, such as bundling/unbundling of claims/procedure codes or allowances, or disputing administrative policies & procedures, administrative terminations, retro-active contracting, or any other issue related to the parties' respective obligations under this Agreement.

1.29 **Provider Manual:** is the set of manuals developed by Health Plan that set forth the operational rules and procedures applicable to Provider and the performance of services hereunder, and such other documents used by Blue Shield to determine reimbursement rates under the terms of this Agreement, including, without limitation Blue Shield's Medical Policy and Blue Shield Medication Policy, and, for physician providers, the Bylaws of Blue Shield.

II. PROVIDER SERVICES

2.1 **Providing Covered Services.** Provider shall provide to Members those Covered Services which Provider is licensed and qualified to provide ("Provider Services"). Consistent with Section 2240.4 of Title 10 of the California Code of Regulations, Provider's primary consideration shall be the quality of the health care services rendered to Members.

2.2 **Non-Discrimination.** Provider shall provide services to Members in a manner similar to that in which Provider furnishes services to all other Provider patients, and with the same availability afforded to such patients. Provider shall not discriminate against Members on the basis of race, sex, gender, gender identity, gender expression, color, religion, national origin, ancestry, age, marital status, physical or mental handicap, health status, disability, need for medical care, utilization of medical or mental health services or supplies, sexual preference

or orientation, veteran's status, health insurance coverage, status as a Member, or other unlawful basis including without limitation, the filing by a Member of any complaint, grievance, or legal action against Provider. In providing services to Members, Provider shall comply with all applicable laws including, without limitation, the Americans with Disabilities Act. If (a) absent this Agreement, Provider would not be obligated to comply with any such laws, or (b) there is a new interpretation of or change to existing law that imposes new obligations on Provider, and (c) Provider reasonably determines that compliance with such laws would represent a material cost to Provider, Blue Shield agrees to meet with Provider in good faith to discuss the additional costs and possible additional compensation. If Blue Shield and Provider are unable to reach agreement regarding additional compensation, then Provider may terminate this Agreement upon sixty (60) days' prior written notice to Blue Shield.

2.3 **Service Authorization.** Provider shall comply with the Authorization procedures and requirements set forth in the Provider Manual and this Section 2.3. Provider understands and agrees that, except in the case of Emergency Services, Medically Necessary post-stabilization care services deemed Authorized pursuant to Section 1300.71.4(b)(2) of Title 28 of the California Code of Regulations, or as otherwise provided in the Provider Manual, Provider Services must be Authorized in advance by Health Plan or its delegate in order for Provider to be eligible for payment hereunder. Health Plan will not retroactively deny Provider's claims on the basis of Medical Necessity for services reviewed and Authorized pursuant to the Quality Improvement and Utilization Management Program, provided that Provider submitted full and accurate information to Health Plan for review under its Quality Improvement and Utilization Management Program. If Provider fails to obtain Authorization prior to providing Provider Services to a Member, as required, or if Provider provides services outside of the scope of the Authorization obtained, then Health Plan, or its delegate, shall have no obligation to compensate Provider for such services; Provider will be deemed to have waived payment for such services and shall not seek payment from Health Plan, its delegate, or the Member.

2.4 **Provider Referrals.** Except as permitted by the Member's Evidence of Coverage, Provider shall not refer a Member to other health care providers without an advance Authorization from Health Plan or its delegate or otherwise in accordance with the utilization management procedures established by Health Plan and as described in the Provider Manual. Without limiting the foregoing, if this Agreement applies to Health Plan commercial HMO, EPO and/or Medicare Advantage Benefit Programs, Provider shall refer commercial HMO, EPO and/or Medicare Advantage Members only to health care providers who/that have entered into agreements with Health Plan to provide Covered Services to Members for the provision of Covered Services. This provision shall not apply in the event a Member requires Emergency Services.

2.5 **Ancillary Tests and Procedures.** Except as otherwise set forth in the Provider Manual, any ancillary testing and/or procedures (e.g., radiologic, laboratory, etc.) required in the treatment of Members shall be performed by Provider unless (a) Provider does not have the

facilities or capacity to perform a particular test or procedure, or (b) it is Medically Necessary to have the test or procedure performed by persons other than Provider. Provider shall, as set forth in the Provider Manual, obtain authorization from Health Plan prior to performing such ancillary test or procedures.

2.6 **Language Assistance Program.** Provider shall cooperate and comply with Health Plan's language assistance program, as set forth in the Provider Manual. Nothing in this Section shall be construed as a delegation to Provider of Health Plan's obligations pursuant to Section 1300.67.04 of Title 28 of the California Code of Regulations or Section 2538.3 of Title 10 of the California Code of Regulation.

2.7 **Tiered Benefit Designs and Narrow Networks.**

(a) Provider acknowledges and agrees that nothing in this Agreement shall limit or otherwise prohibit Health Plan from:

(i) at any time developing, marketing and implementing: (A) tiered products, plans, benefit designs or Benefit Programs; (B) provider networks which tier or rank participating providers (including Provider) and where such tier or rank directly affects the Member's and/or employer's premium, copayment or cost share or restricts or limits network access; and/or (C) narrow, restricted or limited provider networks or products that require Members (or those who pay for their coverage) to pay more for the same (or substantially similar) product or benefit design to access all Health Plan contracted providers compared to a network that does not include Provider (collectively, **"Tiered/Narrow Products"**); and

(ii) except as expressly provided in Exhibit A hereto, including Provider in or excluding Provider from, or tiering or ranking Provider within, any such Tiered/Narrow Product.

2.8 **Members' Rights and Responsibilities.** Health Plan does not delegate or sub-delegate member rights and responsibilities. For additional details and a full listing of these rights and responsibilities, please refer to the Provider Manual.

2.9 **Provider Manual**. Provider shall comply with the Provider Manual, the terms of which are incorporated herein by reference. A Health Plan may, in its sole discretion, periodically modify its Provider Manual. The Health Plan shall notify Provider no fewer than forty-five (45) working days prior to the effective date of any change to the Provider Manual. If Provider reasonably concludes that a change to the Provider Manual is material, Provider shall notify the Health Plan, in writing, prior to the effective date of the change. Following receipt of Provider's notice, Provider and the Health Plan shall confer in good faith regarding the change. If Provider and the Health Plan are unable to reach agreement regarding the change within thirty (30) days of Provider's notice, then, within sixty (60)

days of Provider's notice, Provider may elect to terminate this Agreement for cause pursuant to Section 7.4 hereof and the Provider Manual change to which Provider objected shall not be effective as to Provider during the termination notice period. To the extent of any conflict between this Agreement and the Provider Manual, the terms of this Agreement shall govern.

III. COMPENSATION

3.1 **Compensation.** In exchange for the provision of Covered Services to Members Health Plan shall pay Provider the lesser of (i) the applicable reimbursement rates set forth in Exhibit B hereto, or (ii) Provider's billed charges, in either case, less the Member's applicable Copayment.

3.2 **Payment of Claims.** Health Plan shall pay all valid and complete claims from Provider for Covered Services upon receipt, in accordance with the timeframes set forth in California law and in accordance with the Health Plan claims adjudication rules and procedures as set forth in the Provider Manual. Provider shall accept electronic payment for Covered Services and receive related explanations of payments (**"EOPs"**) via electronic funds transfer (**"EFT"**) and electronic remittance advice (**"ERA"**), respectively. Provider shall bill Health Plan in accordance with the procedures as set forth in the Provider Manual and as described on Health Plan's websites identified in Exhibit A. All claims payments by Health Plan will be accompanied by a remittance advice which describes the manner in which the claim was adjudicated and payment was issued. In the event a claim or any portion thereof is denied payment by Health Plan, Provider will receive an appropriate communication from Health Plan that describes the basis for the denial and contains all appropriate information as may be required by applicable state and federal law.

3.3 **Timely Submission of Claims.** Provider shall submit complete claims to Health Plan for Covered Services furnished to Members no later than twelve (12) months from the date such Covered Services were furnished by Provider or, if Health Plan is not the primary payor under the coordination of benefits rules described in Section 3.6 hereof, the date payment or denial is received by Provider from the primary payor. If Provider fails to submit a claim for Covered Services within the timeframes set forth in this Section, Health Plan may deny payment of the claim. In such event, Provider waives its right to any remedies and to pursue the claim further, and may not initiate a demand for arbitration or other legal action against Health Plan or pursue the Member for additional payment; provided, however, that Health Plan shall, upon submission of a Provider Appeal by Provider, consider good cause for late submission of a claim denied as untimely.

3.4 **Claims Submission.** Provider shall submit claims electronically, following the procedures set forth in the Provider Manual. Payment by Health Plan will be made only upon receipt of a complete claim submitted by Provider in accordance with this Agreement. Failure to submit claims electronically in accordance with the Provider Manual shall be deemed a material breach of the Agreement.

3.5 **Charges to Members.**

(a) In no event, including without limitation nonpayment by Health Plan, or Health Plan's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, impose a surcharge on, seek compensation, remuneration or reimbursement from, or have any recourse against, a Member, or any individual responsible for such Member's care, for Covered Services. Without limiting the foregoing, Provider shall not seek payment from a Member, or any individual responsible for such Member's care, for Covered Services for which payment was denied by Health Plan because the bill or claim for such Covered Services was not timely or properly submitted. If Health Plan receives notice of a violation of this Section, it shall have the right to take all appropriate action, including without limitation, the right, following thirty (30) days' written notice to Provider, to reimburse the Member for the amount of any payment made and to offset the amount of such payment from any amounts then or thereafter owed by Health Plan to Provider.

(b) Provider shall not bill or collect from a Member any charges in connection with non-Covered Services, non-authorized services, or services determined not to be Medically Necessary unless Provider has first obtained a written acknowledgment from the Member, or the individual responsible for such Member's care, that such services are either not Covered Services, not authorized, or not Medically Necessary, as the case may be, and that the Member, or the individual responsible for such Member's care, is financially responsible for the cost of such services. Such acknowledgment shall be obtained prior to the time that such services are furnished to the Member and shall satisfy the applicable requirements set forth in the Provider Manual. Notwithstanding the foregoing, if, due to specific circumstances, Provider is not reasonably able to obtain such acknowledgment prior to the time the services are rendered, Provider shall be permitted to seek payment from the Member for such non-Covered Services.

(c) In the event of Health Plan's insolvency or other cessation of operations, Provider shall continue to provide Covered Services to Members through the period for which such Members' premiums have been paid, or, with respect to Members enrolled in Health Plan's Medicare Advantage Benefit Program, the duration of the contract period for which the **CMS** payments have been made, and, with respect to any Member who is confined in an inpatient facility on the date of insolvency or other cessation of operations, until the Member's discharge.

(d) The provisions of this Section 3.5 shall: (i) survive the expiration or termination for any reason of this Agreement; (ii) be construed to be for the benefit of Members; and, (iii) supersede any oral or written contrary agreement (now existing or hereafter entered into) between Provider and any Member.

3.6 **Coordination of Benefits & Third-Party Recoveries.** Coordination of benefits, benefit determinations under the Medicare Secondary Payor rules, and Workers' Compensation recoveries shall be conducted by Provider in accordance with the procedures set forth in the Provider Manual. Notwithstanding Section 3.1 or the foregoing provisions of this Section 3.6, if Health Plan is not the primary payor under coordination of benefit rules, Provider shall not make any demand for payment from Health Plan until all primary sources of payment have been pursued. In such cases, Health Plan's financial obligation for Provider Services shall be limited to the amount, if any, which, when added to the amount obtained by Provider from all primary payors, equals the amount of compensation to which Provider is entitled under this Agreement for such Provider Services. Notwithstanding the above, in the event it is determined that Member's Medi-Cal coverage is secondary under applicable coordination of benefits rules, Health Plan shall pay Provider no greater amount than that which, when added to amounts payable to Provider from other sources under applicable coordination of benefits rules, does not exceed the maximum allowable Medi-Cal fee-for-service rates.

3.7 **Provider Contracts with Groups or IPAs.** If Provider is a party to an agreement with a medical group or independent provider organization (**"IPA"**) under which Provider agrees to provide services to enrollees of health maintenance organizations, including members of Health Plan, then Provider agrees that such agreement shall apply to services rendered to members of Health Plan to which such agreement applies. This Agreement shall not apply to Covered Services rendered to any such members unless a judicial or regulatory interpretation of existing statutes reaches, or enacted legislation results in, a contrary conclusion.

3.8 **Copayments**. Provider shall collect and retain a Member's applicable Copayment for Covered Services provided pursuant to this Agreement. Provider shall not waive a Member's Copayment obligation. Notwithstanding the foregoing, Provider acknowledges that cost sharing for Members eligible for both Medicare and Medicaid/Medi-Cal (**"Dual Eligible Members"**) is limited to the cost sharing limits established by Medicaid/Medi-Cal. With respect to Covered Services provided to Dual Eligible Members and Medi-Cal Members, Provider shall accept payment by Health Plan as payment-in-full for such Covered Services or will separately bill the appropriate State source for any amounts above the Medicaid/Medi-Cal cost sharing limits.

3.9 **Payments to Subcontractors.** If Provider subcontracts with any individual or entity to provide Covered Services on behalf of Provider, Provider shall process claims from and pay such individual or entity for such Covered Services in compliance with the timeliness requirements set forth in applicable state and federal law.

3.10 **BlueCard Claims**.

(a) If and for so long as Provider is not contracted with another licensee of the Association (as defined in Section 9.13) in the State of California besides any Health Plan, Provider shall submit to Health Plan for processing all claims for

medical services (including, without limitation, Provider Services) furnished by Provider and reimbursable through the BlueCard Program.

(b) Nothing in Section 3.10(a) shall be construed to require Provider to submit to Health Plan for processing claims for Provider Services furnished to a Member enrolled in a benefit plan having an exclusive arrangement with another licensee of the Association in the State of California, it being expressly understood that claims for Provider Services furnished to a Member enrolled in a benefit plan having an exclusive arrangement with a particular licensee of the Association in the State of California should be sent to and processed by such licensee.

3.11 **Directory Information Validation.** Blue Shield, on behalf of itself and its affiliates, or its vendor(s) shall send Provider a notice in accordance with Section 116 of the Consolidated Appropriations Act of 2021 and Health and Safety Code Section 1367.27(l) to validate Provider information in order to maintain the directory of Health Plan Providers described in Section 9.8 of this Agreement. If, after following the process described in the Provider Manual, Health Plan or its vendor(s) have not received a response from Provider, Health Plan may delay payment or reimbursement in accordance with 1367.27 of the California Health and Safety Code and 42 C.F.R. Section 438.10.

3.12 **Claims Overpayments and Recoveries.**

(a) Provider shall notify Health Plan of any payment Provider receives that exceeds the agreed upon amount payable by Health Plan on a claim for reimbursement under this Agreement (a "Claims Overpayment"), and Provider shall return any such Claims Overpayment to Health Plan within thirty (30) business days from the date Provider first becomes aware of the Claims Overpayment.

(b) In the event Health Plan determines that it has issued a Claims Overpayment to Provider, whether in connection with an audit or otherwise, Health Plan shall notify Provider in writing through a separate Claims Overpayment notice clearly identifying the claim, the name of the Member, the date of service, and an explanation of the basis upon which Health Plan 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. Health Plan must issue a Claims Overpayment notice within (i) three hundred sixty-five (365) days of the date of payment on the Claims Overpayment for any claims submitted under Benefit Programs regulated by the DMHC or the California Department of Insurance ("CDI"), or within (ii) three (3) years from the date of payment on the Claims Overpayment for claims submitted under other types of Benefit Programs that are not regulated by the DMHC or the CDI, or (iii) at any time in the event of fraud and/or misrepresentation. Health Plan shall send such Claims Overpayment notice to Provider's address of record with Health Plan for the receipt of claims related correspondence and payments unless Provider informs Health Plan 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.

(c) If Provider does not timely contest Health Plan's Claims Overpayment notice (an "Uncontested Claims Overpayment"), Provider must reimburse Health Plan for the Uncontested Claims Overpayment within thirty (30) business days of Provider's receipt of the Claims Overpayment notice.

(d) If Provider does not reimburse Health Plan for an Uncontested Claims Overpayment within the thirty (30) business day period, then, beginning as of the first calendar day following the expiration of the thirty (30) business day period, Health Plan may commence offsetting the amount of the Uncontested Claims Overpayment from Provider's then-current claims. If Health Plan exercises its offset rights under this Section 3.12(d), Health Plan shall provide Provider a detailed written explanation identifying the specific Claims Overpayments that have been offset against the specific current claims.

(e) In the event Provider desires to contest Health Plan's notice of Claims Overpayment, Provider must do so within thirty (30) business days from the date Provider receives the Claims Overpayment notice, by sending a written notice to Health Plan that contains the following information: Provider's name, identification number, contact information, a clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which Provider believes that the claim was not overpaid and the request for reimbursement of the Claims Overpayment amount is not correct. Provider's notice must be sent to Health Plan's provider appeals unit at the address listed in the Provider Manual. Health Plan shall review and make a decision with respect to Provider's appeal ("Final Claims Overpayment Determination"), and Health Plan shall notify Provider of the Final Claims Overpayment Determination in writing within forty-five (45) business days of the date Health Plan receives Provider's written notice. In the event Health Plan's Final Claims Overpayment Determination upholds the Claims Overpayment, Provider must reimburse Health Plan within thirty (30) business days from the date Provider receives the Final Claims Overpayment Determination.

(f) In the event Provider desires to dispute the Final Claims Overpayment Determination, Provider must timely follow the dispute resolution process set forth in Section 8.2 (subject to Section 8.3) of this Agreement.

(g) If Provider fails to timely reimburse Health Plan for a Final Claims Overpayment Determination that Provider has not timely submitted to dispute resolution under Section 8.2 (subject to Section 8.3) of this Agreement, then the Final Claims Overpayment Determination shall be treated as an Uncontested Claims Overpayment. Beginning as of the first calendar day following the expiration of the date Provider had to dispute the Final Claims Overpayment Determination under Section 8.2 (subject to Section 8.3) of this Agreement, Health Plan may commence offsetting the amount of the Uncontested Claims Overpayment from Provider's then-current claims. If Health Plan exercises its offset rights under this Section 3.12(g), Health Plan shall provide Provider a detailed written explanation identifying the specific Claims Overpayments that have been offset against the specific current claims.

(h) In the event Provider fails to provide Health Plan notice that Provider contests a Claims Overpayment within the timeframe and in the manner set forth herein, and/or if Provider fails to timely initiate the dispute resolution process referenced in Section 3.12(f) above, Provider shall have no right to pursue any further appeal or remedy with respect to the Claims Overpayment or the Final Claims Overpayment Determination, including, without limitation, initiation of any arbitration or civil action in state or federal court, and Provider shall have no right to pursue payment of any disputed amounts from the Member.

IV. REPRESENTATIONS AND WARRANTIES OF PROVIDER

4.1 **Licenses, Privileges & Insurance.** At all times during the term of this Agreement, Provider shall, and if Provider is comprised of a group of licensed providers, each such licensed provider shall:

(a) be licensed under the laws of the State of California to provide the services described in Exhibit A, and such license shall be free of any restrictions or limitations;

(b) be in compliance with all applicable local, state and federal laws relating to the provision of services hereunder, and furnish such services in accordance with all applicable licensing requirements and all local standards of professional ethics and practice;

(c) be a Medi-Cal enrolled provider if providing services to Medi-Cal Members;

(d) maintain in effect such policies of general and professional liability insurance and other insurance as shall be necessary and appropriate to insure him/her/it and his/her/its employees against any claims or claims for damages arising by reason of or indirectly in connection with the provision of Covered Services pursuant to this Agreement; provided that such insurance shall have limits of not less than One Million Dollars ($1,000,000) per each occurrence and not less than Three Million Dollars ($3,000,000) in the aggregate per calendar year; and

(e) if a physician provider, be a member in good standing of the Medical Staff(s) of the physician's health care facility(ies) (if applicable); and

(f) provide evidence to Plans of compliance with the forgoing requirements set forth in this Section 4.1.

4.2 **Authority to Bind Group.** If Provider is comprised of a group of licensed providers, then the signatory hereto warrants that he/she has the authority to bind each of the providers included in the Providers' roster, as from time to time modified in accordance with Section 4.4(a). Moreover, Provider agrees that the provisions of this Agreement bind all officers, members or employees of Provider who are similarly licensed, including all such providers

affiliating with Provider subsequent to the date of this Agreement.

4.3 **Qualification of Group Providers.** If Provider is comprised of a group of licensed providers, all such licensed providers shall at all times while providing Covered Services hereunder: (a) satisfy Health Plan's credentialing requirements, and (b) comply with the requirements of this Agreement, and (c) accept, as payment in full for the provision of Covered Services to Members, the reimbursement rates set forth herein.

4.4 **Disclosures.**

(a) Provider shall promptly notify Plans of any changes in Provider's status, including, without limitation whenever a licensee becomes affiliated with or ceases to be affiliated with Provider or upon any change to the Medical Staff affiliation(s) as included in the Providers' roster, in accordance with and as required by the Provider Manual.

(b) Provider shall notify Plans immediately in writing of the occurrence of any of the following events: (i) Provider or any licensee affiliated with Provider no longer meets any of the Plans credentialing criteria set forth in the Provider Manual; (ii) Provider or any licensee affiliated with Provider is excluded or suspended from participation in, ceases to be certified by, or is sanctioned by any state or federal healthcare program, including, without limitation, Medicare or Medi-Cal; (iii) Provider's liability insurance (or that of any licensee affiliated with Provider) is canceled, terminated, not renewed, or materially modified; (iv) a petition is filed to declare Provider bankrupt or for reorganization under the bankruptcy laws of the United States or a receiver is appointed over all or any portion of Provider's assets; or (vi) any act of nature or other event or circumstance which has, or reasonably could be expected to have, a material adverse effect on Provider's ability to perform its obligations under this Agreement.

(c) Provider shall notify Health Plan within five (5) business days of Provider or any licensee affiliated with Provider opening or closing his/her practice to new Members.

4.5 **Compliance with Administrative Requirements.** Provider shall comply with the policies and administrative procedures of Health Plan set forth in the Provider Manual, the terms of which are incorporated by reference herein, including, without limitation, those relating to the administration of Health Plan's Medicare program(s), as applicable. Failure to comply with such policies and administrative procedures shall be grounds for termination for cause following notice and failure to cure as set forth in Section 7.2 hereof.

4.6 **Compliance With State and Federal Law.** Provider will comply with applicable Laws and Regulations. If this Agreement applies to Medicare Members, provider acknowledges that payments made by Health Plan are, in whole or in part, derived from federal funds. Provider agrees to comply with all applicable Medicare laws, regulations and CMS

instructions as set forth in Exhibit D-1 hereto and to require his/her/its subcontractors to do the same. If, (a) absent this Agreement, Provider would not be obligated to comply with any such laws, or (b) there is a new interpretation of or change to existing law that imposes new obligations on Provider, and (c) Provider reasonably determines that compliance with such laws would represent a material cost to Provider, Blue Shield shall meet with Provider in good faith to discuss the additional costs and possible additional compensation. If Blue Shield and Provider are unable to reach agreement regarding additional compensation, then Provider may terminate this Agreement upon sixty (60) days' notice to Blue Shield.

For services provided under the Medi-Cal Benefit Program, Health Plan is subject to the requirements of the California Health and Safety Code, Welfare and Institution Code, Title 28 of the California Code of Regulations, and Title 22 of the California Code of Regulations, and other applicable State and Federal codes and regulations collectively called "Medi-Cal Acts and Regulations," and any provisions required to be in this Agreement by any of the above Medi-Cal Acts and Regulations, as amended, shall bind the parties whether or not provided in this Agreement. Health Plan is also subject to Health Services Contracts between Health Plan and DHCS, and Health Plan and Local Initiative, as amended from time to time. Any provisions required to be in this Agreement by these Health Services Contracts, as amended, shall bind both parties whether or not provided in this Agreement. Health Plan and Provider agree that each shall comply with all Laws and Regulations, including applicable municipal and county ordinances and regulations, to the extent that they directly or indirectly bear upon the subject matter of this Agreement. In addition, with respect to Medi-Cal Members, Provider agrees to comply with all DHCS requirements and the Local Initiative requirements for Local Initiative Medi-Cal Members, as set forth in Exhibits D-2, D-3, and D-4.

4.7 **Provider Statements.** Provider shall be responsible for all statements made on any claim or supporting documentation submitted to Health Plan. Provider shall be responsible for reimbursement of all overpayments resulting from such misreporting or duplicate claims submission consistent with the requirements set forth in Section 1300.71(b)(5) of Title 28 of the California Code of Regulations.

V. MAINTENANCE AND INSPECTION OF RECORDS

5.1 **Records.**

(a) Provider shall maintain the usual and customary records for Members in the same manner as for other patients of Provider and in accordance with good professional standards.

(b) Provider shall comply with all applicable state and federal laws regarding privacy and confidentiality of medical information and records, including, without limitation, mental health records. Provider shall develop policies and procedures to

ensure that Member medical records are not disclosed in violation of California Civil Code Section 56, et seq. or any other applicable state or federal law. To the extent Provider receives, maintains or transmits medical or personal information of Members electronically, Provider shall comply with all state and federal laws relating to the protection of such information including, without limitation, the Health Insurance Portability and Accountability Act (**"HIPAA"**) provisions on security and confidentiality and any CMS regulations or directives relating to Medicare beneficiaries.

(c) Provider shall ensure that Members have access to their medical records in accordance with the requirements of state and federal law.

(d) Provider shall comply with all provisions of the Omnibus Reconciliation Act of 1980 regarding access to books, documents, and records. Without limiting the foregoing, Provider shall maintain such records and provide such information to Health Plan and to the DMHC, the DHCS, the Department of Health and Human Services (DHHS), CMS, any Quality Improvement Organization ("QIO") with which CMS contracts, the U.S. Comptroller General, their designees and any other governmental officials entitled to such access by law (collectively, **"Governmental Officials"**), as required by law and as may be necessary for compliance by Health Plan with the provisions of all state and federal laws governing Plans. Provider shall grant to Plans and/or Government Officials, upon request and within a reasonable amount of time, access to and copies of, the medical records, books, charts, papers, and computer or other electronic systems relating to the Provider's provision of health care services to Members, the cost of such services, and payment received by the Provider from the Member (or from others on Member's behalf). Such records described herein shall be maintained (i) for Commercial Members, at least six (6) years from the date of service or in the case of financial records of Provider, six (6) consecutive fiscal years; (ii) for Medicare Members, ten (10) years from the end of the final contract period between Health Plan and CMS, as applicable, or the completion of any audit of Health Plan, as applicable, of Health Plan's contract, or of its contractors by DHHS, the General Accounting Office or their designees; (iii) for Medi-Cal Members, for at least ten (10) years following the final date of the contract period for the Health Services Contracts between Health Plan and DHCS, and Health Plan and Local Initiative, or from the date of completion of any audit by DHCS, CMS, or the DHHS Inspector General, whichever is later; and (iv) for all Members or for a particular record or group of records, a longer time period when CMS, DHCS, or DMHC requests such longer record retention and Provider is notified of such request by Health Plan, and in no event for a shorter period than as may be required by the Laws and Regulations. All books, documents, and records of Provider shall be maintained in accordance with the general standards applicable to such book, document or record keeping and shall be maintained during any audit or investigation by Government Officials.

5.2 **Site Evaluations.** Provider shall permit Government Officials and Health Plan to conduct periodic site evaluations, inspections, and onsite audits of their facilities. Health Plan shall provide Provider five (5) business days' advance notice (or fewer if mutually agreed upon by the parties) of any proposed site evaluation or inspection by Health Plan. If Government Officials or Health Plan finds any deficiencies in such facilities, Provider shall have thirty (30) days to correct such deficiencies that are identified by such Government Official or Health Plan, unless the Government Official requires that such deficiency be corrected within a shorter timeframe.

5.3 **Accreditation Surveys.** Provider shall cooperate in the manner described in Sections 5.1 and 5.2 hereof with respect to surveys and site evaluations relating to accreditation of Health Plan by NCQA or any other accrediting organization. Further, Provider agrees to implement any changes reasonably required as a result of all such surveys. Provider shall fully cooperate with Health Plan with regard to the Healthcare Effectiveness Data and Information Set (HEDIS) measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring and quality improvement studies and initiatives.

5.4 **Performance/Compliance Monitoring.** Provider shall cooperate with Health Plan in the performance of any monitoring, studies, evaluations, analyses or surveys required by Government Officials, accrediting organizations, or the Association (as defined in 9.13) of Provider's performance of services hereunder. Provider shall receive reasonable advance notice of any proposed monitoring, studies, evaluations, analyses or surveys by Health Plan. Nothing in this Agreement shall prohibit Health Plan from using, releasing, and/or publishing Provider performance data.

5.5 **Quality Assurance Programs.** Provider agrees to participate in any and all quality improvement and utilization management programs implemented by Health Plan as more fully described in the Provider Manual. Moreover, Provider agrees to participate in Health Plan's provider credentialing and recredentialing programs. If Provider concludes that care recommended or authorized through the utilization management program is medically inappropriate for the Member, Provider may access the expedited appeal process as described in the Provider Manual. Provider may also furnish that care which Provider, in the exercise of good medical judgment, believes is medically appropriate and may appeal any coverage denial by Health Plan in accordance with the provisions of Article VIII hereof.

5.6 **Onsite Audits.** Provider shall permit Government Officials and Health Plan to conduct periodic onsite audits of their records. Health Plan shall provide Provider five (5) business days' advance notice (or fewer if mutually agreed upon by the parties) of any proposed onsite audit by Health Plan. Audits will be performed on-site or otherwise and may involve statistically valid sampling techniques of Provider that are deemed necessary to include, but not limited to, medical practice audits, medical necessity reviews, data validation reviews, billing and claims payment audits, coding audits and quality improvement audits. Further, provider agrees to participate in any corrective action plan required by Health Plan. Based

on such review, Health Plan may deny payment, reject claims, and/or review claims on a retrospective basis and recover any overpayments, consistent with the requirements set forth in Section 1300.71(b)(5) of Title 28 of the California Code of Regulations. Provider may not bill for services rendered by a practitioner if such services are subject to billing independently by practitioner, another provider, and/or another entity subject to another agreement or arrangement with Health Plan.

VI. INDEPENDENT RELATIONSHIP

6.1 **Independent Parties**. None of the provisions of this Agreement are intended to create, nor shall they be deemed or construed to create, any relationship between Plans and Provider other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, employer, employee or representative of the other. Each party is solely responsible for its own acts or omissions to act.

VII. TERM & TERMINATION

7.1 **Term.** This Agreement shall become effective as of the Effective Date; provided, however, that this Agreement shall be implemented, and the Parties shall begin performing obligations under this Agreement only upon the completion of Blue Shield's credentialing of Provider with respect to at least one of the applicable Benefit Programs identified in Exhibit A of this Agreement. The Agreement shall continue in effect for one (1) year. Thereafter, this Agreement will automatically renew for successive one (1) year terms, unless and until terminated or modified in accordance with the terms set forth herein. Either party may terminate this Agreement without cause effective upon the annual renewal date by giving the other party written notice of non-renewal at least one hundred twenty (120) days' prior written notice of termination. Any termination pursuant to this Section 7.1 shall become effective the first day of the calendar month following the expiration of the notice period. Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination.

7.2 **Termination for Cause.** Health Plan may terminate this Agreement for cause if Provider fails to continuously satisfy Health Plan's provider credentialing criteria as set forth in the Provider Manual, following notice of deficiency and failure to cure as set forth herein. Provider will be given written notice of any such termination, which shall occur in accordance with the requirements of California law. Either party may terminate this Agreement for cause due to breach by the other party of any material provision of this Agreement, provided that: (a) the non-breaching party has given the breaching party thirty (30) days' prior written notice which specifies the nature of the breach, and (b) the breaching party has failed to cure the breach within such thirty (30)-day period. Health Plan may also terminate this Agreement if Provider engages in any of the following activities, and following notice of breach as set forth in this Section, fails to correct such

conduct:

(a) Fraudulent billing, or, following written notice to and education of Provider, repeated billing in violation of Health Plan's claims billing policies or procedures, as described in the Provider Manual.

(b) Failure or refusal to comply with Health Plan's administrative compliance program, as described in the Provider Manual.

(c) Failure or refusal to comply with Health Plan Quality Assurance programs, as outlined in the Provider Manual, including, without limitation, repeated failure to provide Medically Necessary services (including significant over- and under-utilization) following peer review and notification of such deficiencies.

(d) A pattern or repeated failure to alert Health Plan to a change in the information required to be in the directory of Health Plan Providers pursuant to Health & Safety Code Section 1367.27.

7.3 **Immediate Termination.** Health Plan may immediately terminate this Agreement if (a) Provider is suspended, excluded or barred from participation in Medicare or Medi-Cal, (b) Provider fails to maintain all insurance required herein, (c) Health Plan, after consultation with Provider, determines in good faith that continuation of this Agreement may reasonably be expected to jeopardize the health, safety, or welfare of Members, or (d) Health Plan reasonably determines, after consulting with Provider, that Provider is likely to be financially unable to provide, in a competent and timely manner, Covered Services. If Provider voluntarily ceases participating in the Medicare program and this Agreement applies to any Medicare Benefit Programs, then Provider's participation in the Medicare Benefit Program(s) may be immediately terminated by Health Plan. The termination of Provider's participation in any Medicare Benefit Program pursuant to this Section shall not be effective as to, and shall have no force or effect upon, the rights, duties and obligations of the parties under the Agreement relating to any other Benefit Programs to which the Agreement applies. Provider may immediately terminate this Agreement if Health Plan ceases to be licensed as a health care service plan, or is suspended, excluded or barred from participation in Medicare or Medi-Cal.

7.4 **Termination by Provider Upon Certain Events.** If Provider objects to any changes in the Provider Manual and/or to the Blue Shield Provider Allowances (as described in the Provider Manual), about which Provider receives notice pursuant to Sections 2.9 hereof, Provider may, within sixty (60) days of receipt of such notice, terminate this Agreement upon sixty (60) days' prior written notice to Health Plan, in which case the proposed changes shall not apply during the termination notice period.

7.5 **Termination of Individual Physician in Group.** If Provider is a group of licensed providers and grounds for termination of any individual provider arise pursuant to Sections 7.2 or 7.3 hereof, then Health Plan may, at its sole election, elect to terminate only the

participation of such individual provider under this Agreement rather than the entire Agreement.

7.6 **Effect of Termination.** As of the date of termination, this Agreement shall be considered of no further force or effect whatsoever, and each of the parties shall be relieved and discharged here from, except that:

(a) Termination shall not affect any rights or obligations hereunder which have previously accrued or shall hereafter arise with respect to any occurrence prior to termination, and such rights and obligations shall continue to be governed by the terms of this Agreement.

(b) In the event of termination of this Agreement, Provider shall comply with all applicable Laws and Regulations, including without limitation those set forth in Cal. Health & Safety Code Section 1373.65 and CAA Section 113.

(c) Following termination, Provider agrees to continue rendering Provider Services that are Continuity of Care Services to Members who qualify for completion of Continuity of Care Services as determined by Health Plan at the rates and under terms set forth herein.

(d) For Members who retain eligibility under the plan contract through which they are enrolled and who are receiving Covered Services from Provider at the time of termination, Provider shall continue to provide Covered Services until such Covered Services are completed or until Health Plan makes reasonable and medically appropriate provision for the assumption of such Covered Services by another provider. Provider shall be compensated for such Covered Services in accordance with the provisions of this Agreement. Health Plan shall make reasonable efforts to timely notify such Members that Provider is no longer a contracting provider and, for Members in HMO plans, shall make reasonable and timely efforts to effectuate the assumption of Covered Services by another provider.

(e) Notwithstanding the above, if the Agreement is terminated by Provider due to nonpayment by Health Plan of amounts due under this Agreement, Provider shall not be limited to compensation under the terms of this Agreement, except to the extent that Health & Safety Code Section 1373.96 and CAA Section 113 requires that Health Plan permit the Member to continue to receive services from Provider.

(f) The following Sections of this Agreement shall survive the termination of this Agreement, whether such termination is the result of rescission or otherwise: Sections 3.1, 3.2, 3.3, 3.4, 3.5, 5.1, 7.6, 8.1, 8.2, and 9.11.

(g) All written, printed, or electronic communications to Members concerning the termination of this Agreement shall comply with Health & Safety Code Section

1373.65(f).

VIII. RESOLUTION OF DISPUTES

8.1 **Claims Dispute Resolution Process.** The parties agree that the terms and conditions set forth in this Section 8.1 shall apply to all disputes relating to or arising out of a Claims Determination.

The term "Claims Determination" as used in this Agreement means the acknowledgement, adjudication, adjustment, denial, contest, payment, and/or any other action by Health Plan following Provider's submission of a claim for reimbursement under this Agreement, including without limitation Health Plan's failure to pay or otherwise take required action with respect to such claims.

(a) **Appeal Process:** If Provider desires to dispute a Claims Determination, it shall submit a written appeal that contains all of the information set forth in the applicable Provider Manual ("Provider Appeal") and is completed by Provider pursuant to the timelines and procedural requirements delineated in the Provider Manual. The Provider Manual is available to Provider on the provider portal of Health Plan's website at www.blueshieldca.com or www.blueshieldca.com/promise, as applicable (the "Appeal Process").

(b) This Section 8.1 does not in any way modify the provisions of Section 8.2 relating to arbitration of disputes that cannot be resolved through the Appeal Process. However, if Provider fails to submit a Provider Appeal within the timeframes set forth in the Provider Manual, and complete the Appeal Process, Provider shall be deemed to have waived its right to any remedies and to further pursue any dispute arising out of or relating to a Claims Determination. Without limiting the foregoing, in such instance, Provider may neither initiate a demand for arbitration pursuant to Section 8.2 and Section 8.3 of this Agreement nor pursue additional payment from the Member.

8.2 **Arbitration of Disputes.** Any dispute between Provider and Health Plan shall be settled by final and binding arbitration in San Francisco, Los Angeles, San Diego or Sacramento, California, whichever city is closest to Provider, including any dispute arising out of or related to (a) a Claims Determination (as defined in Section 8.1 of this Agreement) or a Claims Overpayment or Final Claims Overpayment Determination (as such terms are defined in Section 3.12 of this Agreement) that exceeds the jurisdiction of Small Claims Court and that was reviewed through, but not resolved by, the Appeal Process set forth in Section 8.1 of this Agreement, and (b) other disputes that were reviewed through, but not resolved by, the dispute resolution process set forth in Section 8.4 of this Agreement. The parties agree that (a) timely pursuit and completion of the Appeal Process set forth in Section 8.1 of this Agreement shall be a condition precedent to submitting a demand for

arbitration for disputes arising out of or related to Claims Determinations, and (b) timely notice that Provider contests a Claims Overpayment and completion of the Final Claims Overpayment Determination as set forth in Section 3.12 of this Agreement shall be a condition precedent to submitting a demand for arbitration of disputes arising out of or related to Claims Overpayment and Final Claims Overpayment Determinations, and (c) timely pursuit and completion of the dispute resolution process set forth in Section 8.4 of this Agreement shall be a condition precedent to submitting a demand for arbitration of other disputes. Arbitration shall be conducted by and under the Commercial Rules of the American Arbitration Association. The arbitrator shall be a retired judge of the State of California, unless otherwise agreed to by the parties. The arbitration decision shall be binding on both parties. The arbitrator shall be bound by applicable Laws and Regulations and shall issue written findings of fact and conclusions of law. The arbitrator shall have no authority to award damages or provide a remedy that would not be available to such prevailing party in a court of law nor shall the arbitrator have the authority to award punitive, incidental, or consequential damages, or to add to, modify, or otherwise refuse to enforce any agreements between the parties. The parties acknowledge that arbitration of a dispute under this Agreement may require the disclosure or exchange of confidential or sensitive information. Therefore, the parties agree to enter into protective orders, including without limitation limiting certain discovery documents to "attorney's eyes only" to the extent possible in view of the context and nature of the dispute and documents to be disclosed. The parties further agree that any and all discovery information disclosed or exchanged as part of an arbitration proceeding shall be used solely within the arbitration of the dispute between the parties and shall not be used for any other purpose. Within thirty (30) days following the date of a final arbitration award, each party shall return or destroy any documents of the other party that were subject to a protective order. The cost of the arbitration shall be shared equally by Provider and Health Plan; provided, however, that each party shall be responsible for its own attorneys' fees and costs. Notwithstanding any other term of this Agreement to the contrary, for purposes of clarity, the parties agree that arbitration shall not apply to, and the arbitrator shall have no authority to conduct arbitration or to issue a decision with respect to, any class arbitration or other claim brought by Provider on behalf of the general public under a statute or regulation that allows an individual to sue on behalf of the Attorney General or other federal, state or municipal actor, or in any other representative capacity, or to any claims of medical malpractice, breach of privacy or HIPAA obligations, or intellectual property claims.

8.3 **Limitation of Actions.** A demand for arbitration pursuant to Section 8.2 must be filed within three hundred sixty-five (365) days of the date of the final appeal decision in the Appeal Process or the Final Claims Overpayment Determination, as applicable, notwithstanding any other communication between the parties that may take place, or payment(s) that may be made, subsequent to the final appeal decision in the Appeal Process or the Final Claims Overpayment Determination, as applicable, related to the lack of action or alleged breach that is the subject of the dispute. A demand for arbitration pursuant to Section 8.4 must be filed within three hundred sixty-five (365) days of the date the dispute arose, notwithstanding any meet and confer or other communication between the parties

that may take place related to the dispute. Should the aggrieved party fail to file a demand for arbitration of the dispute within the timeframes set forth herein, the aggrieved party shall have waived its rights and remedies with respect to the dispute and any alleged breach, it shall have no right to pursue any remedy with respect to such dispute and alleged breach, including, without limitation, initiation of any arbitration or civil action in state or federal court, and, if the aggrieved party is Provider, Provider shall have no right to pursue payment of any disputed amounts from the Member. Pursuit by Provider of a dispute through the applicable process described in this Article XI shall neither modify nor relieve Provider of any obligations to continue providing services to Members in compliance with all terms of this Agreement.

In the event Provider, intentionally or unintentionally, initiates a demand for arbitration pursuant to Section 8.2 of this Agreement regarding the alleged underpayment of a claim for reimbursement for which Provider has failed to complete the Appeal Process within the time requirements of Section 8.1 of this Agreement, or regarding any other dispute for which Plan has failed to complete the dispute resolution process under Section 8.4 of this Agreement, then, upon notice from Health Plan, Provider shall immediately dismiss the demand for arbitration as to any such claims and will reimburse Health Plan for its reasonable costs and attorneys' fees associated with its defense of such untimely and/or unappealed claims.

8.4 **Dispute Resolution Process For Disputes Unrelated to Claims Determinations.** The parties agree that this Section 8.4 shall apply to controversies or disagreements between the parties arising out of or relating to the interpretation of the terms of this Agreement or a party's performance of or failure to perform its obligations under this Agreement. The parties further acknowledge and agree that this Section 8.4 shall not apply to controversies or disagreements that arise out of or relate to a Claims Determination, or to Claims Overpayments, or to Final Claims Overpayment Determinations, or to any claims of medical malpractice, breach of privacy or HIPAA obligations, or intellectual property claims.

(a) The aggrieved party shall notify the other party, in writing, of a dispute under this Section 8.4 within one hundred eighty (180) days of the date the dispute arose. The dispute notice shall provide a description of the dispute that includes sufficient detail to reasonably enable the receiving party to evaluate the dispute and prepare to meet and confer with the aggrieved party, the date the dispute arose, reference(s) to any Agreement term(s) applicable to the dispute, supporting documentation, and proposed resolution(s) to the dispute.

(b) Health Plan and Provider shall meet and confer in good faith to resolve the dispute within no more than sixty (60) days following the date of the receiving party's documented receipt of the dispute notice. In order for a meet and confer to satisfy the requirement set forth herein, an actual meeting must take place between employees of the parties, each of whom has the authority to resolve the dispute.

The meet and confer may occur either in person, on the telephone, or through other electronic means that enable each of the participants to hear the other participants, as mutually agreed. The meet and confer meeting and all related communications between the parties, and any documents prepared or collected in connection with, or exchanged as part of the meet and confer process shall be treated as confidential protected compromise and settlement negotiations subject to applicable State law. The parties further acknowledge that the meet and confer requirement is intended to achieve an informal resolution to disputes between parties with an ongoing business relationship. Therefore, unless otherwise mutually agreed by the parties in advance of the meet and confer, neither party is allowed to have legal counsel present at the meeting or to substitute legal counsel for the party's employee(s) attending the meet and confer. If Provider and Health Plan are unable to reach agreement and resolve the dispute through the meet and confer process required under this Section 8.4, then either party can initiate the demand for arbitration as permitted by Section 8.2, subject to Section 8.3 of this Agreement.

IX. GENERAL PROVISIONS

9.1 **Consistency with State & Federal Law.** This Agreement is subject to the requirements of the Knox Keene Act and Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by either of the above Codes shall bind Health Plan and Provider, whether or not provided in this Agreement. With respect to Covered Services provided to Members enrolled in a Health Plan Medicare Benefit Program, Provider shall comply with the applicable statutes, regulations, and CMS instructions. In addition, all such Covered Services shall be performed in a manner consistent and otherwise in compliance with Health Plan's Agreement with CMS. Provider shall also comply with all applicable provisions of the Patient Protection and Affordable Care Act and regulations promulgated thereunder and all such Covered Services shall be performed in a manner consistent and otherwise in compliance with Health Plan's agreement with Covered California.

9.2 **Preemption by Federal Law.** To the extent any of the requirements of the Knox-Keene Act as stated herein is preempted by federal law applicable to the Medicare program, no such requirements shall apply with respect to Health Plan's Medicare Benefit Programs.

9.3 **Precedence.** In the event of any conflict or inconsistency between this Agreement, the Provider Manual and/or any of the cited state or federal laws and regulations, the provision which governs shall be determined by applying the following order of precedence: the Balance Budget Act (BBA), CMS regulations and instructions, the Knox-Keene Act and regulations, the Agreement and the Provider Manual.

9.4 **Disclosure of Information.** The Plans shall make available to Provider, upon contracting and upon written request as well as on-line, such information as is required by the regulations of Title 28 Cal. Code of Regulations Sections 1300.71(l) and (o), the Plans shall make the information available in the Provider Manual and on the provider portal of Plans'

websites identified in Exhibit A.

9.5 **Amendments.** Except as provided in Section 2.9, Section 4.4(a), and this Section 9.5, this Agreement may be amended only by mutual, written consent of Health Plan and Provider. Notwithstanding the foregoing, or if Health Plan's legal counsel determines in good faith that this Agreement must be modified to be in compliance with applicable federal or state law or to meet the requirements of accreditation organizations which accredit Health Plan and its providers, Health Plan may amend this Agreement by delivering to Provider a written amendment to this Agreement incorporating the required modifications (the **"Legally Required Amendment"**), along with an explanation of why such Legally Required Amendment is necessary. If Provider does not object to the Legally Required Amendment, in writing, within sixty (60) days following receipt thereof, such Legally Required Amendment shall be deemed accepted by Provider and an amendment to this Agreement. If Provider timely objects to the Legally Required Amendment, then Provider and Health Plan shall confer in good faith regarding Provider's objection(s). If Provider and Health Plan are unable to resolve Provider's objection(s) to the parties' mutual satisfaction within thirty (30) days of Provider's notice, then, within sixty (60) days of Provider's notice, Provider may elect to terminate this Agreement upon ninety (90) days' prior written notice to Health Plan. Unless Provider so terminates this Agreement, such Legally Required Amendment shall be deemed accepted by Provider and an amendment to this Agreement.

Additionally, this Agreement may be amended by Health Plan to the extent required by DMHC, DHCS or Local Initiative as necessary to ensure that the terms of this Agreement comply with the provisions of the Laws and Regulations and laws governing the Local Initiative. Amendments shall comply with the Laws and Regulations and shall be submitted by Health Plan to DMHC, DHCS and Local Initiative for prior approval, if such approval is required by the Laws and Regulations or by contract. Proposed changes, which require prior regulatory or other approval shall become effective on receipt by the Health Plan of notice of such approval. Proposed changes that do not require DHCS approval and that are not disapproved by DHCS shall become effective by operation of law thirty (30) days after DHCS has acknowledged receipt thereof, or upon the date specified in the amendment, whichever is later, subject to any required DMHC approval.

9.6 **Entire Agreement.** This Agreement, all attachments and Exhibits referenced in this Agreement and attached hereto, and the Provider Manual, as amended from time to time, are incorporated herein by reference, and constitute the entire understanding between the parties relating to the subject matter hereof. This Agreement constitutes the entire understanding and agreement of the parties regarding its subject matter, and supersedes any prior oral or written agreements, representations, understandings or discussions among the parties with respect to such subject matter. Notwithstanding the foregoing, this Agreement does not supersede or modify any agreement between Provider and a medical group or independent practice association as more fully described in Section 3.7 hereof.

9.7 **Assignment and Subcontracting.** The parties shall not assign, transfer, or subcontract any of its rights, interests, duties, or obligations under this Agreement, whether by sale,

assignment, negotiation, pledge or otherwise, without the prior written consent of the other party. Assignment or delegation of this Agreement shall be void unless prior written approval of such assignment or delegation is obtained from DHCS and DMHC, if such approval is required by the Laws and Regulations or by contract. Without limiting the foregoing, the following events shall constitute an assignment of this Agreement by Provider for purposes of this Section 9.7: (a) the sale, transfer or other disposition of all or substantially all of the issued and outstanding voting securities or interests of Provider or Provider's direct or indirect corporate parent; (b) the merger, consolidation or other reorganization of Provider if, immediately following such transaction, either Provider or its member(s) shareholders or other equity holders (as existing immediately preceding such transaction) do not own a majority of all classes of the issued and outstanding membership interests or voting securities of the surviving, consolidated or reorganized entity; and (c) the issuance of any class of voting securities or interests by Provider (or its successor) if, immediately following such transaction, Provider's shareholders or other equity holders existing immediately preceding such issuance do not own a majority of all classes of the issued and outstanding voting securities or interests of Provider. Subject to the foregoing, this Agreement shall be binding on and shall inure to the benefit of the parties and their respective heirs, successors, assigns and representatives.

9.8 **Directory and Use of Names.** Each Health Plan maintains a directory of Health Plan Providers participating in Health Plan that is made available to Members. Provider agrees that the following information may be included in Health Plan's marketing materials, Health Plan publications provided to current or potential Members and subscriber groups, and in other written or electronic information sources: (a) Provider's name, practice location or locations, and contact information, including open and closed panel status for PCPs; (b) type of practitioner; (c) National Provider Identifier number; (d) California license number and type of license; (e) area of specialty, including board certification, if any; (f) Provider's office email address, if available; (g) For physicians, surgeons, and podiatrists, the admitting privileges, if any, at hospitals contracted with the insurer; and (h) such other types of information regarding Provider that are reasonable to include in directories, marketing materials, or publications. The Plans shall maintain said directory pursuant to state and federal law, including, but not limited to, Section 116 of the Consolidated Appropriations Act of 2021, Health and Safety Code 1367.27 and 42 C.F.R. Section 438.10. Health Plan may engage a vendor or vendors that performs some or most of Health Plan's provider directory maintenance tasks of behalf of Health Plan ("Directory Vendor"). Health Plan shall identify any such Directory Vendor to Provider and, throughout the term of this Agreement, Provider shall maintain a participation agreement with such Directory Vendor to facilitate exchange of directory data about Provider. With respect to provisions of this Agreement pertaining to Health Plan's provider directory, Provider shall be equally obligated to respond and otherwise cooperate with either Directory Vendor or Health Plan itself, as Health Plan directs. Provider may identify himself/herself/itself as a participating/contracting provider with Health Plan in all Benefit Programs and Tiered/Narrow Products in which he/she/it participates.

9.9 **Interpretation of Agreement.** This Agreement shall be governed in all respects, whether

as to validity, construction, capacity, performance, or otherwise, by the laws of the State of California and such federal laws as are applicable to Plans. The captions herein are for convenience only and shall not affect the meaning or interpretation of this Agreement. If any provision of this Agreement, in whole or in part, or the application of any provision, in whole or in part, is determined to be illegal, invalid or unenforceable by a court of competent jurisdiction, such provision, or part of such provision, shall be severed from this Agreement. The illegality, invalidity or unenforceability of any provision, or part of any provision, of this Agreement shall have no effect on the remainder of this Agreement, which shall continue in full force and effect.

9.10 **Notices.** All notices or communications required or permitted under this Agreement must be given in writing and must be delivered to the party to whom notice is to be given either: (a) by personal delivery, in which case such notice shall be deemed given on the date of delivery; (b) by next business day courier service (e.g., Federal Express, UPS or other similar service), in which case such notice shall be deemed given on the business day following date of deposit with the courier service; (c) by United States mail, first class, postage prepaid, in which case such notice shall be deemed given on the third (3rd) day following the date of deposit with the United States Postal Service; (d) by United States mail, registered, in which case such notice shall be deemed given on the third (3rd) day following the date of deposit with the United States Postal Service; (e) by United States mail, certified, return receipt requested, in which case such notice shall be deemed given on the third (3rd) day following the date of deposit with the United States Postal Service; or (f) by facsimile transmission, in which case such notice shall be deemed given upon receipt of facsimile transmission confirmation, and, if such notice pertains to the term, termination, an asserted breach, a request for meet and confer, or a demand for arbitration, such notice shall also be accompanied by an electronic notification to the email address listed in Exhibit A or such other email address as may be provided by a party from time to time. Notice must be delivered or sent to the party's address or facsimile number set forth in Exhibit A or such other address or facsimile number as may be provided by a party, from time to time, pursuant to this Section. All of the above-stated delivery methods must be made available to the parties for notices or communications required or permitted under this Agreement.

9.11 **Other Payors.** Blue Shield may contract with employers, insurance companies, associations, health and welfare trusts or other organizations to provide administrative services for plans provided by those entities which are not underwritten by Blue Shield. In addition, Blue Shield may extend this Agreement to managed care arrangements established by Blue Shield subsidiaries, or by persons or entities utilizing the Managed Care Network which Blue Shield has established pursuant to agreements with CareTrust Networks, Blue Shield of California Life & Health Insurance Company and Blue Shield Promise. All such entities shall be referred to as **"Other Payors"**. Blue Shield shall require that: (a) the health programs of Other Payors include provisions to encourage the use of Blue Shield contracting providers, and (b) Other Payors comply with performance standards relating to timely processing of claims which meet or exceed the time

requirements set forth in California law. Provider agrees that, if Blue Shield is not the underwriter of the health plan for the Other Payor, Provider shall look solely to Other Payor for payment for services. The identity of Other Payors shall be disclosed in the Provider Manual. If, despite reasonable efforts, Provider is unable to obtain appropriate payment from an Other Payor, Provider may notify Blue Shield and Blue Shield shall undertake reasonable efforts to assist Provider in obtaining proper payment. If, within fifteen (15) days following notification to Blue Shield, Provider still has not obtained payment from the Other Payor, then Provider may immediately terminate this Agreement.

9.12 **Waiver of Breach.** No delay or failure to require performance of any provision of this Agreement shall constitute a waiver of the performance of such provision or any other instance. Any waiver granted by a party must be in writing and shall apply solely to the specific instance expressly stated. A waiver of any term or condition of this Agreement shall not be construed as a waiver of any other terms and conditions of this Agreement, nor shall any waiver constitute a continuing waiver.

9.13 **Association Disclosure.** Provider hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Provider and Plans, that Plans are independent corporations operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (**"the Association"**) permitting Plans to use the Blue Shield Service Mark in the State of California, and that Blue Shield is not contracting as the agent of the Association. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Health Plan and that no person, entity, or organization other than Health Plan shall be held accountable or liable to Provider for any of Health Plan's obligations to Provider created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Health Plan other than those obligations created under other provisions of this Agreement.

9.14 **Free Exchange of Information.** No provision of this Agreement shall be construed to prohibit, nor shall any provision in any contract between Provider and its employees or subcontractors prohibit, the free, open and unrestricted exchange of any and all information of any kind between health care providers and Members regarding the nature of the Member's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Member's health plan, and the Member's right to appeal any adverse decision made by Provider or Health Plan regarding coverage of treatment which has been recommended or rendered. Moreover, Provider shall not be penalized nor sanctioned in any way for engaging in such free, open and unrestricted communication with a Member nor for advocating for a particular service on a Member's behalf.

9.15 **Payment of Premiums.** Payment of Member premiums by Provider shall be deemed a material breach of the Agreement.

9.16 **Counterparts**. This Agreement may be executed in one or more counterparts, each of

which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

9.17 **Confidentiality**.

Except as otherwise set forth in this Section 9.17, as necessary to Provider's and Health Plan's performance hereunder, or as required by and consistent with the requirements of an applicable law or regulation, the terms and conditions set forth in this Agreement, including, but not limited to, payment rates, shall be considered confidential and may not be disclosed without the written consent of the non-disclosing party. Notwithstanding the foregoing:

(a) Effect of Required Public Disclosure. Upon public disclosure in any format of a term or condition of this Agreement by either party as required by an applicable law or regulation, including but not limited to the Transparency in Coverage Rule promulgated at 85 FR 72158, such term or condition shall no longer be considered confidential.

(b) Permitted Disclosure to Affiliates. Nothing in this Agreement may be construed to prohibit either party from disclosing the Agreement to consultants, vendors, business associates (as defined under HIPAA) or other representatives (each an "Affiliate"), provided that such disclosure shall be limited to the extent needed for such Affiliate to perform its contracted services for the disclosing party.

(c) Permitted Health Plan Disclosures. Nothing in this Agreement may be construed to prohibit Health Plan from disclosing the Agreement to: (i) Covered California and other qualified health oversight agencies as defined at 45 CFR § 164.501; (ii) the California Public Employees Retirement System (CalPERS); (iii) Government Officials; or (iv) current or potential Health Plan customers (or agents thereof).

(d) No Gag Clauses; Compliance with Transparency Requirements. Nothing in this Agreement may be construed to restrict Blue Shield from disclosing information required by applicable state or federal law or regulation including, without limitation, the federal Transparency in Coverage Rule, the federal Consolidated Appropriations Act of 2021, and, where applicable, the implementing regulations thereof, including without limitation 26 C.F.R Section 54.9815-2715A2; 26 C.F.R Section 54.9815-2715A3; 29 C.F.R. Section 2590.715-2715A2; 29 C.F.R. Section 2590.715-2715A3; 45 C.F.R. Section 147.211; and 45 C.F.R. Section 147.212, as they may be amended from time to time. Without limiting the foregoing, nothing in this Agreement shall directly or indirectly restrict Blue Shield from:

(i) providing Provider-specific price, cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, a plan sponsor, Blue Shield Members, or individuals eligible to become Blue Shield Members;

(ii) Electronically accessing de-identified claims and encounter information or data for Members, upon request and consistent with all applicable laws and regulations, including, on a per claim basis: A) financial information, such as the allowed amount, or any other claim-related financial obligations included in this Agreement; B) Provider information, including name and clinical designation; C) service codes; or D) any other data element included in claim or encounter transactions.

(iii) Sharing the information described immediately above in subsections (i) or (ii), or directing that such data be shared, with a business associate as defined under HIPAA, consistent with all applicable laws and regulations.

9.18 **No Volume Guarantee.** Nothing in this Agreement shall be construed to constitute a guarantee by Plan that Provider will be contacted for services by, or have the opportunity to render Covered Services to, any minimum or maximum number of Members.

9.19 **Consistency with California Public Policy**. Notwithstanding anything to the contrary in this Agreement, Blue Shield shall not, and this contract shall not be interpreted to, impose any negative consequence on Provider, including but not limited to termination or non-renewal of this Agreement, reduction of payment, or discrimination in any form, based solely on a civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state, if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in the State of California. If pursuant to this Agreement, Provider credentials, privileges or otherwise arranges for practitioners (such as the members of an IPA or medical group) to render services to Members, Provider agrees to be bound by the same prohibitions set forth herein with respect to such practitioners.

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

BLUE SHIELD OF CALIFORNIA		**«GENERAL>>PROVIDER LEGAL NAME»**	
Signature:	«Signer>>2>>Signature»	Signature:	«Signer>>1>>Signature»
Print Name:	«Signer>>2>>Name»	Print Name:	«Signer>>1>>Name»
Title:	«Signer>>2>>Title»	Title:	«Signer>>1>>Title»
Date:	«Signer>>2>>Date»	Date:	«Signer>>1>>Date»

EXHIBIT A
Independent Provider Agreement

PROVIDER INFORMATION

Provider Name _____ License Number (if individual)

License Type (if individual)

Type of Service Provided (i.e., pediatric/infertility/multi-specialty)

IRS (TIN) and NPI Number

Health Plans subject to this Agreement

(a) California Physicians' Service, d.b.a. Blue Shield of California, a California nonprofit corporation ("Blue Shield")

(b) Blue Shield of California Promise Health Plan ("Blue Shield Promise")

(Continued on next page)

For this Section, complete either 1 or 2 but not both.

1.

☐ All Products. Provider agrees to participate in, and this Agreement shall apply to, all Benefit Programs under which Health Plan compensates Provider for Covered Services pursuant to the compensation described in Section 3.1 of this Agreement, subject to Section 2.7 of this Agreement.

OR

2.

Opt Out. Provider agrees to participate in, and this Agreement shall apply to, Blue Shield's Commercial PPO/EPO (Blue Shield Standard Network) Benefit Programs and all other Benefit Programs under which Blue Shield compensates Provider for Covered Services pursuant to the compensation described in Section 3.1 of this Agreement, except as follows:

Provider does not agree to participate in, and this Agreement shall not apply to, the following Benefit Programs (Check the box for each product):

- ☐ Commercial PPO/EPO (Blue Shield Network A)
- ☐ Commercial PPO/EPO (Blue Shield Network B)
- ☐ Commercial PPO/EPO (Blue Shield Network C)
- ☐ Blue Shield's Medicare Advantage PPO
- ☐ Commercial HMO
- ☐ Blue Shield's Medicare Advantage HMO
- ☐ Medi-Cal

Addresses for Notice:

If to Plans:

NOTICE OF BREACH OR TERMINATION, REQUEST FOR MEET AND CONFER, OR A DEMAND FOR ARBITRATION	ALL OTHER NOTICES
Blue Shield of California	Blue Shield of California
6300 Canoga Avenue, 7th Floor	P.O. Box 629017
Woodland Hills, CA 91367	El Dorado Hills, CA 95762-9017
Attn.: Senior Vice President, Provider Partnerships & Network Management	Attn.: Provider Services
Fax No.: 818-228-5101	Fax No.: 916-350-8860
Email: ContractNotifications@blueshieldca.com	n/a

If to Provider:

«Tables>>Address for Notice»

Website Addresses:

(a) Blue Shield's website: www.blueshieldca.com

(b) Blue Shield of California Promise Health Plan's website: www.blueshieldca.com/promise

EXHIBIT B
Independent Provider Agreement

COMPENSATION RATES

1. **Compensation.** Health Plan shall reimburse Provider for Covered Services provided to Members enrolled in Benefit Programs in which Provider has agreed to participate and to which this Agreement applies, as follows:

(a) Commercial PPO/EPO (Blue Shield Standard Network):

One hundred percent (100%) of the rates set forth in the Blue Shield Provider Allowances. Provider shall be reimbursed for the diagnosis, consultation, or treatment of a Member delivered through telehealth services on the same basis and to the same extent that Provider would be reimbursed through in-person diagnosis, consultation, or treatment.

(b) Commercial PPO/EPO (Blue Shield Network A):

For services other than drugs and immunizations, ninety percent (90%) of the rates set forth in the Blue Shield Provider Allowances. For drugs and immunizations, one hundred percent (100%) of the rates set forth in the Blue Shield Provider Allowances. Provider shall be reimbursed for the diagnosis, consultation, or treatment of a Member delivered through telehealth services on the same basis and to the same extent that Provider would be reimbursed through in-person diagnosis, consultation, or treatment.

(c) Commercial PPO/EPO (Blue Shield Network B):

For services other than drugs and immunizations, eighty percent (80%) of the rates set forth in the Blue Shield Provider Allowances. For drugs and immunizations, one hundred percent (100%) of the rates set forth in the Blue Shield Provider Allowances. Provider shall be reimbursed for the diagnosis, consultation, or treatment of a Member delivered through telehealth services on the same basis and to the same extent that Provider would be reimbursed through in-person diagnosis, consultation, or treatment.

(d) Commercial PPO/EPO (Blue Shield Network C):

For services other than drugs and immunizations, seventy percent (70%) of the rates set forth in the Blue Shield Provider Allowances. For drugs and immunizations, one hundred percent (100%) of the rates set forth in the Blue Shield Provider Allowances. Provider shall be reimbursed for the diagnosis, consultation, or treatment of a Member delivered through telehealth services on the same basis and to the same extent that Provider would be reimbursed through in-person diagnosis, consultation, or treatment.

(e) Commercial HMO:

One hundred percent (100%) of the rates set forth in the Blue Shield Provider Allowances. Provider shall be reimbursed for the diagnosis, consultation, or treatment of a Member delivered through telehealth services on the same basis and to the same extent that Provider would be reimbursed through in-person diagnosis, consultation, or treatment.

(f) Blue Shield's Medicare Advantage HMO:

Ninety-five percent (95%) of the reimbursement established by the Medicare program for such services.

(g) Blue Shield's Medicare Advantage PPO:

Ninety-five percent (95%) of the reimbursement established by the Medicare program for such services.

(h) Medi-Cal:

One hundred percent (100%) of the Medi-Cal Fee Schedule as published by DHCS, subject to any changes made by DHCS. Except as required by DHCS, any change made to the Medi-Cal Fee Schedule will become effective for dates of service on or after the first (1st) day of the month following the month during which such change was published by DHCS.

Covered Services billed under a valid Medi-Cal code for which there is no reimbursement listed on the Medi-Cal Fee Schedule published by DHCS will be reimbursed, exclusive of pharmaceuticals, at thirty percent (30%) of billed charges. Pharmaceuticals for which there is no reimbursement listed on the Medi-Cal Fee Schedule will be reimbursed at an amount equal to the Average Wholesale Price ("AWP") of the pharmaceutical, less sixteen percent (16%). The AWP shall be derived from nationally recognized pricing sources selected by Health Plan and shall be updated by Health Plan quarterly.

2. **Covered Business Expense.** For Members enrolled in a Commercial Benefit Program, to which California Health and Safety Code Section 1374.192 or California Insurance Code Section 10120.35 applies, Health Plan shall reimburse Provider for business expenses to prevent the spread of respiratory-transmitted infectious disease-causing public health emergencies declared on or after January 1, 2022, as specified in California Health and Safety Code Section 1374.192 and the California Insurance Code Section 10120.35 ("Covered Business Expense"). To receive reimbursement, Provider must bill such Covered Business Expense using CPT code 99072. Provider will be reimbursed at one hundred percent (100%) of the rates set forth in the Blue Shield Provider Allowances per in-person Member encounter irrespective of the number of Covered Services rendered during that encounter. Reimbursement for Covered Business Expenses is limited to one encounter per day per Member for the duration of the public health emergency.

EXHIBIT C
Independent Provider Agreement

MEDI-CAL MEMBERS

This Exhibit C only applies to Covered Services rendered to Medi-Cal Members.

1. The following is added to Article II as section 2.4 (b):

   Except with respect to Emergency Services, and family planning and obstetrical/ gynecological services, Provider shall refer Medi-Cal Members for Covered Services to Health Plan Providers. Provider understands and acknowledges that Medi-Cal Members may self-refer for obstetrical/gynecological services without prior approval with any contracted and credentialed Plan OB/GYN provider. Upon and following such referral, Provider shall coordinate the provision of such Covered Services to Medi-Cal Members and ensure continuity of care.

2. The following is added as section 2.9 to Article II:

   Health Plan Utilization Management; Quality Assurance:

   (i) Provider understands that the Local Initiative will place certain obligations on Health Plan regarding Utilization Management of Covered Services received by Medi-Cal Members, and in certain instances the Local Initiative has the right to oversee and review the utilization of Covered Services provided to Medi-Cal Members. Provider agrees to cooperate with the Local Initiative's Medical Director in its review of utilization of services to Medi-Cal Members. Provider shall comply with and participate in, the utilization management programs, including, without limitation, its peer review functions and authorization procedures established by the Local Initiative, and approved by DHCS and DMHC, as amended from time to time. Provider shall cooperate with and participate in the Local Initiative's monitoring and evaluation activities, and shall, if requested by the Local Initiative through Health Plan, make a reasonable effort to serve on the Local Initiative's utilization management subcommittee.

   (ii) Provider understands that the Local Initiative will place certain obligations on Health Plan regarding the quality of care received by Medi-Cal Members, and in certain instances the Local Initiative shall have the right to oversee and review the quality of care administered to Medi-Cal Members. Provider agrees to cooperate with the Local Initiative's Medical Director in their review of the quality of care administered to Medi-Cal Members. Provider shall comply with, and participate in, the quality assurance/improvement programs, peer review functions, and quality improvement committees established by the Local Initiative, and approved

by DHCS and DMHC, as amended from time to time. Provider shall cooperate with and participate in the Local Initiative's monitoring and evaluation activities, and shall, if requested by the Local Initiative through Health Plan, make a reasonable effort to serve on the Local Initiative's quality improvement subcommittee.

3. The following is added as section 2.10 to Article II:

Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for trade name drugs unless a Health Plan Provider writes "dispense as written" on the prescription form.

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EXHIBIT D-1
Independent Provider Agreement

MEDICARE ADVANTAGE REGULATORY EXHIBIT

This exhibit sets forth the requirements, in addition to those set forth elsewhere in the Agreement, applicable to Plans as Medicare Advantage Organizations and shall apply to Covered Services provided to Medicare Advantage Members. In the event of any inconsistency between the terms and conditions of this Exhibit D-1 and the terms and conditions in the remainder of the Agreement, the terms and conditions of this Exhibit D-1 shall govern.

1. **Inspection of Books/Records.** Provider acknowledges and agrees that Plans, the Department of Health and Human Services ("HHS"), the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contracts with the Plans through ten (10) years from the final date of the final contract period of the contract entered into between CMS and Health Plan or from the date of completion of any audit, whichever is later. Provider further agrees that HHS, the Comptroller General or their designees have the right to audit, evaluate, collect, and inspect any records described in the preceding sentence directly from Provider.

2. **Confidentiality.** Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (a) abiding by all Laws and Regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information, (b) ensuring that medical information is released only in accordance with applicable Laws and Regulations, or pursuant to court orders or subpoenas, (c) maintaining the records and information in an accurate and timely manner, and (d) ensuring timely access by Members to the records and information that pertain to them.

3. **Hold Harmless.** Provider agrees that in no event, including, but not limited to, non-payment by Health Plan, insolvency of Health Plan or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons other than Health Plan for payments due Provider pursuant to this Agreement.

4. **Federal Funds.** Provider acknowledges that payments Provider receives from Plans to provide Covered Services to Members are, in whole or part, from Federal funds. Therefore, Provider and any of its subcontractors are subject to certain laws that are applicable to individuals and entities receiving Federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; Section 504 of the Rehabilitation Act of 1973 as implemented by 45 CFR Part 84.

5. **Compliance-Medicare Laws/Regulations.** Provider agrees to comply with all applicable

Medicare laws, regulations, and CMS instructions, including, without limitation, federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. § 3729 et seq.), and the anti-kickback statute (section 1128(B)(b) of the Social Security Act), and HIPAA administrative simplification rules at 45 C.F.R. Parts 160,162 and 164. Further, Provider agrees that any services provided by Provider will be consistent with and will comply with Plans' contract with CMS.

6. **Compliance-Exclusion from Federal Health Care Program.** Provider may not employ, or subcontract with an individual, or have persons with ownership or control interests, who have been, or become, convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social services programs under Title XX of the Social Security Act (the "Act"), and thus have been excluded from participation in any Federal health care program under §§ 1128 or 1128A of the Act (or with an entity that employs or contracts with such an individual) for the provision of any of the following: (i) healthcare; (ii) utilization review; (iii) medical social work; or (iv) administrative services.

7. **Compliance-Training, Education and Communications.** In accordance with, but not limited to 42 C.F.R. §§ 422.503(b)(4)(vi)(C)&(D) and the CMS Compliance Guidelines, Provider agrees and certifies that it will participate in applicable compliance training, education and/or communications as reasonably requested by Health Plan annually or as otherwise required by applicable law, and must be made a part of the orientation for a new employee or subcontractor. Provider acknowledges and agrees that, for purposes of satisfying the training requirement, Provider shall take the training made available by CMS. Plans shall accept the certificate of completion of the CMS training as satisfaction of the training requirement.

8. **Delegated Services.** Plans and Provider shall comply with their respective obligations set forth in the Agreement, including the exhibits hereto, with respect to performance and oversight of delegated services.

9. **Provider Subcontractors.** Provider agrees that if Provider enters into subcontracts for the performance of services under this Agreement ("Downstream Entity"), Provider's subcontracts shall include: (i) an agreement by the Downstream Entity to comply with all of the obligations applicable to Downstream Entities as set forth in this Agreement; (ii) a prompt payment provision as negotiated by Provider and the Downstream Entity, if applicable; (iii) a provision setting forth the term of the subcontract; and (iv) dated signatures of all the parties to the subcontract.

10. **Offshore Subcontractors.** In no event shall Provider employ or contract with a person or entity pursuant to which Medicare beneficiary protected health information will be sent or accessed offshore without the prior written consent of Health Plan. For purposes of this Section 10, "offshore" refers to outside the fifty United States and the United States territories (*i.e.*, American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands).

EXHIBIT D-2
Independent Provider Agreement

LOCAL INITIATIVE REQUIREMENTS APPLICABLE TO SERVICES PROVIDED TO MEDI-CAL MEMBERS

Provider agrees to comply with the following requirements of the Local Initiative with respect to Health Plan Medi-Cal Members in Los Angeles County covered pursuant to the services agreement between Health Plan and Local Initiative ("Plan Contract") and to include such provisions in all agreements between Provider and any health care providers from which Provider obtains usual or frequently used health care services on behalf of those Health Plan Medi-Cal Members in Los Angeles County.

1. **Provision of Covered Services.** Provider shall furnish to Medi-Cal Members those services which is authorized to provide under this Agreement, consistent with the scope of Provider's license, certification or accreditation, and in accordance with professionally recognized standards. Provider shall provide services to Medi-Cal Members in accordance with, and shall otherwise comply with, all of the provisions of the Plan Contract, including but not limited to all Exhibits, with respect to Medi-Cal Members enrolled in Health Plan through the Local Initiative.

2. **Quality Assurance/Improvement Programs.** Provider shall cooperate and comply with and participate in any applicable quality assurance/improvement programs established (or amended from time to time) by Health Plan and by Local Initiative, and approved by DHCS and DMHC. In furtherance thereof, Provider shall cooperate and participate in Local Initiative's monitoring and evaluation activities and shall, if requested by Local Initiative through Health Plan, serve on Local Initiative quality improvement subcommittees.

3. **Local Initiative Member and Provider Grievance/Appeal Procedure.** Provider shall cooperate and comply with any applicable grievance and appeal procedures for review of Medi-Cal Member clinical and non-clinical grievances and provider grievances as established (or amended from time to time) by Local Initiative and by Health Plan and approved by DHCS and DMHC.

4. **Utilization Management Program.** Provider shall cooperate and comply with and participate in any applicable utilization management programs established (or amended from time to time) by Local Initiative and by Health Plan and approved by DHCS and DMHC.

5. **Excluded Services Linkages: Case Management.** Provider shall cooperate and comply with any applicable policies and procedures that are provided or made available to Provider that are developed by Local Initiative and Health Plan with respect to required referral and linkage systems for mental health, dental, California Children's Services, family planning, Indian health services, and Department of Public Health Services and any other community health or excluded services in accordance with the requirements of DHCS (as delineated in the Detailed Design Application and Medi-Cal Agreement governing the Local Initiative Medi-Cal Program).

6. **Cultural/Linguistic Training Programs.** Provider shall participate in and comply with any applicable performance standards, policies, procedures and programs established from time to time by Health Plan, Local Initiative and federal and state agencies and provided or made available to Provider with respect to cultural and linguistic services (CLAS) including, without limitation, attending training programs, and collecting and furnishing cultural and linguistic data to Health Plan, Local Initiative and federal and state agencies.

7. **Performance Standards.** Provider shall comply with all applicable performance standards, as set forth in the Agreement, including but not limited to all Exhibits, and applicable policies and procedures as may be adopted or amended from time to time by Local Initiative, in accordance with the Plan Contract, or as may be required by DMHC or DHCS, that have been provided or made available to Provider, with respect to Medi-Cal Members enrolled in Health Plan through Local Initiative.

8. **Sanctions**. In the event Local Initiative finds Provider non-compliant with Local Initiative, DHCS or DMHC performance standards that have been provided or made available to Provider, Local Initiative shall have the power and authority to impose sanctions upon Provider in accordance with, and subject to all appeal rights under the Local Initiative Sanction policies and procedures as implemented from time to time by Local Initiative and provided or made available to Provider.

9. **Disciplinary Action and Termination**. Provider acknowledges and agrees that, under the Plan Contract, Local Initiative has the right to require Health Plan to suspend assignment of new enrollees to Provider, to transfer Health Plan Medi-Cal Members from Provider or require Health Plan to terminate an individual provider employed or contracted by Provider under the Agreement from the Local Initiative Medi-Cal Plan at any time, subject to such review or appeal right as may be provided pursuant to the Plan Contract, as amended from time to time.

10. **Information.** Provider shall promptly, upon Local Initiative's request, provide financial, capacity and encounter data or other information, reports, documents or forms as may be required to enable Local Initiative to fulfill its reporting and other obligations under the Plan Contract or as otherwise required for purposes of compliance with the Knox-Keene Act, Medi-Cal Acts and Regulations, the DHCS Detailed Design Application, or the Medi-Cal Agreement.

11. **Correspondence**. Provider acknowledges and agrees that Local Initiative expressly reserves the right to directly correspond with, contact, provide information and materials to, or receive information and materials from Provider with respect to operation of the Local Initiative Medi-Cal Plan, subject to Local Initiative having obtained any required DHCS or DMHC approval.

12. **Provider Contract/Plan Contract**. Nothing set forth herein shall be deemed to amend, interpret, construe or otherwise affect in any way the Plan Contract, as amended from time to

time. To the extent that there are any inconsistencies or contradictions between this Agreement and the Plan Contract, the terms and provisions of the Plan Contract shall prevail and control.

13. **Third Party Beneficiary.** Health Plan and Provider acknowledge and agree that the Local Initiative is intended to be benefited by, and shall have the rights of, a third-party beneficiary under, this Agreement.

14. **Cooperation.** Provider shall use its commercially reasonable efforts to maintain a cooperative working relationship to ensure smooth operation of the Local Initiative Medi-Cal Plan. The parties hereto shall, at any time before, at or after execution of this Agreement, sign and deliver (or cause others to do so) all such documents and instruments, and do or cause to be done all such acts and things, and provide or cause to be provided all such information and approvals as may be reasonably necessary to carry out the provisions of this Agreement.

15. **Assignment.** To the extent required by DHCS, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from DHCS.

16. **DHCS Subcontract Approval.** To the extent required by DHCS, any amendment(s) to this Agreement shall be submitted to DHCS for prior approval.

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EXHIBIT D-3
Independent Provider Agreement

DHCS REGULATORY ADDENDUM - PROVIDER

[Bracketed language must be deleted prior to finalizing this exhibit.
The provisions listed below are required by the DHCS Medi-Cal Managed Care Contract so please ensure that these provisions are included in this Agreement.

- This Agreement must include specification of the term of the agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination;
- This Agreement must include full disclosure of the method and amount of compensation or other consideration to be received by Provider.

If Quality Assurance/Improvement Activities are being delegated to Provider/Subcontractor, please reach out to Promise Legal for language that needs to be added to this addendum.]

This Exhibit D-3, Department of Health Care Services Regulatory Addendum ("Addendum") is applicable to [Provider Name] ("Provider") for services provided for Members enrolled in the Medi-Cal program and sets forth the applicable requirements in the Contract ("DHCS Medi-Cal Managed Care Contract") between Blue Shield of California ("Blue Shield") and the California Department of Health Care Services ("DHCS") executed in connection with the Medi-Cal program, in addition to those requirements set forth elsewhere in the Agreement. To the extent that the terms and conditions of the Agreement directly conflict with or contradict any terms and conditions set forth in this Addendum, the terms and conditions of this Addendum shall control. Defined terms that are not otherwise defined in this Addendum or the Agreement shall have the meaning set forth in the Medi-Cal Contract. This Addendum will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

I. Provider agrees to comply with the following requirements of DHCS with respect to Medi-Cal Members for services performed under this Agreement.

1. **Provision of Covered Services.** Provider shall furnish to Medi-Cal Members those services which Provider is authorized to provide under this Agreement, consistent with the scope of Provider's license, certification or accreditation, and in accordance with professionally recognized standards.

2. **Compliance with Laws and Regulations**. Provider agrees that this the agreement will be governed by and construed in accordance with all applicable laws and regulations governing the DHCS Medi-Cal Managed Care Contract, including but not limited to, applicable sections of the Knox Keene Act; Health and Safety Code ("HSC") (unless excluded under the Contract); Title 28 of the California Code of Regulations ("CCR"); Welfare and Institutions Code ("WIC"); and Title 22 of the California Code of Regulations.

3. **Medi-Cal Governance and Compliance**. Provider will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including but not limited to,

all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and provisions of the DHCS Medi-Cal Managed Care Contract.

4. **Prospective Requirements.** Blue Shield must inform Provider of prospective requirements added by State or federal law or DHCS related to the DHCS Medi-Cal Managed Care Contract that impact obligations undertaken through this Agreement before the requirement would be effective, and agreement by Provider to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS.

5. **Provider Data and Encounter Data**. Provider will submit to Blue Shield, either directly or through a subcontractor or Downstream Entity as applicable, complete, accurate, reasonable, and timely Encounter Data and Provider Data, and any other reports or data as needed by Blue Shield, in order for Blue Shield to meet its data reporting requirements to DHCS.

6. **Excluded Services Linkages: Case Management**. Provider shall cooperate and comply with any applicable policies and procedures developed by Blue Shield, and provided or made available to Provider, with respect to required referral and linkage systems for mental health, dental, California Children's Services, family planning, Indian health services, and Department of Public Health Services and any other community health or excluded services in accordance with the requirements of DHCS.

7. **Utilization Data.** To the extent Provider undertakes coordination of care obligations and functions for Members, Blue Shield agrees to share any utilization data that DHCS has provided to Blue Shield, and Provider agrees to receive the utilization data provided and use it solely for the purpose of Member Care Coordination.

8. **Utilization Management Program**. Provider shall cooperate and comply with and participate in any applicable utilization management programs established (or amended from time to time) by Blue Shield and approved by DHCS and DMHC.

9. **Copies of Contracts.** Provider will maintain and make available to DHCS, upon request, copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under this Agreement, and will ensure that all such contracts are in writing.

10. **Fraud, Waste and Abuse.** Provider must notify Blue Shield within ten Working Days of any suspected Fraud, Waste, or Abuse so that Blue Shield can share such information with DHCS in accordance with the DHCS Medi-Cal Managed Care Contract subsection "Contractor's Reporting Obligations" and subsection "Confidentiality."

11. **Books and Records.** Provider will make all of its premises, facilities, equipment, books, records, contracts, and computer and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of this Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the DHCS Medi-Cal Managed Care Contract, section "Inspection and Audit of Records and Facilities," as follows:

a) In accordance with inspections and audits, as directed by DHCS, CMS, U.S. DHHS Inspector General, the Comptroller General, Department of Justice (DOJ), DMHC, or their designees; and

b) At all reasonable times at Provider's place of business or at such other mutually agreeable location in California.

c) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time.

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

d) Provider will maintain all of its books and records, including Encounter Data, in accordance with good business practices and generally accepted accounting principles 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.

12. **Records Related to DHCS Litigation**. Provider will timely gather, preserve and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in Provider's possession, in accordance with the DHCS Medi-Cal Managed Care Contract, section "Litigation Support."

13. **Transfer of Care.** Provider will assist Blue Shield, or if applicable a subcontractor or Downstream Entity, in the transfer of Member's care in accordance with the DHCS Medi-Cal Managed Care Contract, section "Phaseout Requirements" in the event of Medi-Cal Contract termination, or in the event of termination of the Provider for any reason.

Phaseout Requirements

The objective of the Phaseout Period is to ensure that, in connection with the expiration or termination of the DHCS Medi-Cal Managed Care Contract, Blue Shield ensures an orderly transfer of necessary data and history records to DHCS or to a successor Medi-Cal managed care plan. Blue Shield will not provide services to Members during the Phaseout Period.

Within no later than 90 calendar days prior to termination or expiration of the DHCS Medi-Cal Managed Care Contract and through the Phaseout Period for each Service Area, Blue Shield must assist DHCS in the transition of Members and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, Blue Shield will make available to DHCS, without additional compensation, copies of each Member's Medical Records and files, and any other pertinent information, including information maintained by any subcontractor, Downstream Entity, or Provider, necessary to provide effected

Members with case management and continuity of care. In no circumstances will a Medi-Cal Member be billed for this activity.

14. **Hold Harmless.** Provider will hold harmless both the State and Members in the event Blue Shield or, if applicable a subcontractor or Downstream Entity, cannot or will not pay for Covered Services ordered, referred, or rendered by Provider pursuant to this Agreement.

15. **Prohibition on Balance Billing.** Provider will not bill a Member for Medi-Cal Covered Services.

16. **Cultural/Linguistic Training Programs**. Provider shall participate in and comply with any applicable performance standards, policies, procedures and programs established from time to time by Blue Shield and federal and state agencies and are provided or made available to Provider with respect to cultural and linguistic services (CLAS) including, without limitation, attending training programs, and collecting and furnishing cultural and linguistic data to Blue Shield and federal and state agencies.

17. **Diversity, Equity, and Inclusion Training**. Provider must ensure that cultural competency/humility, sensitivity, Health Equity, and diversity training is provided for employees and staff at key points of contact with Members in accordance with the DHCS Medi-Cal Managed Care Contract, section "Diversity, Equity, and Inclusion Training."

18. **Language Assistance and Interpreter Services**. Provider must provide interpreter services for Members and comply with language assistance standards developed pursuant to HSC, section 1367.04.

19. **Threshold Languages and Alternative Format Selections.** To the extent that the Provider is responsible for providing member-facing materials to Blue Shield members, the Provider agrees to comply with DHCS guidance for communicating in the member's request.

20. **Quality Assurance/Improvement Programs**. Blue Shield has not delegated Quality Improvement activities to Provider. Provider shall cooperate and comply with and participate in any applicable quality assurance/improvement programs established (or amended from time to time) by Blue Shield and approved by DHCS and DMHC.

21. **Overpayment.** Provider must report to Blue Shield when it has received an Overpayment; return the Overpayment to Blue Shield, within 60 calendar days of the date the Overpayment was identified; and notify Blue Shield, in writing of the reason for the Overpayment in accordance with the DHCS Medi-Cal Managed Care Contract, subsection "Treatment of Overpayment Recoveries," and 42 Code of Federal Regulations ("CFR"), section 438.608(d)(2).

22. **Monitoring**. Provider must comply with all monitoring provisions of the Medi-Cal Contract and any monitoring requests by DHCS;

23. **Performance Standards**. Provider shall comply with all applicable performance standards, as set forth in the Agreement, including but not limited to all Exhibits, and applicable policies

and procedures as may be required by DMHC or DHCS, and are provided or made available to Provider, with respect to Medi-Cal Members enrolled in Blue Shield.

24. **Health Care Providers' Bill of Rights**. Provider shall be entitled to all protections afforded them under the Health Care Providers' Bill of Rights, including, but not limited to Provider's right to access Blue Shield's dispute resolution mechanism and submit a grievance pursuant to HSC, section 1367(h)(1).

25. **Officers and Directors.** Exhibit D-4 contains the names of all of the officers and directors of Provider, all of the stockholders owning more than ten (10) percent of the issued and outstanding stock of Provider and all major creditors holding more than five (5) percent of the debt of Provider. Provider shall promptly notify Blue Shield of any and all changes in the information contained in Exhibit D-4.

26. **Conflict of Interest.** Provider warrants that no part of the total compensation provided for herein shall be paid directly or indirectly to any officer or employee of the State of California as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to Provider in connection with any services contemplated or performed relative to this Agreement. Provider certifies that no member of or delegate of Congress, the General Accounting Office, DHHS, CMS or any other Federal agency has or will benefit financially or materially from this Agreement.

27. **Assignment.** To the extent required by DHCS, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from DHCS.

28. **Revocation of Delegation.** As applicable, Provider agrees to revocation of delegation of activities or obligations, or specify other remedies, in instances where DHCS or Blue Shield determine that Provider has not performed satisfactorily.

29. **Termination.** This Agreement will be terminated, or subject to other remedies, if DHCS or Blue Shield determine that the Provider has not performed satisfactorily.

30. **Approval by DHCS**. This Agreement and its amendments will become effective only upon approval, as set forth in the DHCS Medi-Cal Managed Care Contract, subsection "DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Entity Agreements." Blue Shield is responsible for seeking approval from DHCS as necessary.

II. If Provider is also a Subcontractor, the Provider must also comply with the following provisions, as applicable, to the specific obligations and functions that Blue Shield delegates in the subcontractor agreement or that the Provider delegates in the Downstream Entity agreement:

1. **Copies of Contracts.** Subcontractor and Downstream Entity must maintain and make available to DHCS, upon request, copies of all contracts it enters into related to the performance of the obligations and functions it undertakes pursuant to the subcontractor agreement, and to ensure that such contracts are in writing.

2. **Amendment or Termination.** Blue Shield, or Provider's behalf must notify DHCS in the event the subcontractor agreement or any Downstream Entity agreement is amended or terminated for any reason.

3. **Quality Improvement Activities.** If subcontractor or Downstream Entity takes on quality improvement activities, the subcontractor agreement or Downstream Entity agreement must include those provisions stipulated in the DHCS Medi-Cal Managed Care Contract, Subsection "Subcontractor and Downstream Entity QI Activities."

4. **Prospective Requirements.** Subcontractor or Downstream Entity must inform the Downstream Entity taking on delegated functions of prospective requirements added by federal or State law or DHCS related to the DHCS Medi-Cal Managed Care Contract that impact obligations and functions undertaken pursuant to the Downstream Entity agreement before the requirement is effective, and the agreement of the Downstream Entity taking on delegated functions to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS.

5. **Performance Standards.** Subcontractor and Downstream Entity must perform the obligations and functions of the Blue Shield undertaken pursuant to the subcontractor agreement or Downstream Entity agreement, including but not limited to reporting responsibilities, in compliance with contractor's obligations under this Contract in accordance with 42 CFR section 438.230(c)(1)(ii).

6. **Enforcement of Provisions.** Subcontractor and Downstream Entity must expressly agree and acknowledge that DHCS is a direct beneficiary of the subcontractor agreement or Downstream Entity agreement with respect to all obligations and functions undertaken pursuant to the subcontractor agreement or Downstream Entity agreement, and that DHCS may directly enforce any and all provisions of the subcontractor agreement or Downstream Entity agreement.

7. **Revocation of Sub-delegation.** Provider agrees to revocation of sub-delegation of activities or obligations or specify other remedies in instances where DHCS or Blue Shield determine that the Provider has not performed satisfactorily.

8. **Assignment**. To the extent required by DHCS, any assignment or delegation of this Agreement to any Downstream Entity, or the Downstream Entity's assignment or delegation of a Downstream Entity agreement to any Downstream Entity shall be void unless prior written approval is obtained from DHCS.

III. Emergency Services and Post-Stabilization Care Services. This Section only applies to Providers who are at risk for non-contracted emergency services.

A. Emergency Services

1. Subject to 42 CFR section 422.113(b), Blue Shield 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 a contract with Blue Shield. Blue Shield may not deny payment for treatment obtained when a Member had an Emergency

Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR section 438.114(a) of the definition of Emergency Medical Condition. Further, Blue Shield may not deny payment for treatment obtained when a representative of Blue Shield instructs the Member to seek Emergency Services. Emergency Services must not be subject to prior authorization by Blue Shield.

2. Blue Shield may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms or refuse to reimburse Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's primary care providers, Blue Shield, or DHCS of the Member's screening and treatment for Emergency Services. A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.

3. Blue Shield must reimburse Providers for Emergency Services received by a Member from Out-of-Network Providers. Payments to non-contracting Providers must be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Blue Shield or Provider or the Member is stabilized sufficiently to permit discharge. The attending emergency Physician or the Provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on Blue Shield. Emergency services must not be subject to Prior Authorization by Blue Shield.

4. At a minimum, Blue Shield must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for physician services at the lowest level of the emergency department evaluation and management physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

5. For all non-contracted Emergency Services providers, reimbursement by Blue Shield or by a subcontractor or Downstream Entity who is at risk for out-of-network Emergency Services for properly documented claims for services rendered by Out-of-Network Provider pursuant to this Provision must be made in accordance with the DHCS Medi-Cal Managed Care Contract, Subsection "Claims Processing" and 42 United States Code ("USC"), section 1396u-2(b)(2)(D).

B. Post-Stabilization Care Services

1. Post-Stabilization Care Services are covered by and paid for in accordance with 42 CFR section 422.113(c). Blue Shield is financially responsible for Post-Stabilization Care Services obtained within or outside Blue Shield's Network that are authorized by Blue Shield, Subcontractor, Downstream Entity, or Provider.

2. In accordance with 28 CCR section 1300.71.4, Blue Shield must approve or disapprove a request for Post-Stabilization Care Services made by a Provider on behalf of a Member

within 30 minutes of the request. If Blue Shield fails to approve or disapprove authorization within the required timeframe, the authorization is deemed approved.

3. Blue Shield is also financially responsible for Post-Stabilization Care Services obtained within or outside Blue Shield's Network that are not authorized by Blue Shield, Provider, subcontractor or Downstream Entity, but administered to maintain, improve, or resolve the Member's stabilized condition if Blue Shield, Provider, subcontractor, Downstream Entity does not respond to a request for authorization within 30 minutes; Blue Shield, Provider, subcontractor, Downstream Entity cannot be contacted; or Blue Shield, Provider, subcontractor, or Downstream Entity and the treating Physician cannot reach an agreement concerning the Member's care. In this situation, the treating Physician may continue with care of the Member until agreement with Blue Shield or its Delegate is contacted and assumes responsibility for the Member's care or one of the criteria of 42 CFR section 422.133(c)(3) is satisfied.

4. Blue Shield's financial responsibility for Post-Stabilization Care Services it has not authorized ends when a Provider with privileges at the treating hospital assumes responsibility for the Member's care, a Provider assumes responsibility for the Member's care through transfer, Blue Shield's representative and the treating Physician reach an agreement concerning the Member's care; or the Member is discharged.

5. Consistent with 42 CFR sections 438.114(e), 422.113(c)(2), and 422.214, Blue Shield is financially responsible for payment of Post-Stabilization Care Services, following an emergency admission, at the hospital's Medi-Cal FFS payment rates for general acute care inpatient services rendered by a non-contracting, Medi-Cal certified hospital, unless a lower rate is agreed to in writing and signed by the hospital.

    a) For the purposes of this Subsection "Emergency Services and Post-Stabilization Care Services," the Medi-Cal FFS payment amounts for dates of service when the Post-Stabilization Care Services were rendered must be the Medi-Cal FFS payment method known as diagnosis-related groups, which for the purposes of this Paragraph 5 must apply to all acute care hospitals, including public hospitals that are reimbursed under the Certified Public Expenditure Basis methodology (WIC §14166 et seq.), less any associated direct or indirect medical education payments to the extent applicable.

    b) Payment made by Blue Shield to a hospital that accurately reflects the payment amounts required by this Paragraph 5 shall constitute payment in full; and must not be subject to subsequent adjustments or reconciliations by Blue Shield, except as provided by Medicaid law and regulations. A hospital's tentative and final cost settlement processes required by 22 CCR section 51536 shall not have any effect on payments made by Blue Shield pursuant to this Paragraph 5.

C. Disputed claims involving Emergency Services and/or Post-Stabilization Care Services may be submitted for resolution under provisions of WIC section 14454 and 22 CCR sections 53620 et seq. (except section 53698) to:

Department of Health Care Services

Office of Administrative Hearings and Appeals
3831 North Freeway Blvd, Suite 200
Sacramento, CA 95834

Blue Shield agrees to implement DHCS' determination and reimburse the Out-of-Network Provider within 30 calendar days of the effective date of a decision that Blue Shield is liable for payment of a claim and must provide proof of reimbursement in such form as DHCS directs. Failure to reimburse the Out-of-Network Provider within 30 calendar days shall result in capitation offsets in accordance with WIC sections 14454(c) and 14115.5 and 22 CCR section 53702 and may subject Blue Shield to sanctions pursuant to WIC section 14197.7.

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EXHIBIT D-4
Independent Provider Agreement

MEDI-CAL BENEFIT PROGRAM DISCLOSURE FORM
(*Welfare and Institutions Code Section 14452, 42 CFR § 455.104)*

_____
Name of the Provider
(The contracting party name under the Agreement)

The undersigned hereby certifies that the following information regarding the Provider is true and correct as of the date set forth below:

I. ***Form of Business****:* (Please state whether a: Corporation, LLC, Partnership, Sole Proprietorship, etc.)

_____

II. **If Provider is a *Corporation*:**

A. Please list the name, address, date of birth (DOB), social security number (SSN) and tax identification number (TIN) for **all shareholders** owning *more than five percent* (5%) of the company stock:

Shareholder Name **(Individual or Corporation)**	Address **(Individual or Corporation)**	DOB **(Individual)**	SSN **(Individual)**	TIN **(Corporation)**

(A separate sheet with all requested information may be included.)

B. Please list the name, address, date of birth (DOB) and social security number (SSN) for **all members of the Board of Directors (BOD)** of the provider company:

BOD Member Name **(Individual or Corporation)**	Address **(Individual or Corporation)**	DOB **(Individual)**	SSN **(Individual)**

(A separate sheet with all requested information may be included.)

C. Please list the name, address, date of birth (DOB) and social security number (SSN) for the designated corporate officers:

Company Officer	Address **(Individual or Corporation)**	DOB **(Individual)**	SSN **(Individual)**
President:			
Secretary:			
Treasurer:			
Other with Title:			

(A separate sheet with all requested information may be included.)

III. **If Provider is an *LLC, Partnership, Sole Proprietorship, or Other Entity*:**

A. Please list the name, address, date of birth (DOB) and social security number (SSN) for the designated company officers:

Company Officer	Address **(Individual or Corporation)**	DOB **(Individual)**	SSN **(Individual)**
President:			
Secretary:			
Treasurer:			
Other with Title:			

(A separate sheet with all requested information may be included.)

B. Please list the name, address, date of birth (DOB), social security number (SSN) and tax identification number (TIN) for **the Owners (those who directly or indirectly own 5% or more of the Provider), Members (if Provider is an LLC) and Partners (if Provider is a partnership)**.

Name **(Individual or Corporation)**	Address **(Individual or Corporation)**	DOB **(Individual)**	SSN **(Individual)**	TIN **(Corporation)**

(A separate sheet with all requested information may be included.

IV. Is any person (individual or corporation) with an ownership or controlling interest in the Provider **related to another person with ownership or controlling interest in the Provider** as a spouse, parent, child, or sibling; **or** is any person (individual or corporation) with an ownership or controlling interest **in any subcontractor** in which the Provider has a ***five percent* (5%) *or more interest***, related to another person with ownership or controlling interest in the Provider as a spouse, parent, child, or sibling? If so, please provide the following:

Name **(Individual or Corporation)**	Address **(Individual or Corporation)**	DOB **(Individual)**	SSN **(Individual)**	Please briefly explain the relationship

(A separate sheet with all requested information may be included.)

V. Is the Provider, or a co-owner, partner, stockholder, director or officer of the Provider, ***either directly or indirectly related to, or affiliated with, Health Plan***? If so, please explain:

_____

_____

VI. ***Major creditors*** holding *more than five percent* (5%) of the Provider debt:

Creditor **(Individual or Corporation)**	Address **(Individual or Corporation)**	DOB **(Individual)**	SSN **(Individual)**	TIN **(Corporation)**

(A separate sheet with all requested information may be included.)

«Signer>>1>>Signature» «Signer>>1>>Title»
Signature: Title:

«Signer>>1>>Name» «Signer>>1>>Date»
Print Name: Date: