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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA, et al.,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF DEBRA HALLADAY, INTERIM CHIEF EXECUTIVE OFFICER OF VALLEY HEALTH PLAN, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, DEBRA HALLADAY, declare:

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Summary Judgment. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

2. I am the Interim Chief Executive Officer of Valley Health Plan. In this role I oversee all health plan operations. I have held this position since July of 2019. I have also served as the Chief Operating Officer for Valley Health Plan since May of 2018. Prior to my current roles at Valley Health Plan, I served as the Director of Planning, Business Development and Managed Care as well as the Director of System Integration and Transformation for the County of Santa Clara Health & Hospital System. Prior to my work with the County, I also worked with several managed care organizations in executive roles. I have served in health care for 30 years.

3. Valley Health Plan is a health maintenance organization ("HMO") owned and operated by the County of Santa Clara since 1985. Our mission is to provide affordable healthcare to a wide spectrum of Santa Clara County residents and community members, and to improve the overall health and wellbeing of Santa Clara County and our members. As an HMO, Valley Health Plan offers a set of different healthcare coverage plans that give enrolled members access to a range of medical services from physicians and other healthcare providers with whom Valley Health Plan contracts. The health plan member, or the entity paying for the member's coverage, selects a plan and pays a predetermined fee in exchange for securing the member's access to a set of covered healthcare services, including access to a network of primary and specialty care providers, nationwide pharmacy locations, and in-state laboratory locations, as well as other health care providers for behavioral health, substance abuse, chiropractic, acupuncture, and related services. Many of our provider partners are primarily focused on safety-net populations and our partnership with them provides them with an alternate and steady stream of payments that can help enable their work with safety net populations.

4. We serve a variety of populations, and many of our members have their healthcare plans with us paid for in whole or in part by the federal government:

a. **Commercial members**: For these members, an employer secures healthcare coverage through Valley Health Plan for its employees. Approximately 22,686 people obtain healthcare through our commercial memberships, and many Santa Clara County employees receive healthcare coverage through this option.

b. **Medi-Cal**: The Santa Clara Family Health Plan (Family Health Plan) is an independent Health Authority created by the County in 1996 that works with the State to provide coverage to Medi-Cal and Healthy Kids enrollees. The Family Health Plan delegates to Valley Health Plan the responsibility for connecting a large portion of its Medi-Cal and Healthy Kids enrollees to covered healthcare services. Thus, Valley Health Plan provides administrative services, including access to its extensive provider network, to the Family Health Plan's Medi-Cal and Healthy Kids enrollees. The Family Health Plan is compensated by the State for providing coverage, and the Family Health Plan in turn compensates Valley Health Plan for its services. Valley Health Plan's current enrollment of Medi-Cal Managed Care and Healthy Kids members is approximately 119,924. Were we to be disqualified from receiving federal funds passed through the Department of Health and Human Services we would no longer be able to offer services to the Medi-Cal Managed Care members.

c. **Covered California Health Exchange Program**: Valley Health Plan is a Qualified Health Plan Issuer for Covered California, the California Health Benefit Exchange. Covered California is the state marketplace for health insurance, established following the enactment of the Patient Protection and Affordable Care Act (ACA). Under the ACA, each state is tasked with creating a marketplace for health insurance plans. The federal government subsidizes these plans for individuals who meet income-based eligibility requirement. Thus, through the Covered California marketplace, Valley Health Plan offers subsidized health insurance plans to eligible persons. There are approximately 16,816 members enrolled in Valley Health Plan through Covered California.

d. **Individual and Family Plans**: Valley Health Plan offers an off-exchange product for individuals and families that allows those who don't qualify for subsidies to obtain insurance under the same terms as those offered through the Covered California exchange. There

are 347 members enrolled in Valley Health Plan's direct family and individual plans.

5. When Valley Health Plan enters into a contract with a provider, Valley Health Plan requires that the provider inform us of the entire range of specific services they provide. A sample of our standard provider agreement is attached as **Exhibit A**. We also require that a provider inform us if the scope of the services it offers is about to change or has changed. Exhibit A at 2.1(l). Without this information, we cannot match our members to providers who can appropriately care for them. For example, an obstetrician/gynecologist is required to list whether they provide abortion and sterilization care as part of the provider contract, and once that provider is part of the VHP network, the provider must provide those services or timely inform us that they no longer offer such services. See Exhibit A at 2.1(l). If providers were to not provide us with accurate information about the care they provide, it could delay or bar members from receiving the healthcare to which they are entitled.

6. We require each provider to sign a nondiscrimination provision stating that it "will not differentiate or discriminate in its provision of Covered Services to Members hereunder, because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or use of medical services, and . . . will render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to other Clinic patients." Exhibit A at 2.1(k). Were our providers allowed to refuse to provide care to specific members on the basis of a member's identity or a connection between a member's identity and the care they were seeking, it would obstruct members' access to healthcare to which they are entitled, undercut our relationship with our members, and endanger member health. We strive to run an inclusive organization, and without the ability to enforce this policy, we would not be able to ensure access to healthcare services.

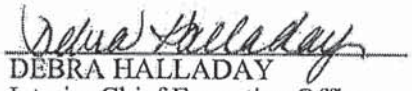
7. When a member is seeking healthcare services they call Member Services to be connected with a provider who can meet their needs. If one of our representatives responsible for answering calls through Member Services objected to connecting a member with care on the basis of the representative's cultural values, ethics, or religious beliefs, this could delay or bar a member's access to the healthcare to which they are entitled. For example, if a Member Services

representative told a member that they could not connect them with services—without noting that this was because of the representative's own provider's cultural values, ethics, or religious beliefs—then that member might be left with the impression that Valley Health Plan would not cover the service the member was seeking. And, while a limited subset of calls are recorded, Valley Health Plan would largely be left entirely unaware that a member sought certain care and was turned away be a Member Services representative.

8. Further, a Valley Health Plan nurse or doctor must review and approve a request for services before a member can obtain certain services. Valley Health Plan's medical management follows national clinical guidelines for determining medical necessity and whether to approve a specific clinical service. It would undermine our review system if a reviewing nurse or doctor—based on their own cultural values, ethics, or religious beliefs—rejected or ignored a request for service that should have been approved under Valley Health Plan's guidelines, particularly if they did so without informing anyone that the denial or non-action was due to their cultural values, ethics, or religious beliefs. Indeed, if the member did not appeal the ruling, Valley Health Plan might never learn that a nurse or doctor had rejected the request based on their cultural values, ethics, or religious beliefs. And as a result, that member might never get the medically indicated care to which they were entitled.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on September 6, 2019 in San José, California.



DEBRA HALLADAY
Interim Chief Executive Officer

EXHIBIT A

PROVIDER AGREEMENT
BY AND BETWEEN
THE COUNTY OF SANTA CLARA, dba VALLEY HEALTH PLAN
AND
PROVIDER_CONTRACT_NAME

This agreement, effective as of **Effective_Date** ("Effective Date"), is made and entered into by and between **Provider_Contract_Name** ("Provider"), and the County of Santa Clara, a subdivision of the state of California, ("County") doing business as Valley Health Plan ("VHP") for **Type_of_Services** ("Agreement"). Provider and Plan may be referred to individually as "Party" and collectively as "Parties".

RECITALS

WHEREAS, County operates VHP ("Plan"), a Health Care Service Plan licensed pursuant to the Knox-Keene Health Care Service Act of 1975, as amended ("Knox-Keene Act");

WHEREAS; VHP arranges for the provision of Covered Services to Members (as hereinafter defined) of Plan;

WHEREAS, such Members may from time to time require the services of a health care Provider, or services at a location, which County is unable to provide, and Plan wishes to insure the provision of such services to Members;

WHEREAS, **Provider_Contract_Name** is a health care Provider duly licensed by the State of California to provide the services under this Agreement and Provider has the authority, applicable knowledge, and expertise to provide **Type_of_Services** at Provider's medical offices located at **«Address», «City», «State» «Zip».**

AGREEMENT

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

ARTICLE I

DEFINITIONS

In addition to the definitions elsewhere in this Agreement, the following capitalized terms shall have the meanings set forth below:

1.1 "Accrediting Agency" means a nationally recognized agency invested in the assurance of quality care to patients, which helps organizations meet regulatory requirements, as well as, distinguish themselves from non-accredited competition. An Accrediting Agency (i) completes initial and periodic assessments of an organization, (ii) evaluates against a defined set of standards, and (iii) determines and issues an official

recognition of accreditation to organizations meeting those set standards. VHP's Accrediting Agency(s) are identified on the Valley Health Plan's website at www.valleyhealthplan.org.

1.2 "Applicable Requirements" means, to the extent applicable to the terms and conditions of this Agreement and the duties, rights and privileges hereunder, the requirements set forth in: (i) the Provider Manual, the VHP Language Assistance Program, and any other policies and procedures of VHP including the Quality Management Programs; (ii) federal and state laws and regulations and any amendments or updates thereto, including the Knox-Keene Act; (iii) the applicable Evidence of Coverage; (iv) Medicare and Medi-Cal laws and regulations or Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) instructions and reporting requirements, including certification requirements; (v) the California Department of Managed Health Care (DMHC); (vi) the California Health Benefit Exchange; and (vii) VHP's Accrediting Agency standards.

1.3 "Authorization" means the written approval by Plan, to be obtained by a Provider, making a Referral or providing certain Covered Services (other than Emergency Services) to any Member, in accordance with Applicable Requirements. Covered Services approved by Plan, as applicable, in accordance with the foregoing are "Authorized".

1.4 "Clean Claim" means a billing form (e.g. UB-04, CMS 1500, or any subsequent form issued by CMS, or applicable electronic claim) submitted by Provider to VHP that (i) identifies the Member; (ii) identifies the items and services with codes listed in this Agreement, including Exhibits, or, if not specifically listed, identifies the items and services provided utilizing codes published in the Current Procedural Terminology ("CPT"), Healthcare Common Procedure Coding System ("HCPCS"), or other industry-standard codes utilized by Provider; (iii) if applicable, contains or attaches a required authorization or form as specified in this Agreement, and (iv) follows all industry standard clean claim practices.

1.5 "Contracted Services" Covered Services that are within Provider's scope of practice provided to a Member pursuant to the Evidence of Coverage in effect at the time services are rendered and compensated in accordance with this Agreement.

1.6 "Coordination of Benefits" ("COB") means the determination of order of financial responsibility that will apply when two (2) or more payors provide coverage of services for an individual Member. When the primary and secondary benefits are coordinated, determination of financial responsibility shall be in accordance with Applicable Requirements.

1.7 "Co-payment" means the amount due from Member for Covered Services that is in accordance with Applicable Requirements and is disclosed and provided for in the Member's Evidence of Coverage. The reference to "Co-payments" may include copayments, deductibles, and co-insurance charges or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

1.8 "Covered California" shall mean Covered California, California Health Benefit Exchange, the independent entity established within the government of the State of California and authorized under the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (collectively, "Affordable Care Act"), and the California Patient Protection and Affordable Care Act, (Chapter 655, Statutes of 2010) and Chapter 659, Statutes of 2010) ("California Affordable Care Act") to selectively contract with health insurance issuers in order to make available to enrollees of the exchange health care coverage choices available to qualified individuals, employers and employees.

1.9 "Covered Services" means all of the health care services and supplies: (i) that are Medically Necessary; (ii) that are generally available from provider; (iii) that provider is licensed to provide to Members; and (iv) that are covered under the terms of the Member's Evidence of Coverage at the time service is rendered. Plan shall retain the right and sole responsibility to determine whether a service is a Covered Service.

1.10 "Emergency Medical Condition" as set forth in Title 22, California Code of Regulations ("CCR"), section 51056, and California Health and Safety Code section 1317.1, means those services required for alleviation of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) Placing the patient's health (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

1.11 "Emergency Services" means those medical and psychiatric services required that are (i) furnished by a physician qualified to furnish emergency services; and (ii) needed to evaluate or stabilize an Emergency Medical Condition.

1.12 "Evidence of Coverage" ("EOC") means the Plan handbook issued to a Member that describes coverage and benefits known as the Combined Evidence of Coverage and Disclosure Form as may be amended, modified, replaced, or supplemented from time to time and issued to Members by Plan pursuant to Title 28 of the California Code of Regulations § 1300.63.2.

1.13 "Language Assistance Program" means the language assistance program established by VHP in compliance with the requirements of the Health Care Language Assistance Act, pursuant to Health and Safety Code Section 1367.04 et seq. and California Code of Regulations ("CCR") 28 CCR 1300.67.04 et seq.

1.14 "Medically Necessary" means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury as determined by a Physician, or, as appropriate, by another Provider under supervision of a Physician, in accordance with accepted medical and surgical practices and standards prevailing at the

time of treatment and in conformity with the professional and technical standards adopted by VHP, as applicable.

1.15 "Member" means each VHP Employer Group, Covered California, Individual and Family Plan, Medi-Cal, Healthy Kids enrollee or other individual included in the products reflected in the exhibits attached to and incorporated by reference to this Agreement.

1.16 "Physician(s)" means each duly licensed and qualified physician who has satisfied Plan's credentialing criteria and is under contract, directly or indirectly, with Plan to provide specified Covered Services to Members.

1.17 "Practitioner(s)" mean the other health care Providers that have entered or will enter into a written agreement, directly or indirectly, with Plan to provide certain Covered Services in return for a negotiated rate of compensation.

1.18 "Provider(s)" means the hospitals, community clinics, primary care and specialty care physicians, skilled nursing facilities, home health agencies, and other health care providers (including institutional, ancillary, behavioral health, and participating Physicians) that have entered or will enter into a written agreement, directly or indirectly, with Plan to provide certain Covered Services in return for a negotiated rate of compensation.

1.19 "Primary Care Physician(s)" ("PCP") means the Physician responsible for supervising, coordinating, and providing initial and primary care to each Member who selects or is assigned to such physician. The PCP is responsible for: managing the delivery of all health and medical care services; for initial referrals for specialist care; and for maintaining the continuity of patient care to such Members. PCP includes physicians practicing in the area of internal medicine, general and family practice, or pediatrics; and may also include physicians in other areas of practice, as applicable, to the extent permitted by VHP and Applicable Requirements.

1.20 "Provider Manual" means, collectively, VHP's standards, protocols, policies and procedures, guidelines, manuals, and related written materials. The Provider Manual(s) are incorporated into this Agreement and may be revised or replaced from time to time, in accordance with the terms of this Agreement. The Provider Manual can be located on Valley Health Plan's website at www.valleyhealthplan.org. If any provisions in the Provider Manual or any amendments thereto are inconsistent with the terms of this Agreement, the terms of this Agreement shall prevail.

1.21 "QHP Contract" shall mean the Qualified Health Plan contract between Plan and Covered California through which Plan is authorized to enroll individuals as Covered California Members.

1.22 "Quality Management Programs" shall include both Quality Improvement and Utilization Management Programs and means VHP policies, procedures, protocols and functions designed to monitor and ensure the quality and appropriate utilization of Covered Services provided to Members. The Quality Management Programs are described in the Provider Manual.

1.23 "Santa Clara Family Health Plan" ("SCFHP") means the health care service plan licensed pursuant to the Knox-Keene Act and governed by the Santa Clara County Health Authority.

1.24 "Surcharge" means an additional fee that is charged to a Member for Covered Services, which is not permitted under applicable legal requirements, and is neither disclosed nor provided for in the Member's Evidence of Coverage.

ARTICLE II

PROVIDER OBLIGATIONS

2.1 Services.

(a) Provider will provide the **Type_of_Services** services ("Contracted Services") to Members included in the product(s) identified in the exhibits attached to and incorporated by reference to this Agreement.

(b) The Provider(s) must submit an application and be approved pursuant to all applicable credentialing procedures, before he or she may provide medical services pursuant to this Agreement.

(c) Provider will maintain a current list of its Providers who are eligible in accordance with Section 2.9 of this Agreement, to provide medical services hereunder. Provider shall provide an updated list of any changes monthly.

(d) Provider agrees to follow treatment guidelines equivalent to those required by the state in which Provider renders services or as outlined by Provider's specialty.

(e) Providers will accept, diagnose, and treat those Members referred to Provider by Plan in accordance with the terms of this Agreement and consistent with accepted principles of medical practice and ethics.

(f) Except for Emergency Services as defined herein and unless otherwise authorized, Provider will make best efforts to use Physicians and a contracted Providers for those Members requiring additional professional and Covered Services.

(g) Subject to other provisions in this Agreement, the Provider will determine the method, details, and means of performing Contracted Services pursuant to this Agreement. Provider acknowledges that all VHP's decisions, policies and procedures regarding the provision of Covered Services to Members apply solely to Provider's rights to compensation, and will not be construed as interference with, or direction or substitution of, Provider's due diligence and judgment in the provision of Covered Services.

(h) Provider will maintain adequate personnel and facilities to meet its responsibilities under this Agreement. Provider will supervise all personnel employed by it. Provider's personnel, equipment and facilities will be licensed or certified to the extent required by law. Plan or its designee(s), the DHCS, the DMHC or other regulatory agencies may conduct periodic site visits to assess the adequacy of personnel and facilities maintained by Provider. If any of the personnel and/or facilities maintained at any site is found to be inadequate, Plan must be notified, and Provider must develop and implement a plan of correction in accordance with Plan's Quality Management Programs and applicable state and federal laws.

(i) Provider will be responsible, at its sole cost and expense, for providing licensed persons or technicians to assist in the performance of Contracted Services hereunder.

(j) Provider will comply with Plan's drug formularies and treatment protocols, subject to generally accepted medical practice standards. Provider will comply with Title 22, CCR, section 53214, and with DHCS standards for the appropriate use, storage and handling of pharmaceutical items.

(k) Provider will not differentiate or discriminate in its provision of Contracted Services to Members hereunder, because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or use of medical services, and Provider will render services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to Provider's other patients.

(l) Provider will notify the Plan of a pending or actual change in scope of service available, or any other factors which might materially affect the Provider's ability to provide services and carry out all other provisions under this Agreement.

(m) Provider agrees to comply with Plan's Language Assistance Program Requirements as outlined in **Exhibit F** that is attached to and incorporated herein by this reference and any other Applicable Requirements.

(n) Provider agrees to comply with Plan's Timely Access Standards as outlined in **Exhibit G** that is attached to and incorporated herein by this reference.

(o) Provider agrees to comply with the Covered California Requirements as specified in **Exhibit H** that is attached to and incorporated herein by this reference.

2.2 Continuity of Care. The completion of Covered Services shall be provided by a terminated Provider to a Member who at the time of the contract's termination was receiving services from that Provider as required by law.

2.3 Standard of Care. Provider shall ensure that Covered Services furnished by Provider to Member are (i) Medically Necessary; (ii) provided in accordance with the standard of care prevailing within the medical community at the time of treatment; (iii)

provided in coordination with appropriate health prevention and education measures; and (iv) in consultation with Plan.

2.4 Improvement Programs. Provider shall establish and maintain quality improvement and utilization management programs to monitor the quality and utilization of Covered Services rendered to members within and across the healthcare organization, settings, and all levels of care. Provider shall fully cooperate with and participate in Plan's Quality Improvement (QI) and Utilization Management (UM) Programs, as applicable. Provider will operate a QI program that is compliant and responsive to public health initiatives, federal, state, and local regulators and accreditation bodies. Provider's QI program shall include a system for monitoring and evaluating accessibility of care. Provider shall support the Plan's ongoing efforts to improve clinical care and services through activities including, but not limited to safe clinical practices, assessment and improvement of clinical care as necessary, measuring quality of services and member experience, and efficient utilization of resources. Provider agrees to implement any reasonable change required by Plan regarding any Provider or problem identified by Plan's Quality Improvement and/or Utilization Management Programs. Provider shall permit Plan personnel to review medical records of Members and Provider shall furnish copies of such pertinent sections of Members' medical records, as may be required, consistent with applicable confidentiality requirements as set forth in this Agreement. Provider agrees to provide to Plan, monthly, all Member data necessary for Plan to maintain and operate its QI and UM Programs and comply with all encounter data submission requirements imposed by Plan and/or any government regulatory agency.

(a) Provider shall designate experienced Utilization Management staff, capable of effectively coordinating the provision of Covered Services to Members. The UM staff shall, among other duties, assist Provider and Plan with respect to implementing Covered Service authorizations, approval of Member referrals, and such other duties as Provider shall designate from time to time. Prior authorization is required for all Covered Services except as determined by DMHC policy. Contacts for prior authorization of Covered Services are referenced in **Exhibit D** which is attached to and incorporated herein by this reference.

(b) Provider shall fully comply with Plan's Quality Management Programs and with any changes thereto. Upon request, Provider agrees to furnish Plan with Provider's performance data for quality improvement activities including compiling and comparing the performance data for display to our Members in order for Plan to meet their regulatory or accreditation requirements. Information requested must be readily available and requested within a reasonable time frame.

(c) Provider shall cooperate with Plan and/or any external peer review organization in the conduct of QI functions and in solving problems which includes potential quality issues. Provider shall provide Plan with information and reports as are reasonably necessary for Plan to conduct, or, if applicable, monitor Provider's delegated conduct of quality improvement functions. Provider shall also provide Plan with information and reports as are necessary for Plan to maintain compliance with DMHC, CMS, Covered California and Accrediting Agency requirements and/or state and federal law.

2.5 Member Transfer or Termination. Provider shall not ask Plan to terminate a Member or transfer a Member to another Provider because of a Member's medical condition or need for, or utilization of Covered Services. However, Plan and Provider may determine that the transfer of certain Members to another Provider may be Medically Necessary. Such determination shall be based on the following: (i) the Member's medical condition; (ii) the standard of care prevailing within the applicable medical community at the time of treatment; (iii) Provider's clinical capabilities, expertise and resources regarding the medical condition and standard of care under review; and (iv) the clinical capabilities, expertise and resources of another Provider under consideration to assume the care of such Member.

2.6 Eligibility Verification. Provider shall obtain from Plan verification of the eligibility of all Members who receive Covered Services pursuant to this Agreement. If eligibility verification is not possible prior to the provision of Covered Services, Provider shall request such verification at the earliest possible opportunity thereafter, prior to billing Plan; provided, however, that Provider shall not be required to obtain Plan's approval prior to rendering Emergency Services to Members. Plan agrees to provide access to eligibility verification twenty-four (24) hours per day, seven (7) days per week. If Provider fails to verify eligibility which results in Provider rendering services to ineligible patients, Plan shall have no financial responsibility to reimburse Provider for any such services rendered to such ineligible patients.

2.7 Authorization Requirements. Provider agrees to comply with VHP's authorization procedures and shall obtain prior authorization from Plan for all Covered Services, as required herein and in the Provider Manual. Additionally, Provider agrees to obtain prior authorization from Plan before providing any item or service not included in the original referral. If prior approval for additional items or services is not obtained, payment for services will be denied. Plan's contacts for prior authorization are set forth in **Exhibit D** to this Agreement.

(a) Upon request, Provider must promptly provide Plan with all information and documentation to enable Plan to determine whether to authorize services. Provider agrees to comply with the prior authorization process as set forth in the Provider Manual, and as required by Plan's Utilization Management Department.

(b) Provider will provide a report to referring physician within three (3) working days, unless a significant finding warrants immediate reporting.

(c) Provider acknowledges that nothing in this contract should be constructed to prevent Provider from freely communicating with patients about treatment options, including medication treatment options, regardless of benefit coverage limitations.

2.8 Member Grievances. Provider shall cooperate with Plan in resolving Member grievances related to the provision of Covered Services in accordance with Plan's Grievance and Appeals Procedures. Provider agrees to make available to Members copies of Plan's Grievance and Appeals Procedures and shall notify Plan within forty-eight (48) hours of the time it becomes aware of any Member grievances. Provider shall investigate all

Member grievances within the time frames specified by Plan and use its best efforts to assist Plan in resolving grievances in a fair and equitable manner.

2.9 Credentialing; Quality Assessment/Improvement; Grievance

(a) Provider must submit an application to Plan in accordance with Plan's credentialing procedures and must provide Plan with any requested information, records, summaries of records and statistical reports specific to Provider including, but not limited to, utilization profiles pertinent to Provider's provision of medical services, professional qualifications, licensing and credentialing information. Provider will not be permitted to provide services to Plan members until they have been notified by Plan that their Credentialing Process is complete and has been approved. Provider will execute any releases requested by Plan to permit credentialing, re-credentialing, discipline, utilization management, and quality assessment and improvement determinations to be made with respect to Provider. Provider must provide such information for all location(s) and/or individual Provider(s) containing the information set forth in **Exhibit C** of this document, which is attached hereto and incorporated herein by reference. Provider will cooperate and assist with site visits required for regulatory, quality assessment or credentialing purposes.

(b) Provider agrees to be bound by and shall fully comply with all Applicable Requirements. Provider shall review the Provider Manual including Plan's Quality Management Programs prior to or promptly following the execution of this Agreement. Provider shall fully comply and cooperate with Plan's Provider Manual requirements including the Quality Management Programs and with any subsequent changes thereto.

(c) Prior to execution of this Agreement and thirty (30) days prior to implementing any change, Provider must provide Plan with the information described in **Exhibit C**, including a list of Providers licensed and/or credentialed employees, Provider sites, addresses and operating hours. Provider will maintain a current list of its Providers who are eligible to provide medical services hereunder. Provider shall provide an updated list specifying any changes of Providers to Plan monthly.

(d) The Parties acknowledge and agree that Plan or another contracting health plan committee that reviews the quality of medical services rendered to Members will act in the capacity of a "peer review committee" for purposes of applicable law. For purposes of this section, "quality of medical services" includes, without limitation, matters involving utilization management and compliance with requirements, rules or regulations relating to the delivery, cost, quality or appropriateness of medical care provided to Members. Except as otherwise provided by law, the immunities and protections provided to peer review committees under applicable provisions of the California Civil, Evidence and Health and Safety Codes will apply to any such committee when performing the function described herein.

(e) Provider acknowledges that Plan is accredited. Provider's performance under this Agreement must comply with applicable Plan and Accrediting Agency standards. Provider certifies that personnel who are to provide

services to Plan Members maintain appropriate skills, competency, and continuing education commensurate with their current job descriptions. Upon request, Provider will provide Plan with documentation evidencing that the aforementioned standards have been met. Further, Provider agrees to cooperate with and/or participate in any Accrediting Agency review or survey as requested by the Plan and/or Accrediting Agency.

(f) Under Plan's direction, Provider agrees to cooperate in the resolution of all Member medical disputes in accordance with the procedures of, and within the timeframes designated by Plan in its Provider Manual.

(g) Provider acknowledges that Plan has independent obligations with respect to quality management under the Knox-Keene Act. Plan shall be responsible for developing and operating a quality assurance and improvement program in connection with Covered Services.

(h) Provider shall fully comply with Plan's Quality Management Programs and with any changes thereto. Upon request, Provider agrees to furnish Plan with Provider's performance data for quality improvement activities including compiling and comparing the performance data for display to our Members in order for Plan to meet regulatory or accreditation requirements. Information requested must be readily available and requested within a reasonable time frame.

2.10 Reporting Requirements. Provider agrees to provide and timely submit to Plan all reports as may be required under this Agreement and/or by federal, state, and local standard regulations and accreditation bodies. Provider agrees to support and promote Plan's Quality Improvement Programs to sustain and/or improve quality of care, safety, efficiency, and continuity and coordination of services, including behavioral health services when applicable. Provider agrees to maintain a systematic process to continuously identify, measure, assess, monitor and improve the quality, safety, and efficiency of clinical care, and quality of service. Provider reports must reveal trends or patterns and identified opportunities for improvement that are based on current scientific knowledge, and evidence-based clinical practice guidelines recognized in the industry. Provider reports must be structured to produce statistically valid performance measures for care and services rendered. Provider shall exercise ongoing efforts supported by concrete data or evidence(s) to improve structural and organizational performance measures. Provider agrees to re-evaluate and determine the effectiveness of measures implemented based on significant statistical findings against organizational goals or benchmarks set. Provider agrees to establish collaborative partnerships with the Plan to implement interventions or service needs of the Plan's Members throughout the entire continuum of care to improve and achieve desired health outcomes. The Plan has the duty to conduct UM, QI, and fraud prevention detection activities in accordance with Plan policies, federal, state, and local regulations, unless Plan delegated those duties. Provider shall cooperate with Plan in the conduct and oversight of those functions and provide Plan with information as is reasonably necessary for Plan to perform its functions.

ARTICLE III

PLAN OBLIGATIONS

3.1 Plan Operations. Plan agrees to conduct the day-to-day administrative operations of a health care service plan for which it is responsible under state and federal law.

3.2 Compensation. Plan shall pay Provider for Contracted Services provided to Members as set forth in Article IV of this Agreement at the rates agreed to in **Exhibits A-1, A-2, A-3, A-4, A-5 and A-6,** Compensation Schedules, attached to and incorporated herein by this reference, less Co-payments, as applicable.

3.3 Quality and Utilization of Covered Services. Plan shall monitor the quality and utilization of Covered Services provided to Members in accordance with the policies and procedures of Plan's Quality Improvement Programs and Utilization Review Programs established by Plan. Plan shall monitor and evaluate accessibility of care and address problems that develop. Plan shall review, at least annually, Provider's compliance with standards established by Plan.

(a) Quality Reviews. The Parties acknowledge and agree that Plan reviews the quality of medical services rendered to Members and shall act in the capacity of a "peer review committee" for purposes of Applicable Requirements. For purposes of this section, "quality of medical services" includes, without limitation, matters involving utilization management and compliance with requirements, rules or regulations relating to the delivery, cost, quality or appropriateness of medical care provided to Members. Except as otherwise provided by law, the immunities and protections provided to peer review committees under applicable provisions of the California Civil, Evidence, and Health and Safety Codes will apply to any such committee when performing the function described herein.

(b) Quality Improvement Services.

i. Plan shall perform quality improvement services.

ii. Plan shall establish a Quality Improvement (QI) Plan and apply criteria and methodologies to review and measure the quality of professional, ancillary and inpatient professional services.

iii. Plan shall conduct, or require a designee to conduct, meetings at least quarterly, pursuant to a set agenda, to review and measure the quality of health care services provided or arranged by Provider or its subcontractors.

iv. Plan shall on a periodic basis, conduct clinical quality improvement evaluations of the care rendered to members, to comply with DMHC requirements, Applicable Requirements and/or Plan policies.

3.4 Provider Manual(s). VHP Provider Manual can be located at www.valleyhealthplan.org. Plan shall make available to Provider a Provider Manual(s) which shall include all administrative policies and procedures of Plan. Plan shall provide forty-five (45) business days' prior written notice to Provider of any amendments to the Provider Manual(s). Such amendments shall become effective upon expiration of the forty-five (45)

business day notice period unless Provider determines that such amendment adversely affects a material duty or responsibility of Provider and/or has detrimental economic effect upon Provider and Provider provides Plan with written notice of such determination within forty-five (45) business days of receiving notice of the applicable amendment from Plan. Plan and Provider shall attempt to agree to a written amendment to the Agreement which addresses the adverse effects of the amendment on Provider. If such an agreement cannot be reached by Provider and Plan, the amendment shall not be effective and shall have no force or effect on Provider and Provider shall have a right to terminate the Agreement in accordance with California Health and Safety Code Section 1375.7(b) prior to the implementation of the amendment.

ARTICLE IV

COMPENSATION

4.1 Billing. Provider shall submit Clean Claims to Plan for all Contracted Services rendered to a Member, within the timeframes established in **Exhibits A-1, A-2, A-3, A-4, A-5 and A-6,** attached to and incorporated herein by this reference.

4.2 Payment.

(a) Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth in **Exhibit A-1, A-2, A-3, A-4, A-5 and A-6** of this Agreement minus the Member's Co-payment. Plan will pay Provider for Covered Services rendered to Member within forty-five (45) business days of receipt of Provider's undisputed, Clean Claim. A Clean Claim must include the information required by of this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

(b) Provider will be responsible for the collection of Coordination of Benefit payments for Members, and Plan will pay in accordance with Article 5 of this Agreement.

(c) Balance Billing. Except for applicable Co-payment, Provider shall not invoice or balance bill Plan's Member for the difference between Provider's billed charges and the reimbursement paid by Plan for any Covered Service rendered.

4.3 Denying, Adjusting or Contesting a Claim and Reimbursement for the Overpayment of Clean Claims.

(a) Denying, Adjusting or Contesting a Clean Claim. For each claim that is either denied, adjusted or contested, Plan shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes as specified in §1300.71(g) and (h) of the Department of Managed Health Care ("DMHC") Regulations.

(b) Time for Contesting, Adjusting or Denying Claims. Plan may contest or deny a claim, or portion thereof, by notifying Provider in writing, that the claim is

contested or denied, within forty-five (45) working days after the date of receipt of the claim by Plan.

(c) Reimbursement for Overpayment of Clean Claim. If Plan determines it has overpaid a Clean Claim, it shall notify Provider in writing through a separate Notice clearly identifying the claim, the name of the patient, date of service and including a clear explanation of the basis upon which Plan believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

i. If Provider contests Plan's notice of reimbursement of the overpayment of a Clean Claim, Provider, within thirty (30) working days of the receipt of the notice of overpayment of a Clean Claim, shall send written Notice to Plan to state the basis upon which Provider believes that the Clean Claim was not overpaid. Plan shall receive and process the contested notice of overpayment of a Clean Claim as a dispute pursuant to this Agreement and applicable DMHC Regulations.

ii. If Provider does not contest Plan's notice of reimbursement of the overpayment of a Clean Claim, Provider shall reimburse Plan within thirty (30) working days of the receipt by Provider of the notice of overpayment of a Clean Claim.

iii. Plan may only offset an uncontested notice of reimbursement of the overpayment of a Clean Claim against Provider's current Clean Claim submission when: (i) Provider fails to reimburse Plan within the timeframe specified above; and (ii) this Agreement specifically authorizes Plan to offset an uncontested notice of overpayment of a Clean Claim from Provider's current Clean Claim submissions. If an overpayment of a Clean Claim(s) is offset against Provider's current Clean Claim(s) pursuant to this section, Plan shall provide a detailed written explanation to Provider, identifying the specific overpayment or overpayments that have been offset against the specific current Clean Claim(s).

4.4 Non-Covered Services. If Provider renders services to Members that are not Covered Services per the Member's EOC in effect at the time service is rendered, Provider may seek payment for such service(s) from the Member as allowed by law. Provider shall refrain from billing and/or collecting from a Member any charges in connection with services provided to the Member that are Non-Covered Services, unless Provider has first obtained a written acknowledgment of financial responsibility from the Member or the Member's legal representative. Such acknowledgement must be obtained in advance of rendering the Non-Covered Services.

ARTICLE V

COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

5.1 Coordination of Benefits. Certain claims for Contracted Services rendered to Members are claims for which another payor may be primarily or secondarily responsible

under Coordination of Benefit rules. For purposes of this Agreement, "Coordination of Benefits" or "COB" shall mean a method of sequentially assigning responsibility for the payment of Covered Services rendered to a Member among two (2) or more insurers or payors (e.g. Medicare). Plan and Provider shall cooperate to exchange information relating to Coordination of Benefits with regard to any Member for whom Provider has provided Contracted Services. In addition, Provider shall comply with the following requirements in such situations:

(a) Plan as Primary Payor. When Plan is the primary payor, Provider shall accept the amount set forth in this Agreement as payment in full for Contracted Services from Plan. However, Provider shall have the right to collect Co-payments and payments for Non-Covered Services from Members and shall have the right to pursue and retain COB revenue from any secondary payor.

(b) Plan as Secondary Payor. When Plan is the secondary payor, Provider shall promptly bill and take reasonable steps to collect payment from the primary payor. Plan shall pay Provider the difference between the amount collected from the primary payor and one hundred percent (100%) of the rates set forth in **Exhibit A-1, A-2, A-3, A-4, A-5 and A-6,** Compensation Schedules, of this Agreement.

5.2 Compliance with Law. Notwithstanding any other provisions of this Agreement to the contrary, Provider shall, in all instances, collect from a Member, or from those who are financially responsible for such Member, the entire amount of such Member's Co-payment obligation(s) that are required to be collected in accordance with applicable state and federal laws.

5.3 Collection of Charges from Third-Parties. If a Member is entitled to payment from a third-party, Plan shall have no objection to Provider engaging in collection of any claims or demands against such third parties for amounts due for Contracted Services, so long as Provider gives Plan prior written notice of its intent to pursue such collection.

5.4 COB Obligations of Plan. Plan shall provide COB information to Provider by supplying available data from the Member at the point of enrollment and supplying such data to Provider when available.

5.5 Assignment of Third-Party Liability Payments. If Provider collects any third-party liability payments for Contracted Services provided to a Member and has also previously received payments for such Contracted Services from Plan, Provider shall reimburse Plan the amount paid by Plan for said Member.

ARTICLE VI

COMPLIANCE WITH DMHC REGULATORY REQUIREMENTS

6.1 Records Maintenance. Provider shall, with respect to services provided under this Agreement, cooperate fully with Plan by, among other things, maintaining and making available to Plan and the Director of the DMHC, all records necessary: (i) to ensure

continuity and quality of care for Members; (ii) to fulfill Plan's obligations under the Knox-Keene Act and implementing regulations; and (iii) for Plan to verify Provider's compliance with any of the terms and conditions of this Agreement. Provider shall maintain medical records, including without limitation their confidentiality as required under federal HIPAA law, and the Confidentiality of Medical Information Act, California Civil Code Section 56 *et seq*., in a manner consistent with the requirements of Applicable Requirements. Provider shall not allow unauthorized persons to view confidential records and shall have safeguards to prevent unauthorized viewing of confidential files. Provider agrees to maintain all books and records in a form in accordance with the general standards applicable to such books and records at Provider's place of business or at such other mutually agreeable location in California. Provider agrees to maintain all books and records provided for in this Section 6.1 for ten (10) years, or as may be otherwise required under Applicable Requirements, or CMS requirements, and such obligation shall not terminate upon termination of this Agreement, whether by rescission or otherwise.

6.2 Access to Records; Inspection. Plan shall have access, at all reasonable times upon reasonable demand, to the books, records and papers of Provider, (including but not limited to patient medical records,) relating to Covered Services provided to Members under this Agreement, to the cost thereof and to payments received by Provider from Members. Provider agrees to permit the DHCS, DMHC, the California Department of Public Health, or their authorized representatives, to conduct a site evaluation of Provider facilities and/or to inspect, examine or copy, at all reasonable times, upon reasonable demand, all such books and records described in this Section 6.2. Provider agrees to cooperate with all regulatory and governmental agencies in all aspects of the inspection process.

6.3 Knox-Keene Act. Provider understands and acknowledges that Plan is subject to the provisions of the Knox-Keene Act (Chapter 2.2 of Division 2 of the Health and Safety Code) and implementing regulations (Chapter 1 of Division 1 of Title 28 of the California Code of Regulations) ("Regulations"). Any provision required to be in this Agreement by either of the above shall bind Plan whether or not provided in this Agreement. Provider shall comply with any and all Applicable Requirements imposed upon Plan and Provider under the Knox-Keene Act and Regulations.

6.4 No Surcharges. In no event, including but not limited to nonpayment by Provider or Plan, Provider's or Plan's insolvency or breach of this Agreement, shall any Member be liable for any sums owed to Provider by Plan, and Provider shall not bill, charge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any action or have any recourse against, or make any Surcharge upon, a Member or other person acting on a Member's behalf. This provision shall not prohibit collection of Co-payments or COB revenues from secondary carriers by which the Member is covered. In the event Plan receives notice that a Member has been surcharged by Provider, Plan shall notify Provider in writing within ten (10) working days of the receipt of said notice and Plan shall take appropriate action. In the event Plan and Provider mutually determine, in writing, that Member has been Surcharged by Provider, Plan may refund the Surcharge to the Member and deduct the amount of such Surcharge from compensation due Provider pursuant to this Agreement. In the event there is a dispute regarding whether Provider has Surcharged a Member, Provider and Plan agree to meet to discuss said dispute no later than ten (10) calendar days following the receipt of a written request by the

other party. Should the Parties fail to mutually resolve said dispute, said dispute shall be submitted by the Parties to dispute resolution as provided in Section 10 of this Agreement within ten (10) calendar days following the aforedescribed meeting of the Parties. The obligations set forth in this Section 6.4 shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of a Member, and the provisions of this Section 6.4 shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Member or persons acting on behalf of either of them.

6.5 Language Assistance Program. Plan shall maintain an ongoing language assistance program to ensure Limited English Proficient ("LEP") Members have appropriate access to language assistance while accessing any health care service, pursuant to California Health and Safety Code §§ 1367(e)(3), 1367.04 and 1367.07 and California Insurance Code §§ 10133.8 and 10133.9. Provider shall make best efforts to cooperate and comply, with Plan's Language Assistance Program, which is outlined in **Exhibit F.**

6.6 Further Amendments. Plan and Provider acknowledge that the DMHC may require that the parties further amend this Agreement to conform to the Knox-Keene Act. If the DMHC requires such further amendments, Plan shall notify Provider in writing of such amendments. Provider shall then have sixty (60) days from the date of Plan's notice to reject the proposed amendments by written notice to Plan. If Plan does not receive such written notice Plan has the option to terminate this Agreement upon sixty (60) days written notice.

6.7 Subcontractors. Without limiting any provision in the Agreement regarding assignment and delegation, Provider agrees to maintain and make available for inspection by Plan and the DMHC, written copies of all contracts between Provider and any of its subcontractors.

6.8 Filing a Complaint. Members of the Plan are entitled to the following information regarding the Department of Managed Health Care:

(a) "The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **408-885-4760 or 1-888-421-8444** (toll-free) and use your health plan's Grievance process before contacting the Department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet website

www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

6.9 Compliance.

(a) Provider certifies that none of its employees or agents providing service under this Agreement (hereafter "Practitioners") have been convicted of a criminal offense related to health care, nor are any listed by any federal or state agency as debarred, excluded or otherwise ineligible for participation in Medicare, Medi-Cal, or any other federal or state funded health care program. Provider certifies that it has performed an appropriate screening of Providers prior to making this certification, that it will screen all new Providers, and that it will monitor the status of existing Providers. Provider certifies that they and their Practitioners possess all licenses required and those said licenses are in good standing. Provider certifies that in providing these Contracted Services, they and their Practitioners are operating within any and all limitations or restrictions of these licenses. Provider further certifies that none of its directors, managing employees, and owners of five percent interest, or more, in Provider's business have been convicted of any health care related offenses nor excluded from Medicare, Medi-Cal, or any other federal or state funded health care program.

(b) Provider agrees to notify the Plan immediately should Provider or Practitioner be investigated, charged, or convicted of a health care related offense. During the pendency of any such proceedings, Provider or a Practitioner may, at the request of the Plan, be removed from any responsibility for, or involvement in, the provision of services under this Agreement. It is the Provider's obligation to keep the Plan fully informed about the status of such proceedings and to consult with the County prior to taking any action which will directly impact the County. This Agreement may be terminated immediately by Plan upon the actual exclusion, debarment, loss of licensure, or conviction of Provider or of a Provider of a health care offense.

(c) Provider will indemnify, defend, and hold harmless Plan for any loss or damage resulting from the conviction, debarment, or exclusion of Provider, or Practitioners, or subcontractors.

6.10 Directory Requirements. Provider agrees to comply with Health and Safety Code Section 1367.27 et seq. Provider agrees to coordinate with VHP to verify and maintain all directory requirements in compliance with HSC § 1367.27. Said requirements shall include; (1) participation in a bi-annual audit to verify the Provider contact information and participating Provider profile(s) information is accurately represented in the VHP Provider Directory, (2) provide an affirmative response to the Provider Directory audit confirming the information represented is current and accurate, and (3) if information is inaccurate, provide VHP with current and accurate information. The Provider Directory audit process shall include a Provider notification informing Providers they have thirty (30) business days to provide VHP with their affirmative response. If a response is not received within 30 business days, VHP shall issue a final notice providing an additional ten (10) business days to receive Providers affirmative response. Provider acknowledges that non-responsive Providers are removed from the VHP Provider Directory until the directory

information is confirmed. Additionally, Provider agrees to timely notify VHP when either of the following occurs:

(a) Provider agrees to inform the Plan within five (5) business days when the Provider is not accepting new patients.

(b) Provider agrees to inform the Plan within five (5) business days when the Provider changes from not accepting new patients to accepting new patients.

ARTICLE VII

MEDICAL RECORDS, HIPAA AND THE HITECH ACT

7.1 Medical Records. Provider shall maintain for Members a single standard medical record, containing such accurate, descriptive and timely information and preserved for such time period(s) as required by the rules and regulations of the California Department of Public Health, and The Joint Commission or any other comparable accreditation organization. Unless otherwise specifically agreed by Provider, it is the understanding and agreement of the parties that the records described herein are deemed to meet all record keeping requirements required of Plan pursuant to Applicable Requirements.

7.2 Member Access to Medical Records. Provider shall ensure that Members have access to their medical records in accordance with the Applicable Requirements of state and federal laws and regulations.

7.3 Right to Inspect Medical Records. The medical records described in Section 7.1 above shall be and remain the property of Provider and shall not be removed or transferred from Provider except in accordance with Applicable Requirements and general Provider policies. Plan, regulatory agencies with jurisdiction over Plan's business, and their designated representatives shall have the right to inspect, review, and make copies of such records upon request to facilitate Plan's obligation to conduct quality improvement, utilization monitoring, and peer review activities as required by the Provider Manual and Applicable Requirements.

7.4 Confidentiality. Provider and Plan agree to maintain the confidentiality of information contained in the medical records of Members in accordance with Applicable Requirements. Medical records may be disseminated to authorized Plan Physicians or Plan representatives or Review Committees, to Plan itself, or to an appropriate Plan peer review, Quality Improvement or Utilization Management Committee or subcommittee identified by Plan, or as otherwise required by law. Provider shall require that all Providers to comply with Applicable Requirements regarding confidentiality and disclosure of mental health records, medical records and other health and Member information.

(a) Provider acknowledges and agrees that all information received from Plan in connection with patients referred to Provider by Plan under this Agreement, including, without limitation, the compensation provisions, Member lists, marketing materials, Quality Management Programs, Provider Manual, telephone numbers, manuals, records, policies and agreements, are proprietary information and trade secrets of Plan. Provider and the officers, employees and agents of Provider will

keep such information confidential, except to the extent that confidentiality may not be maintained as to any such information under Applicable Requirements. Provider will obtain written consent of Plan prior to dissemination of any marketing materials or materials promoting health and wellness activities or other information that refers to Plan.

7.5 Plan and Governmental Agency Access to Records. Provider shall cooperate and assist with Plan, agencies of the state and federal government and their designees in maintaining and providing medical, financial, administrative and other records of Members as shall be requested by Plan, or such agencies. Plan and such agencies shall have access at reasonable times upon demand to the books, records and papers of Provider and their Practitioners relating to services provided to Members, the quality, appropriateness, timeliness, cost thereof, and any payments received by Provider or their Practitioners for Covered Services provided to Members.

7.6 Compliance with HIPAA and the HITECH Act. The parties hereto agree to comply with all applicable requirements of the Health Insurance Portability and Accountability Act of 1966 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), including, but not limited to, the HIPAA Privacy and Security Rules. The parties further agree, if required by HIPAA, or any other Applicable Requirements, to enter into a Business Associate Agreement which complies with the requirements set forth in 45 C.F.R. Sections 164.301, 164.312,164.316, 164.504(e)(2)(i)-(iii) and 42 U.S.C. Sections 17931 and 17935(a).

7.7 Electronic Protected Health Information.

(a) Safeguards. Provider shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information (as defined at 45 C.F.R. 160.103) that it creates, receives, maintains, or transmits on behalf of Plan as required by Subpart 'C' of Part 164 of Title 45 of the Code of Federal Regulations.

(b) Agent and Subcontractors. Provider shall require any agent, including a subcontractor to whom Provider provides Electronic Protected Health Information, to implement reasonable and appropriate safeguards to protect such Electronic Protected Health Information.

(c) Reporting of Unauthorized Use or Disclosure. Provider shall report to Plan any Security Incident (as defined at 45 C.F.R. 160.103) of which Provider becomes aware.

(d) Availability of Records upon Termination. The obligations contained in this Article XIII shall survive termination of this Agreement.

ARTICLE VIII

INSURANCE AND INDEMNITY

8.1 Insurance and Indemnity Requirements. Provider will comply with the insurance and indemnity requirements set forth in **Exhibit E**, which is attached to and incorporated herein by this reference. It is understood and agreed that County is self-insured pursuant to the authority granted in California Government Code section 990.4, and that such self-insurance satisfies Plan's and the County's obligations hereunder.

8.2 Insurance Terms.

(a) Each of the policies required by this Agreement shall provide that, prior to the cancellation, change or amendment thereof; the contracting party shall receive a minimum of thirty (30) days' prior written notice.

(b) If the malpractice insurance coverage provided is "claims made," and either party changes carriers or terminates coverage on or after termination of this Agreement, that party shall purchase a policy of "prior acts" or "tail" coverage for a minimum term of five (5) years from the termination of the policy in effect immediately prior to such tail policy. Such "tail" coverage shall have the same policy limits as the primary malpractice insurance coverage required under this Agreement.

(c) Either party shall provide the other with certificates evidencing such insurance coverages upon the execution of this Agreement or from time to time thereafter as may be requested.

ARTICLE IX

TERM AND TERMINATION

9.1 Term of Agreement. The term of this Agreement shall commence on the Effective Date and continue for a period of one (1) year ("Initial Term") and shall automatically renew thereafter for up to four (4) additional consecutive one-year terms, unless earlier terminated as provided herein. This Agreement shall supersede any Letters of Agreement and/or Payment Agreements that were executed by the Parties prior to the Effective Date of this Agreement. For services rendered on or after the Effective Date of this Agreement, this Agreement's terms shall control.

9.2 Termination without Cause. This agreement may be terminated by the Plan without cause by giving sixty (60) days prior written notice to Provider.

9.3 Termination of Agreement with Cause. Either Plan or Provider may terminate this Agreement for cause as set forth in this Section 9.3, subject to the notice requirement and cure period set forth herein.

(a) Cause for Termination of Agreement by Provider. The following shall constitute cause for termination of this Agreement by Provider:

i. **Failure to Maintain Insurance.** Plan fails to maintain adequate professional and general liability coverage required under this Agreement or to replace coverage that is cancelled or otherwise terminated;

ii. **Insolvency of Plan.** A petition is filed to declare Plan bankrupt or for reorganization under the bankruptcy laws of the United States or a receiver is appointed over all or any portion of Plan's assets, and the insolvency is not cured within thirty (30) days after said event;

iii. **Failure to Maintain Government Approvals.** Plan is unable to secure and maintain in effect any of the necessary governmental licenses required for the performance of its duties under this Agreement, including, but not limited to, its contract with CMS; and

iv. **Breach of Material Term and Failure to Cure.** Plan's breach of any material term, covenant or condition of this Agreement, and subsequent failure to cure such breach as prescribed in Section 9.3 (c).

(b) Cause for Termination of Agreement by Plan. The following shall constitute cause for termination of this Agreement by Plan:

i. **Failure to Maintain Insurance.** Provider fails to maintain adequate professional and general liability coverage required under this Agreement or to replace coverage that is cancelled or otherwise terminated;

ii. **Insolvency of Provider.** 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;

iii. **Failure to Provide Quality Services.** Provider's failure to provide Contracted Services in accordance with the standards set forth in this Agreement, the standards of The Joint Commission or any other comparable accreditation organization and Plan's Quality Improvement and Utilization Management Programs;

iv. **Breach of Material Term and Failure to Cure.** Provider's breach of any material term, covenant or condition of this Agreement, and subsequent failure to cure such breach as prescribed in Section 9.3 (c).

(c) Notice of Termination and Effective Date of Termination. The party asserting cause for termination of this Agreement (the "Terminating Party") shall provide written notice of termination to the other party. The notice of termination shall specify the breach or deficiency underlying the cause for termination. The party receiving the written notice of termination shall have thirty (30) calendar days from the receipt of such notice to cure the breach or deficiency to the satisfaction of the Terminating Party (the "Cure Period"). If such party fails to cure the breach or deficiency to the reasonable satisfaction of the Terminating Party within the Cure Period, or if the breach or deficiency is not curable, this Agreement shall terminate upon the expiration of the Cure Period. Satisfaction of a cure shall not be unreasonably withheld.

9.4 Termination of Provider. Notwithstanding anything to the contrary in this Agreement, Plan shall have the right to sanction Provider or terminate this Agreement upon

ten (10) days' prior written notice in the event that Plan, or any federal or State agency reasonably believes that Provider is providing inadequate quality of care and/or Provider fails to comply with Plan's statutory obligations under the Knox-Keene Act or regulations whether the Plan directly manages and/or delegates responsibilities consistent with the Knox-Keene Act or Medicare and Medi-Cal laws and regulations. During said ten (10) day period, Provider shall cease providing Covered Services to Members.

9.5 Continuing Care Obligations of Provider.

(a) General Obligations. In the event of termination of this Agreement for any cause or reason, Provider shall continue to provide Contracted Services to Members as required by law, including any Members who become eligible during the termination notice period, for a "Continuing Care Period", Plan shall pay Provider for Contracted Services provided by Provider during the Continuing Care Period at the rates set forth in **Exhibit A-1, A-2, A-3, A-4, A-5 and A-6,** Compensation Schedules, attached hereto.

(b) Obligations if Plan Ceases Operating or Agreement is terminated for Nonpayment.

i. Notwithstanding any provisions of this Agreement to the contrary, Provider agrees that in the event Plan ceases operations for any reason, including insolvency, Provider shall continue to provide services as set forth in Section 9.5 (a) above and shall not bill, charge, collect or receive any form of payment from any Member for Covered Services provided by Provider after Plan ceases operations.

ii. In the event Plan ceases operations or Provider terminates this Agreement on the basis of Plan's failure to make timely payments in accordance with the terms of this Agreement, Provider shall continue to provide Services to those Enrollees who are under the care at the time Plan ceases operations or Provider terminates this Agreement until such Members are reassigned by Provider, as set forth in Section 9.5 (a) above and shall not bill, charge, collect or receive any form of payment from any Member for Covered Services.

(c) Survival of Provisions Following Termination. Provider agrees that the provisions of this Section 9.5 (c) and the obligations of Provider shall survive termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Members.

ARTICLE X

DISPUTE RESOLUTION

10.1 Member Grievances and Appeals. Provider shall review and process all complaints and grievances of Members through Grievance and Appeals Procedures established by Plan. Provider agrees to cooperate fully with Plan in the investigation and resolution of any such Member complaint.

10.2 Dispute Resolution. Controversies between Plan and Provider shall be resolved, to the extent possible, by informal meetings or discussions between appropriate representatives of the parties. Provider shall submit disputes to Plan in writing at the address set forth in the Provider Manual(s) and as set forth in this Agreement for resolution pursuant to Plan's dispute resolution procedures described in the Provider Manual(s) to the extent they are not in conflict with the terms and conditions contained herein this Agreement. In the event of any inconsistency between this Agreement and the Provider Manual(s), the terms and conditions of this Agreement shall prevail.

ARTICLE XI

GENERAL PROVISIONS

11.1 Compliance with Applicable Law. Provider and Plan shall comply with all Applicable Requirements, including any amendments or updates thereto. Any provision required to be in this Agreement according to the Applicable Requirements shall bind Plan and Provider whether or not specifically set forth in this Agreement.

11.2 Incorporation of Exhibits. Exhibits A-1, A-2, A-3, A-4, A-5, A-6, B (Reserved), C, D, E, F, G, and H are attached hereto and are hereby expressly incorporated herein by this reference.

11.3 Waiver. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof.

11.4 Assignment. This Agreement shall not be assigned, delegated, or transferred by either Party without the prior written consent of the other Party, except that Plan may assign the Agreement to a parent or affiliate of the Plan that assumes the Plan's obligations as a licensed health care service plan. If required by law, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the appropriate state or federal agencies.

11.5 Invalidity or Unenforceability. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other term or provision.

11.6 Amendment. Except as set forth below, this Agreement may be modified only upon the mutual written consent of both Parties. Notwithstanding the foregoing, if Plan is required to amend this Agreement to comply with any state or federal law, regulation or instruction from any regulatory agency having jurisdiction over Plan's activities, Plan shall provide at least forty-five (45) days' prior written notice to Provider of such amendment. If Provider fails to accept such amendment within thirty (30) Plan has the option to terminate the Agreement immediately.

11.7 Governing Law. This Agreement shall be governed in all respects by the laws of the State of California, and any applicable federal laws.

11.8 Interruption by Disasters. In the event the operations of Provider's facilities or any substantial portion thereof, are interrupted by war, fire, and other elements, insurrection, terrorism, riots, earthquakes, acts of God, or, without limiting the foregoing, any other cause beyond the control of Provider, the provisions of this Agreement (or such portions hereof as Provider is hereby rendered incapable of performing) may be suspended for the duration of such interruption. Such suspension shall be determined by the mutual written agreement of the Parties and shall include an identification of the necessary adjustments to any provision of this Agreement; provided, however, to the extent that services are provided by Provider, Plan shall compensate Provider for said services in accordance with Article IV herein. Should a substantial part of the services which Provider has agreed to provide hereunder be interrupted pursuant to such event(s) for a period in excess of thirty (30) days, Plan or Provider shall have the right to terminate this Agreement upon ten (10) days' prior written notice to the other party.

11.9 Headings. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

11.10 Solicitation of Plan Members, Subscribers or Subscriber Groups. Provider shall not engage in the practice of solicitation of Members, subscribers or subscriber groups without Plan's prior written consent. Solicitation shall mean conduct by an officer, agent, employee of Provider or their respective assignees or successors during the term of this Agreement or during the one (1) year immediately following the effective date of termination of this Agreement which may be reasonably interpreted as designed to persuade Members, subscribers or subscriber groups to disenroll from Plan or discontinue their relationship with Plan. Nothing in this Agreement shall be interpreted to discourage or prohibit Provider from discussing a Member's health care including, without limitation, communications regarding treatment options, alternative health plans or other coverage arrangements, unless such communications are for the primary purpose of securing financial gain.

11.11 Confidential and Proprietary Information. Both Parties agree to maintain confidential, (the "Confidential Information") as specified in the Section 11.11 and Section 11.12: (i) eligibility lists and any other information containing the names, addresses and telephone numbers of Members; (ii) the financial arrangements between either Party and any Provider; (iii) any other information compiled or created by either Party that is proprietary to either Party, and that either Party identifies as proprietary in writing. Neither Party shall disclose or use the Confidential Information for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement. Either Party may use the Confidential Information to the extent necessary to perform its duties under this Agreement or upon express prior written permission of the other Party upon the effective date of termination of this Agreement, each Party shall promptly return to the other Party the Confidential Information in its possession, upon the other Party's notice. Both Parties shall maintain the confidentiality of the rates and special terms of this Agreement that are unique to the other Party. The obligations contained in this Section 11.11 shall survive the termination of this Agreement.

11.12 California Public Records Act. The County is a public agency subject to the disclosure requirements of the California Public Records Act ("CPRA"). If Provider's proprietary information is contained in documents submitted to Plan, and Provider claims

that such information falls within one or more CPRA exemptions, Provider must clearly mark such information "CONFIDENTIAL AND PROPRIETARY," and identify the specific lines containing the information. In the event of a request for such information, the Plan will make best efforts to provide notice to Provider prior to such disclosure. If Provider contends that any documents are exempt from the CPRA and wishes to prevent disclosure, it is required to obtain a protective order, injunctive relief or other appropriate remedy from a court of law in Santa Clara County before the Plan's deadline for responding to the CPRA request. If Provider fails to obtain such remedy within Plan's deadline for responding to the CPRA request, Plan may disclose the requested information.

11.13 Notices. All notices, requests, demands and other communications hereunder shall be in writing (hereafter a "Notice"). A Notice shall be deemed given when delivered (i) delivered in person, or (ii) four (4) days after being mailed by certified or registered mail, postage prepaid, return receipt requested, or (iii) one (1) day after being sent by overnight courier such as Federal Express, to the Parties, their successors in interest or their assignees at the following addresses, or at such other addresses as the Parties may designate by written Notice in the manner aforesaid. In addition to the approved delivery methods, a copy of the Notice shall also be sent via secure email or electronic facsimile as follows:

Provider:	**Plan:**
Provider Contact Name, Title Provider_Contract_Name «Address» «City», «State» «Zip» Phone_# Email	Bruce Butler, Chief Executive Officer Valley Health Plan 2480 North First Street, Suite 160 San Jose, CA 95131 (408) 885-5780 And CC: Valley Health Plan Provider Contracts Administration 2480 North First Street, Suite 160 San Jose, CA 95131 ProviderContracts@vhp.sccgov.org Fax: (408) 954-1027

11.14 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 a Provider 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 Plan regarding coverage of treatment that has been recommended or rendered. Moreover, Provider and Plan agree not to penalize nor sanction any Provider 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.

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

11.16 Attorneys' Fees. Should either party institute any action or procedure to enforce this Agreement or any provision hereof, or for damages by reason of any alleged breach of this Agreement or of any provision hereof, or for a declaration of rights hereunder (including, without limitation, arbitration), each party shall pay its own costs and expenses, including, without limitation, its own attorneys' fees, incurred in connection with such action or proceeding.

11.17 No Third-Party Beneficiaries. This Agreement shall not create any rights in any third-parties who have not entered into this Agreement, nor shall this Agreement entitle any such third-party to enforce any rights or obligations that may be possessed by such third-party.

11.18 Integration of Entire Agreement. This Agreement contains all the terms and conditions agreed upon by the Parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement are null and void and of no further force or effect.

11.19 County No Smoking Policy. Provider and its employees, agents and subcontractors, shall comply with the County's No Smoking Policy, as set forth in the Board of Supervisors Policy Manual section 3.47 (as amended from time to time), which prohibits smoking: (i) at the Santa Clara Valley Medical Center campus and all County-owned and operated health facilities, (ii) within 30 feet surrounding County-owned buildings and leased buildings where the County is the sole occupant, and (iii) in all County vehicles.

11.20 Food and Beverage Standards. Except in the event of an emergency or medical necessity, the following nutritional standards shall apply to any foods and/or beverages purchased by Provider with County funds for County-sponsored meetings or events:

(a) If food is to be provided, healthier food options shall be offered. "Healthier food options" include (i) fruits, vegetables, whole grains, and low fat and low-calorie foods; (ii) minimally processed foods without added sugar and with low sodium; (iii) foods prepared using healthy cooking techniques; and (iv) foods with less than 0.5 grams of trans fat per serving. Whenever possible, Provider shall (i) offer seasonal and local produce; (ii) serve fruit instead of sugary, high calorie desserts; (iii) attempt to accommodate special, dietary and cultural needs; and (iv) post nutritional information and/or a list of ingredients for items served. If meals are to be provided, a vegetarian option shall be provided, and the Contractor should consider providing a vegan option. If pre-packaged snack foods are provided, the items shall contain: (i) no more than 35% of calories from fat, unless the snack food items consist solely of nuts or seeds; (ii) no more than 10% of calories from saturated fat; (iii) zero trans-fat; (iv) no more than 35% of total weight from sugar and

caloric sweeteners, except for fruits and vegetables with no added sweeteners or fats; and (v) no more than 360 mg of sodium per serving.

(b) If beverages are to be provided, beverages that meet the County's nutritional criteria are (i) water with no caloric sweeteners; (ii) unsweetened coffee or tea, provided that sugar and sugar substitutes may be provided as condiments; (iii) unsweetened, unflavored, reduced fat (either nonfat or 1% low fat) dairy milk; (iv) plant-derived milk (e.g., soy milk, rice milk, and almond milk) with no more than 130 calories per 8 ounce serving; (v) 100% fruit or vegetable juice (limited to a maximum of 8 ounces per container); and (vi) other low-calorie beverages (including tea and/or diet soda) that do not exceed 40 calories per 8 ounce serving. Sugar-sweetened beverages shall not be provided.

11.21 Assignment of Clayton Act, Cartwright Act Claims. Provider hereby assigns to the Plan all rights, title, and interest in and to all causes of action it may have under Section 4 of the Clayton Act (15 U.S.C. Sec. 15) or under the Cartwright Act (Chapter 2 (commencing with Section 16700) of Part 2 of Division 7 of the Business and Professions Code), arising from purchases of goods, materials, or services by the Provider for sale to the Plan pursuant to this Agreement.

11.22 Compliance with All Laws, Including Nondiscrimination, Equal Opportunity, and Wage Theft Prevention.

(a) Compliance with All Laws. Provider shall comply with all applicable Federal, State, and local laws, regulations, rules, and policies (collectively, "Laws"), including but not limited to the non-discrimination, equal opportunity, and wage and hour Laws referenced in the paragraphs below.

(b) Compliance with Non-Discrimination and Equal Opportunity Laws: Provider shall comply with all applicable Laws concerning nondiscrimination and equal opportunity in employment and contracting, including but not limited to the following: Santa Clara County's policies for Providers on nondiscrimination and equal opportunity; Title VII of the Civil Rights Act of 1964 as amended; Americans with Disabilities Act of 1990; the Age Discrimination in Employment Act of 1967; the Rehabilitation Act of 1973 (Sections 503 and 504); the Equal Pay Act of 1963; California Fair Employment and Housing Act (Gov. Code § 12900 et seq.); California Labor Code sections 1101, 1102, and 1197.5; and the Genetic Information Nondiscrimination Act of 2008. In addition to the foregoing, Provider shall not discriminate against any subcontractor, employee, or applicant for employment because of age, race, color, national origin, ancestry, religion, sex, gender identity, gender expression, sexual orientation, mental disability, physical disability, medical condition, political belief, organizational affiliation, or marital status in the recruitment, selection for training (including but not limited to apprenticeship), hiring, employment, assignment, promotion, layoff, rates of pay or other forms of compensation. Nor shall Provider discriminate in the provision of services provided under this contract because of age, race, color, national origin, ancestry, religion, sex, gender identity, gender expression, sexual orientation, mental disability, physical disability, medical condition, political beliefs, organizational affiliations, or marital status.

(c) Compliance with Wage and Hour Laws: Provider shall comply with all applicable wage and hour Laws, which may include but are not limited to, the Federal Fair Labor Standards Act, the California Labor Code, and, if applicable, any local minimum wage, prevailing wage, or living wage Laws.

(d) Definitions: For purposes of this Subsection 11.22, the following definitions shall apply. A "Final Judgment" shall mean a judgment, decision, determination, or order (i) which is issued by a court of law, an investigatory government agency authorized by law to enforce an applicable Law, an arbiter, or arbitration panel and (ii) for which all appeals have been exhausted or the time period to appeal has expired. For pay equity Laws, relevant investigatory government agencies include the federal Equal Employment Opportunity Commission, the California Division of Labor Standards Enforcement, and the California Department of Fair Employment and Housing. Violation of a pay equity Law shall mean unlawful discrimination in compensation on the basis of an individual's sex, gender, gender identity, gender expression, sexual orientation, race, color, ethnicity, or national origin under Title VII of the Civil Rights Act of 1964 as amended, the Equal Pay Act of 1963, California Fair Employment and Housing Act, or California Labor Code section 1197.5, as applicable. For wage and hour Laws, relevant investigatory government agencies include the federal Department of Labor, the California Division of Labor Standards Enforcement, and the City of San Jose's Office of Equality Assurance.

(e) Prior Judgments, Decisions or Orders against Provider: By signing this Agreement, Provider affirms that it has disclosed any final judgments that (i) were issued in the five (5) years prior to executing this Agreement by a court, an investigatory government agency, arbiter, or arbitration panel and (ii) found that Provider violated an applicable wage and hour law or pay equity law. Provider further affirms that it has satisfied and complied with – or has reached Agreement with the County regarding the manner in which it will satisfy – any such final judgments.

(f) Violations of Wage and Hour Laws or Pay Equity Laws during Term of Contract: If at any time during the term of this Agreement, Provider receives a Final Judgment rendered against it for violation of an applicable wage and hour Law or pay equity Law, then Provider shall promptly satisfy and comply with any such Final Judgment. Provider shall inform the Office of the County Executive-Office of Countywide Contracting Management (OCCM) of any relevant Final Judgment against it within 30 days of the Final Judgment becoming final or of learning of the Final Judgment, whichever is later. Provider shall also provide any documentary evidence of compliance with the Final Judgment within 5 days of satisfying the Final Judgment. Any notice required by this paragraph shall be addressed to the Office of the County Executive-OCCM at 70 W. Hedding Street, East Wing, 11th Floor, San José, CA 95110. Notice provisions in this paragraph are separate from any other notice provisions in this Agreement and, accordingly, only notice provided to the Office of the County Executive-OCCM satisfies the notice requirements in this paragraph.

(g) Access to Records Concerning Compliance with Pay Equity Laws: In addition to and notwithstanding any other provision of this Agreement concerning access to Provider's records, Provider shall permit the County and/or its authorized representatives to audit and review records related to compliance with applicable pay equity Laws. Upon the County's request, Provider shall provide the County with access to any and all facilities and records, including but not limited to financial and employee records that are related to the purpose of this Subsection 11.22, except where prohibited by federal or state laws, regulations or rules. County's access to such records and facilities shall be permitted at any time during Provider's normal business hours upon no less than 10 business days' advance notice.

(h) Pay Equity Notification: Provider shall (i) at least once in the first year of this Agreement and annually thereafter, provide each of its employees working in California and each person applying to Provider for a job in California (collectively, "Employees and Job Applicants") with an electronic or paper copy of all applicable pay equity Laws or (ii) throughout the term of this Agreement, continuously post an electronic copy of all applicable pay equity Laws in conspicuous places accessible to all of Provider's Employees and Job Applicants.

(i) Material Breach: Failure to comply with any part of this Subsection 11.22 shall constitute a material breach of this Agreement. In the event of such a breach, the County may, in its discretion, exercise any or all remedies available under this Agreement and at law. County may, among other things, take any or all of the following actions:

i. Suspend or terminate any or all parts of this Agreement.

ii. Withhold payment to Provider until full satisfaction of a Final Judgment concerning violation of an applicable wage and hour Law or pay equity Law.

iii. Offer Provider an opportunity to cure the breach.

(j) Subcontractors: Provider shall impose all of the requirements set forth in this Subsection 11.22 on any subcontractors permitted to perform work under this Agreement. This includes ensuring that any subcontractor receiving a Final Judgment for violation of an applicable Law promptly satisfies and complies with such Final Judgment.

11.23 Contracting Principles. All entities that contract with the County to provide services where the contract value is $100,000 or more per budget unit per fiscal year and/or as otherwise directed by the Board of Supervisors, shall be fiscally responsible entities and shall treat their employees fairly. To ensure compliance with these contracting principles, all Providers shall: (i) comply with all applicable federal, state and local rules, regulations and laws; (ii) maintain timekeeping and expense records, and make those records available upon request; (iii) provide to the County unaudited balance sheet and financial information; (iv) upon County's request, provide County reasonable access, through representatives of Provider, to facilities, timekeeping and expense records that are related to the purpose of the Agreement, except where prohibited by federal or state laws, regulations or rules.

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11.24 Electronic Signature. Unless otherwise prohibited by law or County policy, the parties agree that an electronic copy of a signed contract, or an electronically signed contract, has the same force and legal effect as a contract executed with an original ink signature. The term "electronic copy of a signed contract" refers to a transmission by facsimile, electronic mail, or other electronic means of a copy of an original signed contract in a portable document format. The term "electronically signed contract" means a contract that is executed by applying an electronic signature using technology approved by the County.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed by their duly authorized representatives effective as the Effective Date.

Provider_Contract_Name

Signing_Authority's_Name Date
Title

«TaxId»

TAX ID #

Billing NPI #

NPI #

County of Santa Clara dba **Valley Health Plan**

Bruce Butler Date
Chief Executive Officer, Valley Health Plan

Approved By:

Jeffrey V. Smith, MD, JD Date
County Executive

Approved as to form and legality:

Jennifer S. Sprinkles Date
Deputy County Counsel

Exhibits incorporated into Agreements:

Exhibit A-1	Compensation Schedule – Employer Group-Classic
Exhibit A-2	Compensation Schedule – Employer Group-Preferred
Exhibit A-3	Compensation Schedule – Covered California and Individual & Family Plan
Exhibit A-4	Compensation Schedule – Medi-Cal Managed Care
Exhibit A-5	Compensation Schedule – Healthy Kids
Exhibit A-6	Compensation Schedule – County Responsibility Patients
Exhibit B	*RESERVED*
Exhibit C	List of Individual Providers & Sites
Exhibit D	Contacts for Prior Authorization
Exhibit E	Insurance & Indemnity Requirements
Exhibit F	Language Assistance Program Requirements
Exhibit G	Timely Access Standards
Exhibit H	Covered CA Requirements

EXHIBIT A-1
COMPENSATION SCHEDULE
Line of Business: Commercial
Product: Employer Group-Classic

PROVIDER_CONTRACT_NAME

BILLING:

Provider shall submit Clean Claims in an electronic format approved by Plan within ninety (90) days of the date in which service was rendered. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s) as required by this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

Claims shall be submitted electronically to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

VHP's Trading Partner Number: HT007700-001
Customer Service Number: 877-693-3071

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately to the address below:

VHP Commercial
P.O. Box 26160
San Jose, CA 95159

PAYMENT:

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Plan Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth below, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the Centers for Medicare and Medicaid Services (CMS), Medicare billing and reimbursement guidelines, including any applicable reductions and/or discounts, which may be amended by CMS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable and prevailing Medicare rate, less applicable reductions for the Region where services were provided, as of the date services were rendered.

Covered Services for which there are no CMS defined billing and reimbursement guidelines or for which Medicare has not established a rate and which are eligible for payment using industry standard coding and billing conventions shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

EXHIBIT A-2
COMPENSATION SCHEDULE
Line of Business: Commercial
Product: Employer Group-Preferred

PROVIDER_CONTRACT_NAME

BILLING:

Provider shall submit Clean Claims in an electronic format approved by Plan within ninety (90) days of the date in which service was rendered. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s) as required by this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

Claims shall be submitted electronically to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

VHP's Trading Partner Number: HT007700-001
Customer Service Number: 877-693-3071

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately to the address below:

VHP Commercial
P.O. Box 26160
San Jose, CA 95159

PAYMENT:

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Plan Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth below, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the Centers for Medicare and Medicaid Services (CMS), Medicare billing and reimbursement guidelines, including any applicable reductions and/or discounts, which may be amended by CMS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable and prevailing Medicare rate, less applicable reductions for the Region where services were provided, as of the date services were rendered.

Covered Services for which there are no CMS defined billing and reimbursement guidelines or for which Medicare has not established a rate and which are eligible for payment using industry standard coding and billing conventions shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

EXHIBIT A-3
COMPENSATION SCHEDULE
Line of Business: Commercial
Product: Covered California and Individual & Family Plan

PROVIDER_CONTRACT_NAME

BILLING:

Provider shall submit Clean Claims in an electronic format approved by Plan within ninety (90) days of the date in which service was rendered. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s) as required by this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

Claims shall be submitted electronically to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

VHP's Trading Partner Number: HT007700-001
Customer Service Number: 877-693-3071

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately to the address below:

VHP Covered California / IFP
P.O. Box 26160
San Jose, CA 95159

PAYMENT:

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Plan Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth below, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the Centers for Medicare and Medicaid Services (CMS), Medicare billing and reimbursement guidelines, including any applicable reductions and/or discounts, which may be amended by CMS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable and prevailing Medicare rate, less applicable reductions for the Region where services were provided, as of the date services were rendered.

Covered Services for which there are no CMS defined billing and reimbursement guidelines or for which Medicare has not established a rate and which are eligible for payment using industry standard coding and billing conventions shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

EXHIBIT A-4
COMPENSATION SCHEDULE
Line of Business: Government
Product: Medi-Cal Managed Care

PROVIDER_CONTRACT_NAME

BILLING

(a) Provider shall submit Clean Claims for all Contracted Services rendered to a Member, within six (6) months in which services were rendered, pursuant to this Agreement within the requirements set forth below:

(b) VHP Medi-Cal Managed Care: Original (or initial) Medi-Cal claims must be received within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit. Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delay reasons allowed by regulations. Claims that are not received within the six-month billing limit and do not meet any of the other delay reasons are subject to be reimbursed at a reduced rate or will be denied as follows, in compliance with *California Welfare and Institutions Code, Section 14115.*

- Claims received during the seventh through ninth month after the month of service will be reimbursed at 75 percent of the payable amount.
- Claims received during the tenth through twelfth month after the month of service will be reimbursed at 50 percent of the payable amount.
- Claims received after the twelfth month following the month of service will be denied.

(c) Claims Submission. Provider shall submit Clean Claims in an electronic format approved by Plan. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s).

- Electronic Clean Claims shall be submitted to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

  VHP's Trading Partner Number: HT007700-001
  Customer Service Number: 877-693-3071

Further information can be located within the VHP Provider Manual or by contacting the Plan's Provider Relations Department at 408-885-2221.

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately as follows:

VHP Medi-Cal Managed Care
P.O. Box 28407
San Jose, CA 95159

PAYMENT

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the following rates, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the California Department of Health Care Services (DHCS) Medi-Cal billing and

reimbursement guidelines, including any applicable reductions, which may be amended by DHCS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable Medi-Cal Fee Schedule, less applicable reductions in effect on the date services are rendered.

Covered Services for which there are no DHCS defined billing and reimbursement guidelines or for which Medi-Cal has not established a rate and which are eligible for payment utilizing industry standard coding and billing conventions, shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

EXHIBIT A-5
COMPENSATION SCHEDULE
Line of Business: Government
Product: Healthy Kids

PROVIDER_CONTRACT_NAME

BILLING

(a) Provider shall submit Clean Claims for all Contracted Services rendered to a Member, within six (6) months in which services were rendered, pursuant to this Agreement within the requirements set forth below:

(b) VHP Healthy Kids: Original (or initial) Healthy Kids claims must be received within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit. Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delay reasons allowed by regulations. Claims that are not received within the six-month billing limit and do not meet any of the other delay reasons are subject to be reimbursed at a reduced rate or will be denied as follows, in compliance with *California Welfare and Institutions Code, Section 14115.*

- Claims received during the seventh through ninth month after the month of service will be reimbursed at 75 percent of the payable amount.
- Claims received during the tenth through twelfth month after the month of service will be reimbursed at 50 percent of the payable amount.
- Claims received after the twelfth month following the month of service will be denied.

(c) Claims Submission. Provider shall submit Clean Claims in an electronic format approved by Plan. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s).

- Electronic Clean Claims shall be submitted to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

  VHP's Trading Partner Number: HT007700-001
  Customer Service Number: 877-693-3071

Further information can be located within the VHP Provider Manual or by contacting the Plan's Provider Relations Department at 408-885-2221.

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately as follows:

VHP Healthy Kids
P.O. Box 28410
San Jose, CA 95159

PAYMENT

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the following rates, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the California Department of Health Care Services (DHCS) Medi-Cal billing and

reimbursement guidelines, including any applicable reductions, which may be amended by DHCS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable Medi-Cal Fee Schedule, less applicable reductions in effect on the date services are rendered.

Covered Services for which there are no DHCS defined billing and reimbursement guidelines or for which Medi-Cal has not established a rate and which are eligible for payment utilizing industry standard coding and billing conventions, shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

EXHIBIT A-6
COMPENSATION SCHEDULE
Line of Business: Coverage Program
Product: County Responsibility Patients

PROVIDER_CONTRACT_NAME

BILLING:

Provider shall submit Clean Claims in an electronic or written format approved by Plan within ninety (90) days of the date in which service was rendered. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s) as required by this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

Approved written format claims shall be submitted appropriately to the address below:

Valley Health Plan
VMC / APD Claims
2480 N. First St., Suite 160
San Jose, CA 95131

PAYMENT:

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

County agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth below, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Authorized Covered Services shall be reimbursed at one hundred percent (100%) of the applicable and prevailing Medi-Cal Fee Schedule as of the date services were rendered.

Authorized Covered Services billed with a valid code for which Medi-Cal does not report a prevailing rate, will be reimbursed at twenty-five percent (25%) of billed charges.

EXHIBIT C
LIST OF INDIVIDUAL PROVIDERS & SITES

PROVIDER_CONTRACT_NAME

The following list includes the most current roster submitted by Provider as of the Agreement's Effective Date. Updates thereto shall be provided in accordance with Section 2.9 of this Agreement.

Name	Address	Phone No.	NPI # / Type	License Type	License No. & Expiration date

EXHIBIT D
CONTACTS FOR PRIOR AUTHORIZATION OF COVERED SERVICE

PROVIDER_CONTRACT_NAME

Valley Health Plan Customer Service Department

1-888-421-8444, select **option 4** for *VHP Customer Service Department*
Select **option 2** to check *Benefits*, Coverage*, Eligibility, & Authorization Status'.*

- Specify to representative the MEMBER's Plan ID#

**Questions for Medi-Cal and Healthy Kids Members, relating to benefits, coverage limitation/exclusions, and/or description of covered services will be redirected to SCFHP.*

Emergency Department to notify Plan immediately post stabilization by calling 855-254-8264

For further information regarding VHP's Authorization and Referrals Process, please reference the Provider Manual which can be located on the VHP Website at https://www.valleyhealthplan.org/sites/p/manual/Pages/home.aspx.

EXHIBIT E
INSURANCE & INDEMNITY REQUIREMENTS FOR
VHP MEDICAL PROVIDER

PROVIDER_CONTRACT_NAME

Indemnity

The Provider shall indemnify, defend, and hold harmless the County of Santa Clara (hereinafter "County"), its officers, agents and employees from any claim, liability, loss, injury or damage arising out of or in connection with, performance of this Agreement by Provider and/or its agents, employees or sub-Providers, excepting only loss, injury or damage caused by the sole negligence or willful misconduct of personnel employed by the County. It is the intent of the Parties to this Agreement to provide the broadest possible coverage For the County. The Provider shall reimburse the County for all costs, attorneys' fees, expenses and liabilities incurred with respect to any litigation in which the Provider is obligated to indemnify, defend and hold harmless the County under this Agreement.

Insurance

Without limiting the Provider's indemnification of the County, the Provider shall provide and maintain at its own expense, during the term of this Agreement, or as may be further required herein, the following insurance coverages and provisions:

A. Evidence of Coverage

Prior to commencement of this Agreement, the Provider shall provide a Certificate of Insurance certifying that coverage as required herein has been obtained. Individual endorsements executed by the insurance carrier shall accompany the certificate. In addition, a certified copy of the policy or policies shall be provided by the Provider upon request. The Certificate of Insurance shall list the certificate holder as follows:

County of Santa Clara
c/o EBIX RCS, Inc.
P.O. Box 257
Portland, MI USA 48875

This verification of coverage shall be sent to the requesting County department, unless otherwise directed. The Provider shall not receive a Notice to Proceed with the work under the Agreement until it has obtained all insurance required and such insurance has been approved by the County. This approval of insurance shall neither relieve nor decrease the liability of the Provider.

B. Qualifying Insurers

All coverages, except surety, shall be issued by companies which hold a current policy holder's alphabetic and financial size category rating of not less than A-V, according to the current Best's Key Rating Guide or a company of equal financial stability that is approved by the County's Insurance Manager.

C. Notice of Cancellation

All coverage as required herein shall not be canceled or changed so as to no longer meet the specified County insurance requirements without 30 days' prior written notice of such cancellation or change being delivered to the County of Santa Clara or their designated agent.

D. Insurance Required

1. ***Commercial General Liability Insurance*** - for bodily injury (including death) and property damage which provides limits as follows:

   a. Each occurrence - $1,000,000
   b. General aggregate - $2,000,000
   c. Personal Injury - $1,000,000

2. ***General liability coverage shall include:***

   a. Premises and Operations
   b. Personal Injury liability
   c. Severability of interest

3. **Workers' Compensation and Employer's Liability Insurance**

   a. Statutory California Workers' Compensation coverage including broad form all-states coverage.
   b. Employer's Liability coverage for not less than one million dollars ($1,000,000) per occurrence.

4. **Professional Errors and Omissions Liability Insurance**

   a. Coverage shall be in an amount of not less than one million dollars ($1,000,000) per occurrence/aggregate.
   b. If coverage contains a deductible or sell-retention, it shall not be greater than fifty thousand dollars ($50,000) per occurrence/event.
   c. Coverage as required herein shall be maintained for a minimum of two years following termination or completion of this Agreement.

5. **Claims Made Coverage**

If coverage is written on a claim made basis, the Certificate of Insurance shall dearly state so. In addition to coverage requirements above, such policy shall provide that:

a. Policy retroactive date coincides with or precedes the Provider's start of work (including subsequent policies purchased as renewals or replacements).

b. Policy allows fix reporting of circumstances or incidents that might give rise to future claims.

E. Special Provisions

The following provisions shall apply to this Agreement:

1. The foregoing requirements as to the types and limits of insurance coverage to be maintained by the Provider and any approval of said insurance by the County or its insurance consultant(s) are not intended to and shall not in any manner limit or qualify the liabilities and obligations otherwise assumed by the Provider pursuant to this Agreement, including but not limited to, the provisions concerning indemnification.

2. The County acknowledges that some insurance requirements contained in this Agreement may be fulfilled by self-insurance on the part of the Provider. However, this shall not in any way limit liabilities assumed by the Provider under this Agreement. Any self-insurance shall be approved in writing by the County upon satisfactory evidence of financial capacity. Provider's obligation hereunder may be satisfied in whole or in part by adequately funded self-insurance programs or self-insurance retentions.

3. Should any of the work under this Agreement be sublet, the Provider shall require each of its subcontractors of any tier to carry the aforementioned coverages, or Provider may insure subcontractors under its own policies.

4. The County reserves the right to withhold payments to the Provider in the event of material noncompliance with the insurance requirements outlined above.

Acknowledgement of Insurance Requirements

I, ***Signing Authority's Name***, on behalf of ***Provider Contract Name*** have read and understand the terms and conditions of the Insurance Requirements under this Agreement. I understand that all Insurance certificates MUST be in effect, prior to the services rendered. I understand that if ***Provider Contract Name*** is not compliant with these insurance requirements, ***Provider Contract Name*** will not be compensated for services rendered until insurance certification is obtained that meets the requirements set forth in this agreement. In addition, if ***Provider Contract Name*** fails to obtain the required insurance certification in a timely manner, this agreement may be terminated.

_____

Signature Date

EXHIBIT F
LANGUAGE ASSISTANCE PROGRAM REQUIREMENTS

PROVIDER_CONTRACT_NAME

Without limiting any of other obligations of the Parties under this Agreement, the Parties shall comply with such regulatory requirements of the Health Care Language Assistance Act, pursuant to Health and Safety Code Section 1367.04 et seq. and California Code of Regulations ("CCR") 28 CCR 1300.67.04 et seq., key provisions of which are summarized in this exhibit. To the extent that the provisions in this exhibit are inconsistent with provisions in the Agreement, the terms in this exhibit shall prevail as to the obligations of the Parties under the Health Care Language Assistance Act ("Act").

Plan Responsibilities:

- Plan shall provide a copy of the Plan's Language Assistance Program requirements and all written policies and procedures regarding the Language Assistance Program and the Act.
- Plan shall ensure that the threshold language needs of Plan Members are identified and made available to Provider. Provide list of covered languages and update list as necessary.
- Plan shall generate and periodically update a list of vital documents that Provider shall translate in threshold languages. Vital documents are those documents that contain information that is critical for accessing medical services and/or benefits and are identified in the Plan's operating guidelines and provided to Provider.
- Plan will monitor and audit Provider regarding compliance with language assistance requirements.

Provider Responsibilities:

- Provider agrees to provide or arrange for the provision of qualified interpretation services to Limited English Proficiency (LEP) Members, in threshold languages, at no cost to the Member. Provider shall comply with Plan's Language Assistance Program requirements, policies and procedures so long as they conform to Provider's own Language Assistance Policies and applicable law.
- Provider agrees to provide or arrange for the translation of vital documents in threshold languages.
- Provider will document in the medical record if patient authorizes use of family member as an interpreter.

EXHIBIT G
TIMELY ACCESS STANDARDS

PROVIDER_CONTRACT_NAME

I. Appointments

a. To ensure members have timely access to care, Provider shall follow the following standards set by DMHC and Accrediting Agency.

SERVICE	ACCESS TIME FRAME
Urgent Care Appointment PCP and Specialists • Services not requiring a prior Authorization • Services requiring a prior Authorization	• Within 48 hours of request for appointment • Within 96 hours of request for appointment
Non-urgent Appointment For the diagnosis or treatment of injury, illness, or other health condition. PCP and All Mental Health Providers Specialist and Ancillary Services	Within 10 business days of request for appointment Within 15 business days of request for appointment
Preventative Care Appointment All Practitioners • Periodic follow-up • Standing referrals for chronic conditions • Pregnancy • Cardiac condition • Mental health conditions • Laboratory and radiology monitoring	May be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed healthcare Provider acting within the scope of his/her practice.
Telephone Triage or Screening All Practitioners	• Triage or screening waiting time does not exceed 30 minutes. • Triage or screening must be available to Enrollees 24 hours per day, 7 days a week.

b. When it is necessary for a Practitioner or Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs and ensures continuity of care consistent with professionally recognized standards of practice.

c. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care Provider, or the health care professional

providing triage or screening-services, as applicable, acting within the scope of his or her practice and, consistent with professionally recognized standards of practice; has determined and noted in the relevant records that a longer waiting time will not have a detrimental impact on the health of Member. (1300.67.2.2 (c)(5)(G))

II. During and After Business Hours Services

Provider shall employ an answering service or a telephone answering machine during and after business hours, which provide instructions regarding how Members may obtain urgent or emergent care including, when applicable, how to contact another Practitioner who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care, and length of wait time for a return call from the Practitioner. (1300.67.2.2 (c)(8)(B)(1))

III. Timely Access Reporting

Provider shall work with Plan's Quality Management to develop a process for tracking and reporting timely access compliance. Provider shall provide a report of their findings to Plan on a quarterly basis if required.

EXHIBIT H
COVERED CALIFORNIA REQUIREMENTS

PROVIDER_CONTRACT_NAME

Provider shall comply with the following terms required by the QHP Contract. These provisions apply only to services provided to Covered California and Individual & Family Plan Members, collectively "Covered California Members".

1. **Compliance.**

   a. **Compliance Coordination**. Provider shall coordinate and cooperate with Plan to the extent necessary to promote compliance by Plan and Provider with the applicable terms of the QHP Contract.

   b. **Compliance with All Laws.** Provider shall comply with all applicable federal, state, and local laws, regulations, executive orders, ordinances and guidance, including without limitation, the Affordable Care Act and the California Affordable Care Act; the Americans with Disabilities Act, the Anti-Kickback Statute, the Public Contracts Anti-Kickback Act, the Stark Law, and the Knox-Keene Health Care Service Plan Act of 1975, as applicable.

2. **Independent Contractors**. The Parties acknowledge and agree that, as required by 45 C.F.R. § 155.200(e), in carrying out its responsibilities, Covered California is not operating on behalf of Plan or Provider. In the performance of this Agreement, Plan and Provider shall always be acting and performing as an independent contractor, and nothing in the Provider Agreement shall be construed or deemed to create a relationship of employer and employee or partner or joint venture or principal and agent between or among Plan and Provider. Neither Plan, Provider, or any agents, officers or employees of any of them are agents, officers, employees, partners or associates of Covered California.

3. **Disclosure of Financial Information**. Provider agrees that Plan may disclose information relating to contracted rates between the Plan and Provider that is treated as confidential information by the DMHC pursuant to Health and Safety Code § 1385.07(b). Provider shall cooperate with Plan in providing Covered California with financial information relating to Provider that is (i) provided by Provider or Plan to the DMHC or other regulatory bodies, and (ii) reasonable and customary financial information that is prepared by Provider, including, supporting information relating to Covered California Members as required by Covered California. Possible requests may include (but not be limited to), annual audited financial statements, and annual profit and loss statements.

4. **Network Disruption.**

   a. Plan and Provider shall implement policies and practices designed (i) to reduce the potential for disruptions in Plan's Provider network, and (ii) to minimize the amount of uncertainty, disruption, and inconvenience of Covered California Members in the execution of the transition of care as required under state laws, rules and regulations in connection with any such disruption. Plan and Provider will maintain adequate

records, reasonably satisfactory to Covered California, documenting its policies and its compliance with these requirements by Plan and Provider.

b. In the event termination of the Agreement requires a block transfer of Covered California Members from Provider to a new Provider, Provider shall cooperate with Plan and Covered California in planning for the orderly transfer of Covered California Members as necessary and as required under applicable laws, rules, and regulations including but not limited to those relating to continuation of care set forth at Health and Safety Code § 1373.95.

c. Provider shall notify Plan with respect to any material changes in its Provider network as of and throughout the term of this Agreement. For purposes of this Agreement, a material change in the disclosures shall relate to an event or other information that may reasonably impact Provider's ability to perform under this Agreement.

5. Member Out-of-Network and Other Costs; Hold Harmless.

a. Plan shall and shall require Providers to, comply with applicable laws, rules and regulations governing liability of Members for Covered Services provided to Members, including, those relating to holding a Member harmless from liability in the event Plan fails to pay an amount owing by Plan to a Provider as required by federal and state laws, rules and regulations.

b. To the extent that Plan (i) provide coverage for out-of-network services and/or (ii) impose additional fees for such services, Plan shall disclose to the Member the amount it will pay for covered proposed non-emergent out-of-network services when requested by the Member.

c. Plan shall require its Providers to inform every Member in a manner that allows the Member the opportunity to act upon that Provider's proposal or recommendation regarding (i) the use of a non-network Provider or facility or (ii) the referral of a Member to a non-network Provider or facility for proposed non-emergent Covered Services. Plan shall require Providers to disclose to the Member who is proposing or considering using out-of-network non-emergent services if a non-network Provider or facility will be used as part of the network Provider's plan of care. Plan's obligation for this provision can be met through an update to their Provider's contract manual that is effective as of January 1, 2014. Providers may rely on Plan's Provider directory as updated from time to time in fulfilling their obligation under this provision.

6. Nondiscrimination.

a. In accordance with the Affordable Care Act § 1557 (42 U.S.C. 18116), Provider shall require as well as its agents and employees to refrain from causing an individual to be excluded from participation in, or to be denied the benefits of, or to be subjected to discrimination under, any health program or activity offered through Covered California on grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), § 504 of

the Rehabilitation Act of 1973 (29 U.S.C. 794), or any other applicable state and federal laws.

b. Provider shall, as well as its agents, employees and sub-contractors to refrain from unlawful discrimination or harassment or from allowing harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (40 or over), marital status, genetic information, sexual orientation, gender identity or use of family and medical care leave. Participating Provider Group (PPG) shall and shall require its Sub-Subcontractors as well as their agents and employees to evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. PPG shall and shall require its Sub-Subcontractors as well as their agents and employees to comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et seq.) and the applicable regulations promulgated thereunder (2 CCR 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in CCR Chapter 5 of Division 4 of Title 2, including, 2, CCR Section 8103, et seq., are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider shall give written notice of its obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

7. **Conflict of Interest; Integrity.**

a. Provider shall be free from any conflicts of interest with respect to Covered Services provided under this Agreement. Provider represents that Provider and its personnel do not currently have and will not have throughout the term of the Agreement, any direct or interest which may present a conflict in any manner with the performance of Covered Services required under this Agreement. Provider also represents that it is not aware of any conflicts of interest of any Sub-Subcontractors or any basis for potential violations of Provider with respect to laws, rules and regulations that govern referrals required for the provision of certain Covered Services to Covered California Members, including, federal and state anti-kickback and anti-self-referral laws, rules and regulations. Provider shall immediately (i) identify any conflict of interest that is identified during the term of the Agreement and (ii) take any necessary action to assure that any activities are not properly influenced by a conflict of interest.

b. Provider shall comply with all applicable policies adopted by Covered California regarding conflicts of interest and ethical standards.

8. **Customer Service.** Provider shall meet all state requirements for language assistance services that are applicable to Plan's Commercial HMO line of business.

9. **Credentialing.** Plan shall perform, or may delegate activities related to, credentialing and re-credentialing in accordance with this Agreement. Plan agrees to maintain quality accreditation as outlined in this Agreement.

10. Other Laws. Provider shall comply with applicable laws, rules and regulations, including the following:

a. Americans with Disabilities Act. Provider shall comply with the Americans With Disabilities Act (ADA) of 1990, (42 U.S.C. 12101, et seq.), which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA, unless specifically exempted.

b. Drug-Free Workplace. Provider shall comply with the requirements of the Drug-Free Workplace Act of 1990 (Government Code Section 8350, et seq.).

c. Child Support Compliance Act. Provider shall fully comply with all applicable state and federal laws relating to child and family support enforcement, including, but not limited to, disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of Part 5 of Division 9 of the Family Code.

d. Domestic Partners. Provider shall fully comply with Public Contract Code Section 10295.3 with regard to benefits for domestic partners.

e. Environmental. Provider shall comply with environmental laws, rules and Regulations applicable to its operations, including, those relating to certifies compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30, commencing with Section 42460 of the Public Resources Code, relating to hazardous and solid waste.

f. Other Laws. Provider shall comply with all other state and federal laws, rules and regulations applicable to this Agreement and Provider's provision of Covered Services under this Agreement.

11. Continuity of Care, coordination and cooperation upon termination of Agreement and transition of Members.

a. Upon the termination of the Agreement, Provider shall fully cooperate with Plan or Covered California (the "Exchange") in order to affect an orderly transition of Members to another Provider or Certified QHP as directed by the Exchange. This cooperation shall include, without limitation, (i) attending post-termination meetings, (ii) providing or arranging for the provision of Covered Services as may be deemed necessary by Providers to assure the appropriate continuity of care, and/or (iii) communicating with affected Members in cooperation with the Exchange and/or the succeeding Provider, each as shall be reasonably requested by Covered California.

b. In the event of the termination or expiration of the Agreement that requires the transfer of some or all Members into any other health plan, the terms of coverage under Plan's QHP Contract shall not be carried over to the replacement Qualified Health Plan (QHP) but rather the transferred Members shall be entitled only to the extent of coverage offered through the replacement QHP as of the effective date of transfer to the new QHP.

c. Notwithstanding the foregoing, the coverage of Member under Plan's QHP Contract may be extended to the extent that a Member qualifies for an extension of benefits including, those to affect the continuity of care required due to hospitalization or disability pursuant to Health and Safety Code section 1373.96 et. seq. as amended.

d. For purposes of this Agreement, "disability" means that the Member has been certified as being totally disabled by the Member's treating physician, and the certification is approved by Plan. Such certification must be submitted for approval within thirty (30) calendar days from the date coverage is terminated. Recertification of Member's disability status must be furnished by the treating Provider not less frequently than at sixty (60) calendar day intervals during the period that the extension of benefits is in effect. The extension of benefits shall be solely in connection with the condition causing total disability. This extension, which is contingent upon payment of the applicable premiums, shall be provided for the shortest of the following periods:

(i) Until total disability ceases;
(ii) For a maximum period of twelve (12) months after the date of termination, subject to plan maximums;
(iii) Until the Member's enrollment in a replacement plan; or
(iv) Recertification.