PROVIDER SERVICES AGREEMENT

This Provider Services Agreement (this "Agreement") is dated as of [MARCH 15, 2015] (the "Effective Date"), and is made by and between **College Health IPA**, a California medical professional corporation, with its principal office at 5665 Plaza Drive, Suite 400, Cypress, California 90630 ("CHIPA"), and County of Marin, a Mental Health Services Provider, with its principal office at 20 North San Pedro, Suite 2021 San Rafael, California 94903("Provider") (individually "Party" and collectively, "Parties"). The terms used herein are fully set forth in Exhibit B, section 1.0 entitled "Definitions."

RECITALS

WHEREAS, CHIPA contracts with a governmental entity, a health maintenance organization ("HMO"), or any other entity that arranges and provides Plans that operate Programs under which Members (as defined in Exhibit B) receive mental health services;

WHEREAS, CHIPA desires to engage Provider to provide such mental health or substance abuse services as a part of the Programs;

WHEREAS, Provider is qualified and willing to provide such services and wishes to become a recognized provider of mental health services for the Programs on the terms and conditions set forth in this Agreement and Exhibits A and B, which are incorporated by reference.

WHEREAS, Provider desires to participate as a provider in CHIPA's contracted provider network to enrollees of CHIPA's contracted Plans.

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

AGREEMENT

1. ENGAGEMENT.

   CHIPA engages Provider to provide, and Provider agrees to provide, the Services (as defined in Exhibit B) at the rates set forth on Exhibit A to Members in accordance with the terms and conditions of this Agreement.

2. NEW PLANS AND PROGRAMS.

   In the event that CHIPA contracts with a Plan with which CHIPA did not have a contract as of the Effective Date to provide one or more Programs to Members pursuant to this Agreement then (a) CHIPA shall provide Provider at least sixty (60) Days prior written notice that such Programs will be offered to Members under this Agreement, and (b) notwithstanding any agreement between Provider and any such Plan, the rates for Services provided to Members under any such Program shall be the rates set forth in Exhibit A.

3. DURATION.

This Agreement shall take effect as of the Effective Date and shall continue for the term set forth in Exhibit B. The Effective Date shall be the date set forth by CHIPA on the signature page of this Agreement.

4. EXHIBITS.

Except where expressly stated otherwise in this Agreement, references to an "Exhibit" mean an Exhibit to this Agreement.

With respect to Exhibit F, CHIPA shall provide Provider at least forty-five (45) Working Days written notice prior to making a modification to the Provider Manual. In the event Provider objects to such modification, CHIPA and Provider shall confer in good faith regarding the modification. In the event CHIPA and Provider cannot agree regarding the proposed modification within thirty (30) Days, CHIPA may terminate this Agreement on at least thirty (30) Days' notice.

The Exhibits listed and checked below are attached to, incorporated by reference, and made a part of this Agreement if the applicable box is checked:

Exhibit A – Services and Rates	☒
Exhibit B – Standard Terms and Conditions	☒
Exhibit E – California Specific Requirements	☒
Exhibit F – Partnership Health Plan – CHIPA Provider Manual	☒

[*Signature page follows.*]

IN WITNESS WHEREOF, CHIPA and Provider have executed this Agreement as an instrument under seal.

COLLEGE HEALTH IPA
5665 Plaza Drive, Ste. 400
Cypress, CA 90630

By: _____
Authorized Signatory

BJ Beck, MD
Typed or Printed Name

Chief Medical Officer
Title

_____
Signature Date

PROVIDER NAME:
Address:

By: _____
Authorized Signatory

_____
Typed or Printed Name

_____
Title

_____
Signature Date

Signatory Authority for Provider

This Agreement must be executed as follows:

- If Provider is a corporation, by one or more officers duly and properly authorized to bind the corporation in contract;
- If Provider is a general partnership, by one or more partners authorized to bind the partnership in contract under the partnership agreement;
- If Provider is a limited partnership, by one or more general partners authorized to bind the partnership in contract under the partnership agreement;
- If Provider is a trust, by one or more trustees authorized to bind the trust in contract under the trust instrument;
- If Provider is a governmental agency, by the individuals authorized by statute or ordinance to bind the agency in contract;
- If Provider is a sole proprietorship, by the sole proprietor; or
- If Provider is a limited liability company, by all the members or, with evidence of proper authorization, by an appropriately designated manager.

EXHIBIT A
SERVICES AND RATES

Medi-Cal Solano, Marin, and Napa Counties

CPT Code	Description				
	Diagnostic Evaluation	***MD***	***PhD/ PsyD***	***ARNP***	***LCSW/ LMFT***
90791	Diagnostic evaluation with no medical	$ 133.10	$ 133.10	$ 113.13	$ 99.82
90792	Diagnostic evaluation with medical	$ 105.74	-	$ 89.88	-
Medical Evaluation and Management (E/M)					
99205	New Patient, Evaluation and Management (60 min):	$180.66	-	$153.56	-
99212	Medication Management - 10 min	$40.38	-	$34.33	-
99213	Medication Management - 15 min	$65.98	-	$56.09	-
99214	Medication Management - 25 min	$96.46	-	$81.99	-
99215	Medication Management - 45 min	$128.34	-	$109.09	-
	Psychotherapy				
90832	Psychotherapy 30 (16-37) min	-	$ 54.72	-	$ 41.04
90834	Psychotherapy 45 (38-52) min	-	$ 68.86	-	$ 51.65
90837	Psychotherapy 60 (53+ min	-	$ 100.33	-	$ 75.25
90853	Group Therapy (per each member of the group)	-	$ 20.65	-	$ 15.49
Psychological and Neuropsychological Testing					
96101	Psychological testing		$ 71.06		
96111	Developmental Testing, extended		$ 103.50		
96116	Neurobehvioral status exam		$ 76.87		
96118	Neuropsychological testing (per hour of face-to-face time)		$ 80.23		

All claims must be submitted using the appropriate CPT code(s) for the service rendered.

For telemedicine services, use the applicable CPT code with the modifier GT.

EXHIBIT B
STANDARD TERMS AND CONDITIONS

1.0 **DEFINITIONS.**

For purposes of this Agreement, the following terms shall have the meanings indicated.

1.1 "Agreement" means the Provider Services Agreement to which this Exhibit B is attached and all of the Exhibits and other attachments to the Provider Services Agreement as such Exhibits and attachments may be amended from time to time.

1.2 "CHIPA" has the meaning set forth in the recitals.

1.3 "Books and Records" has the meaning set forth in Section 8.1.

1.4 "Clean Claim" means a claim for Services rendered by Provider which accurately contains all data elements required by CHIPA, a Plan, or other Payor as specified in the Provider Manual, and all data elements required by federal Medicare provider manuals and/or program transmittals (if applicable) or applicable California law, timely submitted by Provider, for Services rendered to a Member, within the time frame specified in Section 4.2 or by California law.

1.5 "CMS" means Centers for Medicare & Medicaid Services, the federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs under Titles XVIII and XIX of the Social Security Act.

1.6 "Copayment" means the amount specified by the Plan to be paid by a Member for Services and includes applicable copayments, coinsurance, and deductibles. The Copayment amount is specified on the Member's insurance card or may be obtained by contacting the applicable Plan's member services department.

1.7 "Days" means calendar Days unless otherwise specified. Days shall be counted by excluding the first day and including the last day, provided that when the last day falls on a Saturday, Sunday, or federal or legal holiday, the last day shall be the next day which is not a Saturday, Sunday, or legal holiday.

1.8 "Effective Date" shall be the date set forth by CHIPA on the signature page of this Agreement.

1.9 "Emergency Medical Condition" means (a) a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (i) placing the health of a Member or another person (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily function, and/or (iii) serious dysfunction of any body organ or part; or (b) with respect to a pregnant woman who is having contractions, a situation where (i) there is inadequate time before delivery to effect a safe transfer to another hospital or (ii) transfer may post a threat to the health or safety of the woman or unborn child.

1.10 "HEDIS" means the Healthcare Effectiveness Data and Information Set quality measurement tool.

1.11 "HHS" means the United States Department of Health and Human Services.

1.12 "HIPAA" has the meaning set forth in Section 3.6.

1.13 "HITECH" has the meaning set forth in Section 3.6.

1.14 "Medical Necessity" or "Medically Necessary" means, in reference to a health care service, a service that, as determined by CHIPA or Payor, is:

(a) consistent with generally accepted principles of professional medical practice for mental or behavioral health conditions;

(b) consistent with the diagnosis and treatment of the Member's mental or behavioral health condition and is essential to improve the Member's health outcome through a positive effect on overall health;

(c) consistent with the level of skilled services that are provided and is furnished in the least intensive type of clinical setting required by the Member's condition;

(d) as cost effective as any established alternatives;

(e) not furnished solely for the convenience or religious preference of the Member or his/her family, caregiver or Provider;

(f)) based on scientific evidence, professional standards and expert opinion in improving health outcomes; and

(g) not experimental; or for services and interventions not in widespread use, is based on scientific evidence, in each case as determined by CHIPA.

1.15 "Member" means any individual who is eligible to receive Services from a Plan under a Program, including: (a) individuals and their dependents enrolled through group accounts, on an individual basis, or through a Plan's agreement with governmental agencies or (b) any member of a health plan or program with which a Plan or CHIPA has entered into a reciprocity or similar arrangement.

1.16 "NCQA" means the National Committee for Quality Assurance.

1.17 "Network Payor" has the meaning set forth in Section 4.9.

1.18 "Other Carrier" has the meaning set forth in Section 4.3.

1.19 "Payor" means CHIPA, a Plan, a Network Payor, or any other entity that retains financial responsibility for payment of claims for Services provided to Members under this Agreement.

1.20 "Plan" means a Medical health benefit plan offered by, a governmental entity, a health maintenance organization (HMO), or any other entity that arranges and provides a Medi-Cal benefits to individuals and with which CHIPA has entered into a contract.

1.21 "Policies" has the meaning set forth in Section 10.0.

1.22 "Professional Staff" means duly accredited or licensed, or otherwise qualified, professional mental health or substance abuse staff employed or contracted by Provider. Clinical interns and externs are not Professional Staff and are precluded from providing Services to Members under this Agreement. If Provider is identified as a sole proprietor in the Provider Application, the term Professional Staff shall mean and include Provider.

1.23 "Program" means a mental or behavioral services managed care program administered by CHIPA on behalf of a Plan for the provision of mental health services to Members.

1.24 "Provider" has the meaning set forth in the recitals.

1.25 "Provider Manual" means the applicable CHIPA or Payor Provider Manual issued by the applicable CHIPA entity or Payor with respect to the Programs, as revised from time to time by CHIPA or Payor. The provider manual is available at chipa.com under the provider tab.

1.26 "Qualified Facilities" means facilities suitably constructed, equipped and located, and to the extent required, duly licensed or accredited for provision of the Services.

1.27 "Services" means the Medically Necessary mental health and substance abuse services set forth on Exhibit A that are covered by the Programs and are provided in accordance with the applicable Provider Manual and other Policies. All other services shall be considered Non-Covered Services under this Agreement.

1.28 "Special Meeting" has the meaning set forth in Section 15.1.

1.29 "Subcontractor" has the meaning set forth in Section 16.0.

1.30 "Utilization Review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

1.31 "Working Days" shall mean Monday through Friday, excluding recognized federal holidays.

2.0 GENERAL OBLIGATIONS.

2.1 General. Provider shall provide Services to Members in accordance with the applicable Provider Manual and other Policies (including policies governing notice of non-coverage and referrals to other Participating Providers if applicable), the applicable Plan's policies and procedures (including policies governing notice of non-coverage or referrals to other Participating Providers if applicable), generally accepted and professionally recognized standards for medical, mental health and substance abuse practice, and applicable laws and regulations. Provider shall provide Services in a timely and efficient manner by Professional Staff in Qualified Facilities. Professional Staff must be credentialed in accordance with Section 3.8 before providing Services under this Agreement. Should Member require care not within Provider's scope of practice or specialization, Provider shall refer Member to Member's primary care physician or the Plan and shall assist Member in accessing the required care.

2.2 Member Access to Provider. Provider may limit acceptance of Members, who are not already patients of Provider, as patients only if the same limitations apply to all other potential new patients of Provider, with the exception of services delivered by Provider under its contracts for other government-funded or County-funded health services.

2.3 Prior Authorization for Psychological and Neuropsychological Testing. Provider shall obtain prior authorization for Services from CHIPA or Payor as applicable and required by the Provider Manual. Notwithstanding anything to the contrary in this Agreement or the Provider Manual, the prior authorization requirements are for testing services only and corresponding payment limitations in this Agreement the Provider Manual

2.4 Verification of Eligibility. Provider shall verify a Member's eligibility for Services as outlined in the Provider Manual prior to providing any Services to such Member. Such verification shall be used to determine the initial and continuing qualification of an individual to receive Services as a Member under this Agreement. If Provider discovers a discrepancy in Provider's records as to an individual's eligibility for Services as a Member, Provider shall notify the applicable Plan's member services department or CHIPA's member services department to resolve the discrepancy regarding the individual's eligibility.

2.5 Emergency Services. Notwithstanding Sections 2.3 and 2.4, as indicated in the Provider Manual, no prior authorization is required for the treatment of an Emergency Medical Condition.

2.6 Accuracy of Information. Provider represents and warrants that any information submitted to CHIPA or Payor as applicable describing Provider's credentials, programs and services, prior to or after the Effective Date, is, to the best of Provider's knowledge and belief, true, accurate and complete as of the Effective Date. Provider shall notify CHIPA and Payor, as applicable in the event of any significant change to Provider's program or services, including (a) a change in the address or telephone number of any service, linguistic capability, specialty or program; (b) discontinuation of any Service; (c) addition or departure of any Professional Staff; or (d) any denial, modification, reduction, restriction, suspension or termination (either voluntary or involuntary) of Physician's or any of its Professional Staff's privileges at any hospital or other facility; and (e) any (i) modification, restriction, suspension, relinquishment or revocation of Physician's authorization to prescribe or to administer controlled substances; (ii) imposition of sanctions against Physician under the Medicare program or any other governmental program; or (iii) other professional disciplinary action or criminal or professional liability action of any kind against Physician which is either initiated, in progress, or completed as of the Effective Date of this Agreement and at any time during the term of this Agreement. Provider shall provide such notice to CHIPA and Payor as applicable in writing, ninety (90) Days prior to a planned change or as soon as Provider becomes aware of an unplanned change.

2.7 Notice of Events. Provider shall promptly notify CHIPA in the event that Provider: (a) is no longer accepting new Members; (b) is available during limited hours or only in certain settings; (c) has any other restrictions on treating Members; or (d) is temporarily or permanently unable to meet CHIPA's standards for appointment access. For purposes of the preceding sentence, CHIPA's standards for appointment access require that (x) a routine appointment be offered within ten (10) Working Days after the request; (y) an urgent visit be offered within forty-eight (48) hours after the request; and (z) non-life-threatening emergency services be offered or arranged within six (6) hours of the request.

2.8 Organization of Provider. During the term of this Agreement, Provider shall maintain its Professional Staff, its administrative staff organization, and its Qualified Facilities in substantially the form described in the Provider Application provided to CHIPA and shall make reasonable attempts, to the extent possible, to provide written notice to CHIPA thirty (30) Days prior to the additional or termination of a Professional Staff or making any material change thereto.

2.9 Qualifications of Provider. Provider shall secure and maintain in full force and effect all licenses, permits, certifications and other approvals, which are required under federal, state or local law with respect to its provision of Services under this Agreement, including those licenses, permits, certificates and other approvals specified in the

Provider Application. Provider shall promptly notify CHIPA if any such license, permit, certificate, or other approval is denied, suspended, revoked, modified, not renewed, not extended or is otherwise terminated, or if any Professional Staff is deemed an excluded provider from any federal or state health care program, including the Medicare and Medicaid programs, and shall ensure that such Professional Staff does not provide Services to Members until such license, permit, certificate or other approval is reinstated. Provider shall also maintain in full force and effect any accreditation by The Joint Commission or by any other accreditation body specified in the Provider Application and shall promptly notify CHIPA if such accreditation is denied, suspended, revoked, not renewed, or not extended or otherwise terminated.

2.10 Excluded Parties. Provider shall determine whether its owners, directors, employees, individuals having controlling interest in Provider, Professional Staff and Subcontractors for which it is billing are excluded from participating in federal and state health care programs. Provider acknowledges that submitting claims for services ordered or provided by a provider or entity that has been excluded from federal or state health care programs constitutes fraud and further, that HHS, through the Office of Inspector General, maintains a List of Excluded Individuals/Entities. Provider agrees that it shall check the List of Excluded Individuals/Entities, or any successor thereto published and maintained by the federal government, at least monthly during the term of this Agreement for any of its owners, directors, individuals with controlling interest in Provider, employees and for any Professional Staff or Subcontractors for which it is billing under this Agreement. Provider shall notify CHIPA in the event that any of its owners, directors, individuals with controlling interest in Provider, employees or any employee, Professional Staff member or Subcontractor for which Provider is billing under this Agreement become excluded from a federal or state health care program and shall immediately cease any billing to CHIPA related to such excluded Party. Without limiting any other rights under this Agreement, CHIPA shall have the right to immediately terminate this Agreement in the event of such notice of exclusion by Provider.

2.11 Approval, Suspension or Termination of Professional Staff. CHIPA and the Plans will have the right to approve, suspend, or terminate any individual member of the Professional Staff selected by Provider from the provider network. Notwithstanding the foregoing, Provider shall retain the ultimate decision making, discretion, authority and control over Provider's employees.

2.12 On-Call Services. As required by the Provider Manual, Provider shall maintain a system of twenty-four (24) hour on-call Services for all Members under treatment by Provider. Upon the Effective Date, Provider shall provide CHIPA with written documentation of Provider's on-call services program.

2.13 Provider Directory. Provider authorizes CHIPA and each Plan to list the name, business address and area of practice of Provider and any Professional Staff employed or contracted by Provider in its provider directory.

2.14 California Law. For any Services governed by California law, the requirements contained in Exhibit E shall apply. In the event of any conflict between any provision of Exhibit E and any other provision in this Agreement, the provisions of Exhibit E shall govern if the Services in question are governed by California law. If the Services in question are not governed by California law, the terms and conditions of Exhibit E shall not govern in the event of a conflict.

3.0 QUALITY IMPROVEMENT.

3.1 General. Provider shall use best efforts to cooperate with and make such reasonable modifications to Provider's methods of service delivery as may be necessary to satisfy CHIPA's and Payor's quality management and improvement programs, quality assurance programs, medical management programs, utilization management

programs, credentialing programs, and other such programs to the extent such programs are consistent with state, federal or NCQA-mandated standards (as may from time to time be established by CHIPA or Payor and incorporated into the Provider Manual) to facilitate care under this Agreement. Without limiting the generality of the foregoing, Provider shall cooperate with all reasonable independent quality review and improvement organization activities required by CHIPA, any Plan, or CMS pertaining to the provision of Services to Members. Provider shall allow CHIPA, the Plans and their designees reasonable access to its facilities for the purpose of site review, case management and other quality management activities.

3.2 Professional Staff and Subcontractor Compliance. Without limiting the requirements in Section 16.0, Provider shall cause all Professional Staff and Subcontractors to agree to participate in and cooperate with the quality management and utilization management programs of CHIPA and the Plans, including: (a) the orientation program of operations and departmental functions, when necessary, (b) referral procedures set forth in the Provider Manual, and (c) the provision of data and access to medical records for CHIPA's and the Plan's quality management, HEDIS and NCQA studies.

3.3 Disclosure of Healthcare Integrity and Protection Data. Provider shall report in writing to CHIPA and Payor within thirty (30) Days of Provider's knowledge of any civil judgments and "other adjudicated actions or decisions" against Provider or any of its Professional Staff related to the delivery of any health care item or service (regardless of whether the civil judgment or other adjudicated action or decision is the subject of a pending appeal). In making its report to CHIPA or Payor under this Section, Provider shall include all information required to be reported as set forth in the Provider Manual attached hereto as Exhibit F.

"Other adjudicated actions or decisions," as used in this Section, means any action taken by a governmental entity or a health plan against a health care provider, supplier or practitioner based on acts or omissions that affect or could affect the delivery, provision or payment of a health care item or service. An action by a health plan taken following adequate notice and hearing requirement that meets the standards of due process set out in section 412(b) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. § 11112(b)) would qualify as a reportable adjudicated action or decision. The fact that the subject elects not to use the due process mechanism provided by the authority bringing the action is immaterial, as long as such a process is available to the subject before the adjudicated action or decision is made final.

3.4 Training. Provider shall provide its Professional Staff with ongoing training and supervision according to generally accepted medical, mental health and substance abuse practice and, to the extent such training and supervision is consistent with such practices, according to established credentialing or certification standards. Provider shall, upon request by CHIPA, provide reports to CHIPA as to such training and supervision activities. Submit to CHIPA an annual summary of trainings provided in the previous twelve (12) months, upon CHIPA's request.

3.5 Medical Charts and Records. Provider shall prepare and preserve current, detailed and organized medical charts and records, including complete daily progress notes for each Member receiving inpatient or diversionary treatment and notes of every clinical contact for each Member receiving outpatient treatment, as required by the terms of the Provider Manual, and by generally accepted medical practice or by law. In no event shall Provider dispose of medical charts and records for a Member prior to ten (10) years from the date of last service, or such period as may be required by applicable law, whichever is longer. In a manner consistent with applicable data privacy laws, Provider shall grant CHIPA access to such charts and records during normal business hours and shall, upon written request by CHIPA or a Plan, provide CHIPA or the Plan, as applicable, with copies of such charts and records. Provider shall make reasonable attempts to secure from Members written consent to release such records and

related patient information to CHIPA, and the Plan as applicable. CHIPA will reimburse Provider for the cost of copies, at a rate to be mutually determined by the Parties.

3.6 Privacy and Security Laws. Provider shall safeguard the privacy of any information that identifies a particular Member and comply with applicable provisions of the Provider Manual and other Policies, the Plans' policies and procedures (including, if applicable, the provisions in the Plan's Medicare contract), and all applicable privacy and security laws, including the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and any regulations promulgated thereunder. Without limiting the generality of the foregoing, Provider shall (a) safeguard the privacy of all Member medical records and other information that identifies (or could be used to identify) a particular Member; (b) ensure that Members' records are released only in accordance with applicable federal or state laws or pursuant to court orders or subpoenas; (c) maintain Members' records and information in an accurate and timely manner; (d) ensure timely access by Members to records and information that pertain to them; and (e) abide by all applicable federal and state laws regarding confidentiality and disclosure for mental health records, medical records, and other health information and Member information (including, where applicable, requirements established by the Medicare Advantage program, if applicable).

3.7 Complaint Resolution. Provider shall cooperate fully with CHIPA to resolve complaints from Members relating to Provider's services in accordance with CHIPA's grievance procedures. Upon a Member request, CHIPA shall distribute to such Member its grievance procedures.

3.8 Credentialing Activities. Provider shall comply with CHIPA's and Payor's credentialing activities in accordance with CHIPA's and Payor's Policies, the Provider Manual, NCQA standards, and state and federal law. Provider shall not bill CHIPA or any Payor for Services provided by Professional Staff that were not properly credentialed in accordance with this Section 3.8 at the time such Services were provided.

4.0 PAYMENTS.

4.1 Reimbursement. Payor shall reimburse Provider the lesser of billed charges or the applicable rates of payment specified in Exhibit A for Services provided to Members. Provider acknowledges and agrees that the rates of payment set forth in Exhibit A or billed charges, if less, will be its only compensation from Payor for Services provided under this Agreement. Payor shall have no obligation to pay for Services rendered (a) without prior authorization as and to the extent required under the Provider Manual (except that in the event a Member is unable to communicate due to the Member's condition, Provider may obtain subsequent authorization for Services within twenty-four (24) hours of Provider becoming aware that the patient is a Member)or (b) to a person who was not a Member as of the time Services were rendered. CHIPA will use commercially reasonable efforts to verify Member eligibility at the time authorizations are requested by Provider. If after CHIPA provides authorization it is determined that the Member was not eligible during the dates Services were provided, Payor will have no obligation to pay for such Services provided when the Member was ineligible. Payor shall not pay for Services furnished, directed or prescribed by any Professional Staff who has been excluded from providing Services to Members pursuant to Section 2.9. In accordance with applicable state law, CHIPA may collect as an offset against reimbursement due hereunder any overpayments or other incorrect payments made to Provider.

4.2 Global Rates. Provider shall not bill the Member, any state agency, or any other third party other than Payor for any Service covered by CHIPA or any balance after reimbursement by Payor, except that Provider may accept Copayments from Members and bill Other Carriers pursuant to Section 4.3. Provider shall reimburse the clinician for the professional component, as appropriate, out of the global rates that Provider receives from Payor, as set forth

on Exhibit A. CHIPA may from time to time authorize services not listed in Exhibit A and Payor shall reimburse Provider for such services as mutually agreed upon in advance by CHIPA and Provider. Provider shall give prior written notice to CHIPA of its intent to enter into any contract with a Member that requires payment of a fee, other than a Copayment, as a condition to receive Services.

4.3 Claim Submission. Provider shall submit Clean Claims for payment to Payor in accordance with the Provider Manual. Without limiting the generality of the foregoing, Provider shall submit Clean Claims for payment to Payor no later than one hundred and eighty (180) Days after the Services were rendered. Provider, on behalf of itself and any permitted assignees, waives any claims for payment for Services, which are not the subject of a Clean Claim submitted within such one hundred and eighty (180) Day period. Notwithstanding the foregoing, upon termination of this Agreement, Provider shall submit Clean Claims for all Services provided prior to termination within one hundred and eighty (180) Days for in-network providers and three hundred and sixty (360) Days for non-contracted facilities and Payor will have no obligation to pay Provider for claims submitted after such date. For purposes of this Section 4.2, a Clean Claim is considered to be "submitted" when it is received by Payor with all information required to be provided in accordance with the Provider Manual. For purposes of prompt pay rules only, the Provider deems CHIPA to be its agent for receipt of payment.

4.4 Other Carriers. In the event that a Member has coverage through a third party that is not under contract with CHIPA ("Other Carrier") and such Other Carrier is primarily responsible for payment of mental health and/or substance abuse services provided to such Member, Provider shall bill and seek to collect payment from such Other Carrier for Services provided to such Member before seeking payment from Payor. If such Other Carrier refuses to pay Provider's claim in full, Payor shall pay Provider the lesser of (a) the balance remaining after Provider has been paid by such Other Carrier (less the Member's Copayment), or (b) the applicable payment rate listed on Exhibit A, but in no event shall Payor be obligated to pay Provider any amount if the total received from such Other Carrier exceeds billed charges or the applicable payment rate specified on Exhibit A.

4.5 Non-Covered Services. Provider shall not provide Non-Covered Services to Members or seek to obtain payment from such Members for such Non-Covered Services; provided, however, that Provider may provide Non-Covered Services to a Member and request payment from such Member for such Non-Covered Services at a rate not in excess of the rate that Provider bills the general public as listed in Provider's schedule of charges if (a) such Member is enrolled in a Plan other than a Medicaid managed care plan and (b) Provider has obtained from such Member prior written acknowledgment that such services will be Non-Covered Services and Member will be held financially responsible. Provider shall submit to CHIPA any Member's written acknowledgment to accept responsibility for Non Covered Services provided by Provider.

4.6 Member Hold Harmless. In no event will Provider, any of its Professional Staff or any Subcontractor bill, charge, or collect a deposit from, seek compensation, remuneration, or reimbursement from; or have any recourse against a Member or any person acting on a Member's behalf except for Copayments or charges for Non-Covered Services in accordance with Section 4.5. Provider shall look solely to Payor (or to an Other Carrier pursuant to Section 4.3, as the case may be) for payment for Services.

Without limiting the generality of the foregoing, Provider shall not maintain any action at law or in equity against any Member to collect any sums that are owed by CHIPA, a Plan or any other Payor under this Agreement or owed by any Other Carrier, including in the event that Payor or the Other Carrier fails to pay Provider, becomes insolvent, or otherwise breaches the terms and conditions of this Agreement or any other undertaking to pay Provider. Members and persons acting on Members' behalf shall be third party beneficiaries of this Section 4.6. This Section 4.6 supersedes any oral or written contract or agreement now existing or hereafter entered into

between Provider and a Member or persons acting on behalf of a Member, insofar as such contract or agreement relates to liability for payment for continuation of Services provided under the terms and conditions of this Agreement.

4.7 CHIPA Hold Harmless. Provider shall not request payment for Services provided under this Agreement from any CHIPA, in the event that a court of competent jurisdiction adjudicates CHIPA to be bankrupt or insolvent; provided, however, that Provider may request payment for Services provided under this Agreement from a Plan that is Payor for such Services. In the event that Provider is not able to obtain payment from such a Plan, Provider may become a creditor of CHIPA in the aforementioned bankruptcy proceedings.

4.8 Copayment. Provider shall bill Members for, and collect from Members, Copayments relating to Services provided under this Agreement. For purposes of clarity, Provider's failure to collect Copayments in accordance with the Provider Manual will be considered a breach of this Agreement.

4.9 Network Leasing. CHIPA reserves the right to lease its provider network to health and welfare funds and other entities or Payors ("Network Payors") in accordance with applicable state law. CHIPA will provide Provider with ninety (90) Days prior notice of any such leasing arrangement. CHIPA reserves the right to develop policies and procedures for the implementation and operation of network leasing programs and will provide Provider with ninety (90) Days prior written notice of such policies and procedures. Provider may then enter into an agreement with Network Payor regarding Network Payor's policies and procedures. Provider will be able to accept payment directly from Network Payors, as applicable in accordance with the terms of this Agreement. CHIPA guarantees that all CHIPA obligations set forth in this Agreement shall be adhered to by the Network Payor. In the event CHIPA fails materially to meet this guarantee for a particular Network Payor, Provider may give CHIPA thirty (30) Days prior written notice to cure such failure, and if CHIPA does not cure such failure within such thirty (30) Day time period, Provider may, upon ninety (90) Days prior written notice to CHIPA cease participation in the network of providers leased to such Network Payor.

4.10 Amendments to Exhibit A. No amendment to Exhibit A will be valid unless in writing and signed by an authorized representative of the Parties.

5.0 SOLICITATION.

Nothing contained herein shall be construed as an arrangement or an agreement for solicitation of patients for Provider, nor shall CHIPA be required to advertise or promote Provider's services. CHIPA shall list all providers in the same manner in any published provider directories.

6.0 NON-EXCLUSIVITY.

Nothing herein shall be construed as limiting Provider's ability to enter into agreements with other organizations or CHIPA's ability to enter into agreements with other providers.

7.0 INDEMNIFICATION AND LIABILITY INSURANCE.

7.1 Provider Indemnification of CHIPA. Provider shall defend, hold harmless and indemnify CHIPA and its directors, officers, members, agents, contractors and employees from and against any claims, suits, liabilities, damages, judgments, costs and expenses, including reasonable attorney's fees, which may be imposed upon, or suffered or incurred by, any of them as a result of claims by third parties or by employees of Provider and which arise out of, derive from or pertain to any negligence, actual or alleged acts or omissions by, or on the part of, Provider or any of

its directors, officers, members, agents, contractors or employees in providing the Services or otherwise performing its obligations under this Agreement, including its obligations under Section 3.6. In the event that CHIPA claims rights to indemnity under this Section 7.1, CHIPA shall give fourteen (14) Days prior written notice to Provider, upon becoming aware of any claim that may be subject to such indemnity.

7.2 CHIPA Indemnification of Provider. CHIPA shall defend, hold harmless and indemnify Provider and its directors, officers, members, agents, contractors and employees from and against any claims, suits, liabilities, damages, judgments, costs and expenses, including reasonable attorney's fees and punitive damages, which may be imposed upon, or suffered or incurred by, any of them as a result of claims by third parties or by employees of CHIPA and which arise out of, derive from or pertain to any negligence, or actual or alleged acts or omissions by, or on the part of, CHIPA or any of its directors, officers, members, agents, contractors or employees in the performance of CHIPA's obligations to Provider under this Agreement. Notwithstanding the foregoing, CHIPA is not required to indemnify Provider for any claim or action brought against Provider based on Provider's professional decisions, actions or inactions. In the event that Provider claims rights to indemnity under this Section 7.2, Provider shall give fourteen (14) Days prior written notice to CHIPA, upon becoming aware of any claim that may be subject to such indemnity

7.3 Insurance. Except as otherwise required under CHIPA and Payor's credentialing standards or Provider Manual, Provider shall secure and maintain at its own expense (a) comprehensive general liability insurance having combined single limits of not less than $1,000,000 dollars if Provider is an individual and not less than $2,000,000 if Provider is an organization, and (b) professional liability insurance having limits of (i) not less than $1,000,000 per occurrence and $1,000,000 in the aggregate if Provider is an individual and (ii) not less than $1,000,000 per person per occurrence and $3,000,000 in the aggregate if Provider is an organization; or (c) other such insurance as approved by CHIPA. All such insurance shall be maintained during the entire period when Services are rendered hereunder, and any such insurance written on a so-called claims-made basis shall be maintained for an additional three (3) years following the date when Services are last rendered hereunder. All such insurance shall be maintained with companies duly qualified to conduct business in the State of California. Provider shall provide for at least ten (10) Days' advance notice to CHIPA in the event of any cancellation, non-renewal or decrease in coverage. CHIPA shall have ten (10) Days to submit to Provider its object to the selection of the insurance carrier at issue, following written notice to CHIPA. Provider shall upon CHIPA's written request provide CHIPA with copies of insurance policies satisfying the foregoing requirements or such certificates with respect thereto, as may be satisfactory to CHIPA. Provider shall notify CHIPA if Provider receives any claim or notice of intent to commence legal action alleging professional negligence against Provider with respect to treatment or non-treatment of any Enrollee, or if a final judgment is rendered against Provider in any such legal action.

If the Provider is deemed by the Department of Health and Human Services to be covered by the Federal Tort Claims Act, pursuant to 42 U.S.C. § 233, this meets the requirement of 7.3 of this agreement that the Provider has professional liability insurance.

8.0 RECORDKEEPING, AUDIT AND INSPECTION OF RECORDS.

8.1 Recordkeeping. Provider shall maintain any pertinent contracts, books, documents, papers and records, including medical records (collectively, "Books and Records") pertaining to Provider's provision of Services and fulfillment of its obligations under this Agreement, including such Books and Records as may be necessary to properly substantiate claims for payment hereunder. Provider shall maintain its financial Books and Records in accordance with generally accepted accounting principles. All Books and Records shall be kept for a period of at least ten (10) years from the later of (a) the first day after final payment hereunder, (b) termination of the Plan's Medicare

Contract, if applicable, or (c) such longer time period as may be required by applicable state or federal requirements, including the Medicare Advantage regulations, if applicable; provided, however, that if any litigation, claim, negotiations, audit or other action involving such Books and Records is commenced prior to the expiration of such retention period, all Books and Records shall be retained at least until completion of such action and resolution of all issues resulting therefrom, or until the end of such ten (10) year period, whichever is later.

8.2 Audit. CHIPA, Payors, the Plans and, to the extent Services are provided under a federal or state health care program, HHS, the Comptroller General of the United States, CMS, the Department of Managed Health Care and any applicable state officials (including, in each case, any of their duly authorized representatives or designees) shall have the right, subject to applicable law, at reasonable times and upon reasonable notice, to examine and copy, at reasonable expense, Books and Records related to this Agreement, including the Services and Provider's obligations under this Agreement. Without limiting the generality of the foregoing, such right shall include the right to examine and copy Books and Records at the location of Provider or any of its Professional Staff. Provider shall, and shall cause its Professional Staff, to fully cooperate with such audits. Provider shall make the Books and Records available for such audit, evaluation, and inspection for a period of ten (10) years from the later of (a) the first day after final payment hereunder, (b) termination of the Plan's Medicare Contract, if applicable, (c) such longer time period as may be required by the Medicare Advantage regulations, if applicable, or (d) the completion of any audit.

8.3 Reimbursement of Disallowed Payments. Without limiting Provider's right to appeal audit results as set forth in the Provider Manual or any agreement between Provider and CHIPA, Provider shall reimburse CHIPA for any payments disallowed as a result of an audit or other review pursuant to this Agreement in such a manner and timeframe as agreed to by CHIPA and Provider. In the event that Provider does not reimburse CHIPA for such disallowed payments, CHIPA shall have the right, in its sole discretion, to offset such disallowed payments (or to direct Payor to offset such disallowed payments) against payments due under this Agreement or any other agreement between CHIPA and Provider. In the event that CHIPA must reimburse Provider due to an audit, CHIPA may reimburse Provider by (a) making a lump sum payment, (b) making regularly scheduled payments or (c) offsetting the disallowed payments against payments due under this Agreement or any other agreement between Provider and CHIPA, as determined by CHIPA in its sole discretion.

9.0 COMPLETE AGREEMENT; AMENDMENTS.

This Agreement sets forth the complete agreement of the Parties with respect to the provision of Services by Provider as a part of the Programs and supersedes all prior or oral agreements relating thereto. No amendment to this Agreement will be valid unless in writing and signed by an authorized representative of the Parties; provided, however, that CHIPA may amend this Agreement in its sole discretion as necessary to comply with applicable federal or state law, accreditation requirements, which amendment will be effective sixty (60) Days after CHIPA sends such notice to Provider, unless otherwise required by law.

10.0 REVISIONS TO PROVIDER MANUAL AND OTHER POLICIES.

CHIPA and Payor reserve the right to revise the Provider Manual or the Policies from time to time (including Policies that may impact Provider's rights or responsibilities). CHIPA or Payor shall notify Provider of changes to its Policies (including those associated with Utilization Review, quality management and improvement, credentialing and preventive health services) that have a substantial impact on the rights or responsibilities of Provider and the effective date of such amendments. CHIPA or Payor shall provide such notice to Provider at least forty-five (45) Working Days prior to the implementation to seek Provider objections that have a substantial impact

on the rights or responsibilities of Provider and the effective date of such amendments. CHIPA or Payor shall provide final notice to Provider at least thirty days (30) Days prior to the effective date of such amendments unless such other date for notice is mutually agreed upon between CHIPA or Payor and Provider or such change is mandated by state or federal law. For purposes of clarity, revisions to Policies shall not constitute amendments to this Agreement for purposes of Section 9.0. In the event Provider objections are not satisfied CHIPA may not unilaterally implement any changes unless mandated by state and federal law.

11.0 TERM AND TERMINATION.

11.1 Term. The term of this Agreement shall continue for one (1) year from its effective date, and shall automatically renew for additional terms of one (1) year, unless either Party notifies the other in writing at least ninety (90) Days prior to the expiration date of its intent not to renew this Agreement.

11.2 Termination. Either Party may terminate this Agreement at any time for any reason by giving written notice to Provider at least sixty (60) Days prior notice. Notice of termination shall be by written notice to the other Parties and be sent by registered mail.

11.3 Termination for Breach. Subject to Section 11.4, if either Party breaches any material term or condition of this Agreement or fails to perform or fulfill any obligations required hereby, the other Party may terminate this Agreement by giving written notice to the breaching Party at least fifteen (15) Days prior to the effective date of termination unless such breach is cured to the reasonable satisfaction of the non-breaching Party during such time period. Any such written notice shall state the circumstances of the alleged breach and shall include a statement of the reason or reasons for such termination. Notice shall be by written notice to the other Parties and be sent by registered mail.

11.4 Other Termination with Cause. CHIPA may, upon written notice to Provider, which shall include a statement of the reason(s) for such termination, effective immediately or otherwise as specified in such notice, terminate or suspend this Agreement in the event: (a) in the reasonable judgment of CHIPA, any act or omission by Provider places Members receiving Services in immediate danger of life, health or safety; (b) of suspected or actual fraud by Provider related to the provision of Services; (c) criminal proceedings are initiated against Provider or any of its executive officers; (d) Provider initiates or consents to any judicial or non-judicial insolvency proceedings, including any composition or assignment for the benefit of creditors; (e) Provider is the subject of any involuntary insolvency proceedings that are not terminated within thirty (30) Days of initiation; (f) Provider's professional liability coverage no longer meets the requirements of Section 7.3 of this Agreement; (g) CHIPA's agreement with any of the Plans for management of their respective Program is terminated, suspended or not renewed; (h) Provider cannot or will not comply with any amendment to this Agreement submitted to Provider by CHIPA pursuant to Section 9.0; (i) Provider is debarred from contracting with any agency, division or other instrumentality of the state in which it is located or of the government of the United States; (j) Provider loses or relinquishes its license or any other public agency approval to provide Services under applicable statutes or regulations of the state in which it is located; (k) Provider's license to practice medicine or authorization to administer controlled substances is denied, modified, reduced, restricted, suspended, relinquished or terminated in California or any other jurisdiction (either voluntarily or involuntarily); (l) Provider's medical staff privileges at any licensed general acute care hospital or other facility are denied, modified, reduced, restricted, suspended, relinquished or terminated (either voluntarily or involuntarily), other than temporary suspensions (*i.e.*, of fewer than ten (10) days duration) due solely to Provider's failure to complete medical records on a timely basis; (m) if Provider is a medical professional corporation, Provider ceases to be a corporation in good standing under the laws of the State of California, or there is a change in the majority ownership or control of Provider; or (n) in the reasonable judgment of CHIPA, actions or inactions

of Provider could put the reputation or business of CHIPA at risk. As set forth in Section 11.5, in all cases involving termination of this Agreement, the Parties agree to arrange for the smooth transition of Members to appropriate continuing clinical services.

11.5 Continuation of Services upon Termination. Upon termination or expiration of this Agreement for any reason, Provider shall, unless otherwise directed by CHIPA, continue to provide Services to Members being served as of the date of termination or expiration until CHIPA has made arrangements to affect the transfer of such Members. Payor shall pay Provider for such continued Services at the rates of payment specified in Exhibit A. Provider shall have the right to notify Members of the termination or expiration of Provider's status as a provider under this Agreement, provided that Provider shall cooperate with CHIPA in developing an appropriate form of notification.

11.6 Remedies. Neither expiration nor termination by either Party shall relieve the other Party of liability for any costs, injuries, penalties, damages or other charges sustained by either Party, by virtue of any breach or default by either Party, and each Party retains the right to pursue any available legal and equitable remedies.

12.0 **FORCE MAJEURE.**

Neither Party shall be liable to the other nor be deemed to be in breach of this Agreement for failure or delay in rendering performance arising out of causes beyond its control and without its fault or negligence. Such causes may include acts of God or the public enemy, wars, fires, floods, epidemics, quarantine restrictions, strikes, unforeseen freight embargoes or unusually severe weather. Dates or times of performance shall be extended to the extent of delays excused by this Section, provided that the Party whose performance is affected notifies the other promptly of the existence and nature of such delay. It is agreed that since time is of the essence with respect to the performance dates set forth in this Agreement, Provider's continued failure to perform for a period of thirty (30) or more Days, even for causes beyond the control of Provider, shall entitle CHIPA to terminate this Agreement.

13.0 **RIGHT OF APPEAL.**

Provider's right to appeal a determination of Medical Necessity of Services, if any, shall be set forth in the Provider Manual.

14.0 **NON-DISCRIMINATION.**

14.1 General. To the extent applicable, neither Party shall discriminate against any qualified employee or applicant because of race, color, national origin, ancestry, age, sex, religion, disability or sexual orientation. Without limiting the generality of the foregoing, Provider agrees to comply with all laws applicable to individuals and entities receiving federal funds, including (a) all applicable state Department of Public Health, CMS, and Food and Drug Administration regulations, (b) Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. Part 84; (c) The Age Discrimination Act of 1975 as implemented by regulations at 4 C.F.R. Part 91; (d) The Americans with Disabilities Act; (e) The Rehabilitation Act of 1973; (f) Section 542 of The Public Health Service Act; (g) Title 45, Part 46 of the Code of Federal Regulations; and (h) all other laws applicable to recipients of federal funds.

14.2 Members. In compliance with applicable state and federal regulations, Provider shall not deny, limit, or condition the furnishing of Services to a Member or otherwise discriminate against a Member for any reason including the Member's race, color, national origin, ancestry, age, gender, religion, disability, sexual orientation, financial status, insurer or mental or behavioral health coverage, diagnosis, mental or physical illness or medical condition, claims experience, receipt of health care, medical history, genetic information, or evidence of insurability (including

conditions arising out of acts of domestic violence). If Provider provides inpatient Services under this Agreement, Provider shall accept for admission or treatment all Members for whom CHIPA has determined admission or treatment to be Medically Necessary, regardless of clinical presentation, when a bed is available in an age-appropriate unit.

Nothing herein shall prohibit or be construed to prohibit Provider from in good faith communicating with a Member regarding any and all available treatment options related to Member and Provider shall provide information regarding treatment options (including the option of no treatment) to all Members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and individuals with physical or mental disabilities, in a culturally-competent manner. Provider shall use best efforts to ensure that Members with disabilities have effective communication with Provider in making decisions regarding treatment options.

15.0 DISPUTE RESOLUTION.

15.1 Definition of Provider Dispute. A "provider dispute" is a Provider's written notice to CHIPA challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each Provider Dispute must contain, at a minimum, the following information: Provider's name, billing provider's tax ID number or CHIPA's Provider ID number, Provider's contact information, and a clear explanation of the issue and the Provider's position on such issue; and if the contracted provider dispute involves an patient or group of patients, the name and identification number(s) of the patient or patients. If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from CHIPA to a contracted provider the following must be provided: original claim form number, a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.

15.2 Sending a Contracted Provider Dispute to CHIPA. Provider Disputes may be submitted in writing to CHIPA at the following address:

College Health IPA

Attn: Claims Department

5665 Plaza Drive, Ste. 400, Cypress, CA 90630

15.3 Time Period for Submission of Provider Disputes. Provider Disputes must be received by CHIPA within 365 Days from CHIPA's action that led to the dispute or the most recent action if there are multiple actions that led to the dispute in the case of inaction, Provider Disputes must be received by CHIPA within 365 Days after CHIPA's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

15.4 Acknowledgment of Contracted Provider Disputes. CHIPA will provide written acknowledgement of receipt of all contracted provider disputes within fifteen (15) Working Days of the Date of Receipt by CHIPA.

15.5 Contact CHIPA Regarding Provider Disputes. All inquiries regarding the status of a contracted Provider Dispute or about filing a contracted provider dispute or other inquiries must be directed to the CHIPA Claims Department at 888-249-0478.

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

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

15.8 Special Meeting. In the event of any dispute or disagreement between the Parties with respect to this Agreement including claims settlements pursuant to California Managed Health Care regulation 1300.71, are not resolved by the dispute resolution procedures outlined in sections 15.1 through 15.7 of this Agreement, the Parties shall conduct a special meeting for the resolution of the dispute (a "Special Meeting"). The Special Meeting shall be held at CHIPA's offices or at another mutually agreed upon location within ten (10) Days of a written request for the meeting, which request shall specify the nature of the dispute to be resolved. The Special Meeting shall be attended by representatives of both Parties who have reasonable authority to resolve the dispute. The Parties retain discretion to allow legal counsel to be present at the Special Meeting. The Parties shall attempt in good faith to resolve the dispute.

16.0 DELEGATION AND SUBCONTRACTING.

Subject to any restrictions on delegation and subcontracting set forth elsewhere in this Agreement (including the prior consent of CHIPA, if applicable), if Provider enters into any arrangement with a related entity, contractor or subcontractor, including contracted Professional Staff (collectively, "Subcontractors") to provide services under this Agreement, each such subcontract shall require, and Provider shall cause, the Subcontractor to comply with the applicable terms and requirements in this Agreement to the same extent that such terms and requirements apply to Provider.

17.0 MISCELLANEOUS.

17.1 Compliance with Laws. In the performance of Provider's obligations under this Agreement, Provider shall comply with all applicable state and federal laws (including HIPAA and HITECH), regulations, and rules, and agrees that in the event of conflict with this Agreement, such laws, regulations, or rules shall control. Without limiting the foregoing, Provider shall comply with applicable state and federal laws, regulations, and rules regarding physician compensation and financial relationships, referrals, physician incentive plans, fraudulent practices, fraud and abuse, false health care claims, and physician self-referral. Provider shall notify CHIPA and Payors, as applicable, in writing of any investigation or adverse action taken by any regulatory agency (including the Office of Inspector General, CMS, and the Internal Revenue Service) for violations of any applicable law, rule, or regulation.

17.2 Changes in Law. In the event of any legislative, judicial, or regulatory change, determination or interpretation, whether federal or state, which has or would have significant adverse impact on either CHIPA or Provider, or in the event that performance by either Party of any term, covenant, condition, or provision of this Agreement should for any reason be in violation of any statute, regulation or otherwise be deemed illegal, the affected Party shall have the right to require that the other Party renegotiate the terms of this Agreement, such renegotiated terms to become effective not later than thirty (30) Days after receipt of written notice of such request for renegotiation, the Party requesting such renegotiation may terminate this Agreement upon thirty (30) Days' prior written notice to the other Party or sooner if required by law.

17.3 Confidentiality. Except as may be required by law or governmental rules and regulations, Provider agrees not to publicly or privately announce or disclose the terms and conditions of this Agreement, including the rates set forth in Exhibit A, without the written consent of CHIPA.

17.4 Governing Law. This Agreement shall be construed under and governed by the laws of California. Provider agrees to bring any federal or state legal proceeding arising under this Agreement, in which CHIPA is a Party, before the Marin County Superior Court. This Section shall not be construed to limit any rights a Party may have to intervene in any action, in any court or wherever pending, in which the other is a Party. For purposes of clarity, neither Party may bring an action in a court of law regarding a dispute that arises under this Agreement until the dispute resolution procedures set forth in Section 15.0 have been followed.

17.5 Severability. The unenforceability of any clause or provision in this Agreement shall in no way affect enforceability of any other clause or provision or this Agreement as a whole.

17.6 Assignment. Provider's obligations hereunder constitute a personal service, and Provider may not assign its rights or obligations, or subcontract any of its duties, under this Agreement without the prior consent of CHIPA, which may be withheld by CHIPA in its discretion. The approval by CHIPA of assignment or subcontracting in any one instance shall not constitute approval of any other assignment or subcontracting. CHIPA may assign any of its rights or obligations under this Agreement in its discretion. This Agreement shall be binding upon, and inure to the benefit of, the respective successors and assignees of CHIPA and Provider.

17.7 Notices. All notices, requests, consents and other communications hereunder, unless otherwise stated, shall be in writing, shall be addressed to the receiving Party's address as first set forth in this Agreement or to such other address as a Party may designate by notice hereunder, and shall be (a) delivered by hand, (b) made by facsimile transmission, (c) sent by recognized overnight courier or (d) sent by regular, registered or certified mail, return receipt requested, postage prepaid. All notices, requests, consents and other communications hereunder shall be deemed to have been received (w) if by hand, at the time of the delivery thereof to the receiving Party at the address of such Party first set forth in this Agreement, (x) if made by facsimile transmission, at the time that receipt thereof has been acknowledged by electronic confirmation or otherwise, (y) if sent by overnight courier, on the next business day following the day such communication is delivered to the courier service, or (z) if sent by regular, registered or certified mail, on the fifth business day following the date such mailing is made.

17.8 Waiver. Waiver of, or failure of either Party to enforce, the terms of this Agreement in one instance shall not constitute a waiver of said Party's rights under this Agreement in any other respect.

17.9 Independent Contractor. The relationship of Provider and CHIPA is that of independent contractors only. Nothing contained in this Agreement shall be deemed or construed to create any partnership, joint venture, employer-employee, or other relationship between CHIPA and Provider, nor shall any of their respective employees be construed or deemed to be agents, employees or representatives of the other.

17.10 Survival. In addition to other terms that under a plain read of the language and intent indicate survivability of such terms after expiration or termination of this Agreement, Sections 3.5 (Medical Charts and Records), 3.6 (Privacy and Security Laws), 4.6 (Member Hold Harmless), 4.7 (Plan Hold Harmless), 7.0 (Indemnification and Liability Insurance), 8.0 (Recordkeeping, Audit and Inspection of Records), 11.5 (Continuation of Services upon Termination), 11.6 (Remedies), 15.0 (Dispute Resolution), 17.3 (Confidentiality) and 17.4 (Governing Law) shall survive expiration or termination of this Agreement.

17.11 Interpretation. Except where expressly stated otherwise in this Agreement, the following rules of interpretation

apply to this Agreement: (a) "include," "includes" and "including" are not limiting and mean include, includes and including, without limitation; (b) definitions are applicable to the singular as well as the plural forms of such terms; (c) references to an agreement, statute or instrument mean such agreement, statute or instrument as from time to time amended, modified or supplemented; (d) references to a "Section" refer to a Section of the Exhibit in which such reference is located, unless otherwise indicated; (e) references to an "Exhibit" or "Schedule" refer to an Exhibit or Schedule to this Agreement unless otherwise indicated; (f) the word "will" shall be construed to have the same meaning and effect as the word "shall;" and (g) the word "any" shall mean "any and all" unless otherwise indicated by context.

EXHIBIT E
CALIFORNIA SPECIFIC REQUIREMENTS

In addition to the obligations set forth elsewhere in this Agreement, CHIPA and Provider agree to comply, and Provider agrees to cause its Professional Staff to comply, with the following requirements with respect to Services governed by California law, including, but not limited to, the Knox-Keene Health Care Services Act of 1975, as amended, and regulations promulgated thereunder. Capitalized terms used but not defined in this Exhibit E shall have the meanings set forth in Exhibit B.

1.0 GENERAL OBLIGATIONS.

1.1 Prior Authorization. In addition to the requirements set forth in Section 2.3 of Exhibit B, CHIPA will not retrospectively rescind or modify an authorization issued to Provider after Provider renders a Service in good faith pursuant to such authorization.

1.2 Emergency Services. Payor shall pay Provider for all Medically Necessary Services for treatment of an Emergency Medical Condition prior to stabilization of the Member's condition (or during periods of destabilization after initial stabilization) when such Member requires immediate Medically Necessary Services.

In the event that a Member is stabilized after the treatment of an Emergency Medical Condition and Provider believes that the Member requires additional Medically Necessary Services and may not be discharged safely, CHIPA shall approve or disapprove Provider's request for prior authorization to provide such Medically Necessary Services within thirty (30) minutes of Provider's request.

If CHIPA fails to approve or disapprove such request for prior authorization within thirty (30) minutes, CHIPA's authorization shall be deemed granted. Notwithstanding the foregoing, CHIPA will have the right to disapprove payment for the delivery of such Medically Necessary post-stabilization Services or Provider's continuation of other Services provided that: (a) CHIPA notifies Provider prior to the commencement of the delivery of such Medically Necessary post-stabilization Services or during the continuation of the delivery of such Services (in which case, Payor shall not be obligated to pay for the continuation of such Services from and after the time CHIPA provides such notice to Provider, subject to the remaining provisions of this Section) and (b) in both cases, the disruption of such Services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact upon the efficacy of such Services or the Member's medical condition. Notwithstanding the foregoing, Payor shall pay for all Medically Necessary Services provided to a Member that are necessary to maintain the Member's stabilized condition up to the time that CHIPA effectuates the Member's transfer or the Member is discharged.

In the event of a disagreement between CHIPA and Provider regarding the need for Medically Necessary Services, following stabilization of the Member, CHIPA may assume responsibility for the care of the Member either by having medical personnel contracting with CHIPA personally take over the care of the Member within a reasonable amount of time after the disagreement, or by having another provider under contract with CHIPA agree to accept the transfer of the Member in accordance with applicable law. If CHIPA fails to satisfy the requirements of this provision, further Medically Necessary Services shall be deemed to have been authorized by CHIPA.

1.3 Timely Access. Providers shall provide timely access to Covered Services for Members in compliance with all applicable federal and state requirements, including but not limited to the Department of Managed Health Care

regulation 1300.67.2.2 "Timely Access to Non-Emergency Health Care Services", as required by the Plan, and Payor's applicable policies on timely access to services set forth in the Provider Manual. Provider may limit acceptance of Members if in Provider's reasonable professional judgment, accepting such new patients would endanger patients' access to or continuity of care.

1.4 Interpreter/Language Access. Providers shall provide interpreter and other language access services for non-English speaking Members in compliance with all applicable federal and state requirements, including but not limited to the Department of Managed Health Care regulation 1300.67.04 "Language Assistance Programs", as required by the Plan, and Payor's applicable policies on culturally and linguistically appropriate services set forth in the Provider Manual.

1.5 Pervasive Developmental Disorder/Autism. If applicable to the services provided by Provider, Provider shall provide services for pervasive developmental disorder/autism in compliance with all applicable federal and state requirements, including but not limited to Sections 1374.72 and 1374.73 of California Senate Bill 946, and as required by the Plan.

2.0 **PAYMENTS.**

2.1 Claims Payment. Payor shall identify and acknowledge to Provider the receipt of each claim, whether or not a Clean Claim, within two (2) Working Days for an electronic claim or fifteen (15) Working Days for a paper claim of the date of receipt of the claim. Payor shall compensate Provider no later than thirty (30) Working Days after receipt by Payor of any Clean Claim for Services rendered to a Member. If Payor contends that a claim submitted by Provider is not a Clean Claim, Payor shall notify Provider of such contention no later than thirty (30) Working Days from the date of receipt and shall include in such notice all information or data that is required to make a Clean Claim. If Payor fails to compensate or reject Provider's claim within thirty (30) Working Days of receiving a Clean Claim, Payor shall pay Provider interest on any unpaid amounts at the annual rate of fifteen (15) percent or such other amount provided under state law, as amended from time to time, beginning with the first calendar day after the thirtieth Working Day. Provider must resubmit claims after receipt of notice of a rejection by Payor in the timeframe required by the Provider Manual, if any. In the event Payor fails to process resubmitted claims within thirty (30) Days of receipt, Payor shall pay Provider interest as provided above. If Payor fails to automatically include interest due on a late claim payment as set forth above, Payor shall pay Provider ten (10) dollars for the late claim, in addition to any amounts already due. For the purposes of this Section 2.1, a claim shall be deemed to be received on the date of electronic submission, or for paper claims on the date of receipt, each as documented by Payor.

2.2 Member Ineligibility. In addition to the requirements set forth in Section 4.1 of Exhibit B and except as otherwise provided in an Enrollee Plan contract, should an Enrollee erroneously be represented by a Plan as eligible for Covered Services and be found to be ineligible after having been referred to Provider for Covered Services, CHIPA shall honor claims from Provider for dates of service prior to the date CHIPA informed Provider of Enrollee's ineligibility.

3.0 **COMPLETE AGREEMENT; AMENDMENTS.**

3.1 Amendments. Notwithstanding anything to the contrary in Exhibit B, this Exhibit may be amended only with the written consent of Provider; provided, however, that CHIPA may amend this Agreement as necessary to comply with applicable federal or state law or accreditation requirements of a private sector accreditation organization upon forty-five (45) Working Days' notice to Provider or such shorter notice time period as may be required for

compliance with applicable law or accreditation requirements. In the event Provider rejects such amendment, such amendment shall nonetheless become effective as of the date set forth in the notice, and in the event CHIPA and Provider cannot resolve Provider's objection, Provider may terminate this Agreement on thirty (30) Days prior written notice to CHIPA.

4.0 **REVISIONS TO PROVIDER MANUAL AND OTHER POLICIES.**

4.1 Revisions to Provider Manual and Other Policies. CHIPA shall provide Provider at least forty-five (45) Working Days written notice prior to making a modification to the Policies, including the Provider Manual and the quality improvement and utilization management programs and procedures of a Plan or CHIPA. In the event Provider objects to such modification, CHIPA and Provider shall confer in good faith regarding the modification. In the event CHIPA and Provider cannot agree regarding the proposed modification within thirty (30) Days, CHIPA may terminate this Agreement on at least thirty (30) Days' notice.

4.2 Revisions to Quality Improvement and Utilization Management Programs. Notwithstanding Section 4.1, CHIPA may amend the quality improvement or utilization management Policies at any time if the amendment is necessary to comply with federal or state law or any accreditation requirements of a private sector accreditation organization.

5.0 **MEDI-CAL.**

5.1 Participation in Medi-Cal Managed Care Plans. Provider shall provide Covered Services to enrollees in Medi-Cal managed care plans operated by CHIPA.

5.2 Disclosure. Provider shall disclose to CHIPA and the Plans the names of the officers of Provider, owners of Provider, and stockholders of Provider owning more than ten (10) percent of the stock issued by Provider, if any, and major creditors holding more than five (5) percent of the debt of Provider. For purposes of such disclosures, Provider shall complete the disclosure form required by California Welfare and Institutions Code, § 14452(a).

5.3 Reporting. Provider shall provide CHIPA and the Plans, within the timeframe requested by CHIPA or the applicable Plan, with all such reports and information, including, but not limited to, encounter data, as CHIPA or the applicable Plan may require to allow CHIPA or the applicable Plan to meet the reporting requirements under the Medi-Cal agreement or any applicable law. Provider shall make available its books, records, and any subcontracts pertaining to services furnished by Provider upon request to the U.S. Department of Justice ("DOJ"), the U.S. Department of Health and Human Services ("HHS"), the California Department of Managed Health Care ("DMHC"), and the California Department of Health Care Services ("DHCS").

5.4 Hold Harmless. Provider shall hold Medi-Cal managed care plan enrollees and the state of California harmless in the event CHIPA or the applicable Plan cannot pay for services performed by Provider.

5.5 Quality Improvement System. Provider shall assist efforts by CHIPA and the Plans to implement a Quality Improvement System compliant with Title 28 of the California Code of Regulations § 1300.70. CHIPA will keep Provider informed about Quality Improvement System activities and written guidelines and acknowledges that Provider is an integral part of CHIPA's Quality Improvement System.

5.6 Termination of Agreement with DHCS, Transfer of Records. In the event that DHCS or CHIPA terminate their agreement to provide Medi-Cal Covered Services, Provider will assist CHIPA in its efforts to transfer medical records, patient files, and other pertinent information to DHCS or a successor health plan.

5.7 Notice to DHCS in the Event of Amendment, Termination, or Assignment. Provider hereby agrees to notify DHCS using first class registered mail in the event that Provider or CHIPA amend or terminate this Agreement. Provider will not assign this Agreement without obtaining prior written approval from DHCS. Notice to DHCS shall be sent to the following address:

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

6.0 **MISCELLANEOUS.**

6.1 Quality Improvement and Utilization Management Programs. Provider acknowledges and agrees that CHIPA disclosed to it the requirements under this Agreement to comply with the quality improvement and utilization management programs of CHIPA and the Plans, including the requirements in Section 3.1 of Exhibit B, fifteen (15) Days prior to the Effective Date.

6.2 Compliance with Law. CHIPA and Provider shall comply with all California laws governing this Agreement and the provision of Services to Members including Section 1375.7 of the California Health and Safety Code, the Health Care Providers' Bill of Rights. In the event that any California law conflicts with the terms of this Exhibit E, such terms shall be deemed to be amended to the extent necessary for consistency with such California law.

7.0 **CONFLICTS OR INCONSISTENCIES.**

In the event of any conflict or inconsistency between the terms in this Exhibit E and the terms in any other section of the Agreement, then this Exhibit E shall control; provided, however, that if CHIPA and Provider are capable of complying with both the requirements of such other section and this Exhibit E, nothing herein shall be construed as waiving the obligations of CHIPA or Provider under such other section.

EXHIBIT F

PARTNERSHIP HEALTH PLAN OF CALIFORNIA- CHIPA PROVIDER MANUAL