# INDEPENDENT PROVIDER AGREEMENT
# [FEE FOR SERVICE]

This INDEPENDENT PROVIDER AGREEMENT (this **"Agreement"**) is entered into between California Physicians' Service, dba Blue Shield of California, a California nonprofit corporation, (**"Blue Shield"**) and Tehama County Health Services Agency (**"Provider"**), with reference to the following:

## RECITALS

A. Blue Shield is licensed as a prepaid health care service plan under the Knox-Keene Act of 1975 and the regulations promulgated thereunder, each as amended (the **"Knox-Keene Act"**). Blue Shield contracts with individuals, associations, employer groups, and governmental entities to provide or to arrange for the provision of covered health care services to Members (as defined herein) enrolled in health maintenance organization (**"HMO"**), point of service (**"POS"**), exclusive provider organization (**"EPO"**) and preferred provider organization (**"PPO"**) benefit plans.

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

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

NOW, THEREFORE, the parties hereto agree as follows:

## I. DEFINITIONS

The terms set forth in this Agreement shall have the meanings described below, except where the context indicates that such meanings are not intended. In the event of any dispute with regard to the definition of any of the terms, reference to the use of any such disputed term in the Knox-Keene Act shall be controlling:

1.1 **Authorization/Authorized**: is the approval of Blue Shield, or its delegate, for the provision of Covered Services obtained in accordance with, and as further described in, the Provider Manual and Section 2.3 of this Agreement.

1.2 **Benefit Program**: is a group or individual Health Maintenance Organization (HMO), including Point-of-Service (POS), Exclusive Provider Organization (EPO), or Preferred Provider Organization (PPO) health care product offered by Blue Shield pursuant to a Health Services Contract (and riders, if any, thereto).

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

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

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

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

1.7 **Emergency Services:** are Covered Services required to address an unexpected medical condition, including a psychiatric emergency 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: (a) placing the Member's health in serious jeopardy, or in the case of a pregnant woman, the health of the woman or her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. For Blue Shield Medicare Members, Emergency Services also include any other services defined as emergency services in Title 42 of the Code of Federal Regulations, Section 422.113.

1.8 **Evidence of Coverage:** is the document issued to the Member pursuant to California law which describes the benefits, limitations and other features of the Benefit Program in which the Member is enrolled.

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

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

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

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

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

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

## II. PROVIDER SERVICES

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

2.2 **Non-Discrimination.** Provider shall provide services to Members in a manner similar to that in which Provider furnishes services to all other Provider patients, and with the same availability afforded to such patients. Provider shall not discriminate against Members on the basis of race, sex, gender, gender identity, gender expression, color, religion, national origin, ancestry, age, marital status, physical or mental handicap, health status, disability, need for medical care, utilization of medical or mental health services or supplies, sexual preference or orientation, veteran's status, health insurance coverage, status as a Member, or other unlawful basis including without limitation, the filing by a Member of any complaint, grievance, or legal action against Provider. In providing services to Members, Provider shall comply with all applicable laws including, without limitation, the Americans with Disabilities Act. If (a) absent this Agreement, Provider would not be obligated to comply with any such laws, or (b) there is a new interpretation of or change to existing law that imposes new obligations on Provider, and (c) Provider reasonably determines that compliance with such laws would represent a material cost to Provider, Blue Shield agrees to meet with Provider in good faith to discuss the additional costs and possible additional compensation. If Blue Shield and Provider are unable to reach agreement regarding additional compensation, then Provider may terminate this Agreement upon sixty (60) days' prior written notice to Blue Shield.

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

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

2.5 **Ancillary Tests and Procedures.** Except as otherwise set forth in the Provider Manual, any ancillary testing and/or procedures (e.g., radiologic, laboratory, etc.) required in the treatment of Blue Shield Members shall be performed by Provider unless (a) Provider does not have the facilities or capacity to perform a particular test or procedure, or (b) it is Medically Necessary to have the test or procedure performed by persons other than Provider. Provider shall, as set forth in the Provider Manual, obtain authorization from Blue Shield prior to performing such ancillary test or procedures.

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

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

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

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

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

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

2.9 **Provider Manual**. Provider shall comply with the Provider Manual, the terms of which are incorporated herein by reference. Blue Shield may, in its sole discretion, periodically modify its Provider Manual. Blue Shield shall notify Provider no fewer than forty-five (45) working days prior to the effective date of any change to the Provider Manual. If Provider reasonably concludes that a change to the Provider Manual is material, Provider shall notify Blue Shield, in writing, prior to the effective date of the change. Following receipt of Provider's notice, Provider and Blue Shield shall confer in good faith regarding the change. If Provider and Blue Shield are unable to reach agreement regarding the change within thirty (30) days of Provider's notice, then, within sixty (60) days of Provider's notice, Provider may elect to terminate this Agreement for cause pursuant to Section 7.4 hereof and the Provider Manual change to which Provider objected shall not be effective as to Provider during the termination notice period. To the extent of any conflict between this Agreement and the Provider Manual, the terms of this Agreement shall govern.

## III. COMPENSATION

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

3.2 **Payment of Claims.** Blue Shield shall pay all valid and complete claims from Provider for Covered Services upon receipt, in accordance with the timeframes set forth in California

law and in accordance with the Blue Shield claims adjudication rules and procedures as set forth in the Provider Manual. Provider shall accept electronic payment for Covered Services and receive related explanations of payments (**"EOPs"**) via electronic funds transfer (**"EFT"**) and electronic remittance advice (**"ERA"**), respectively. Provider shall bill Blue Shield in accordance with the procedures as set forth in the Provider Manual and as described on Blue Shield's websites at www.blueshieldca.com. All claims payments by Blue Shield will be accompanied by a remittance advice which describes the manner in which the claim was adjudicated and payment was issued. In the event a claim or any portion thereof is denied payment by Blue Shield, Provider will receive an appropriate communication from Blue Shield which describes the basis for the denial and contains all appropriate information as may be required by applicable state and federal law.

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

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

3.5 **Charges to Members.**

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

Provider.

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

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

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

3.6 **Coordination of Benefits & Third Party Recoveries.** Provider agrees that coordination of benefits will be conducted in accordance with established California law and the provisions of the Member's Evidence of Coverage. If another payor, including Medicare, is primary, in no event will application of the coordination of benefits rules result in a combined payment to Provider which is lower than the amount that would have been paid to Provider under this Agreement in the absence of the other payor. If Medicare is primary and the Medicare allowance for a Covered Service exceeds the Blue Shield Provider Allowance, payment by Blue Shield will be based on the higher Medicare allowance. In the event a Member seeks and obtains a recovery from a third party or a third party's insurer for injuries caused to that Member, Provider shall have no right to assert or pursue a third party lien for any Covered Services provided to that Member.

3.7 **Provider Contracts with Groups or IPAs.** If Provider is a party to an agreement with a medical group or independent provider organization (**"IPA"**) under which Provider agrees to provide services to enrollees of health maintenance organizations, including Members of Blue

Shield, then Provider agrees that such agreement shall apply to Services rendered to Members of Blue Shield to which such agreement applies. This Agreement shall not apply to Covered Services rendered to any such Members unless a judicial or regulatory interpretation of existing statutes reaches, or enacted legislation results in, a contrary conclusion.

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

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

3.10 **BlueCard Claims**.

(a) If and for so long as Provider is not contracted with another licensee of the Association (as defined in Section 9.13) in the State of California, Provider shall submit to Blue Shield for processing all claims for medical services (including, without limitation, Provider Services) furnished by Provider and reimbursable through the BlueCard Program.

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

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

3.12 **Claims Overpayments and Recoveries.**

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

(b) In the event Blue Shield determines that it has issued a Claims Overpayment to Provider, whether in connection with an audit or otherwise, Blue Shield shall notify Provider in writing through a separate Claims Overpayment notice clearly identifying the claim, the name of the Member, the date of service, and an explanation of the basis upon which Blue Shield believes the amount paid on the claim was in excess of the amount due, including any interest and penalties that may be due on the claim. Blue Shield must issue a Claims Overpayment notice within (i) three hundred sixty-five (365) days of the date of payment on the Claims Overpayment for any claims submitted under Benefit Programs regulated by the DMHC or the California Department of Insurance ("CDI"), or within (ii) three (3) years from the date of payment on the Claims Overpayment for claims submitted under other types of Benefit Programs that are not regulated by the DMHC or the CDI, or (iii) at any time in the event of fraud and/or misrepresentation. Blue Shield shall send such Claims Overpayment notice to Provider's address of record with Blue Shield for the receipt of claims related correspondence and payments unless Provider informs Blue Shield in writing of an alternative address to which such notices are to be sent at least thirty (30) days in advance of the address change.

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

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

(e) In the event Provider desires to contest Blue Shield 's notice of Claims Overpayment, Provider must do so within thirty (30) business days from the date Provider receives the Claims Overpayment notice, by sending a written notice to Blue Shield that contains the following information: Provider's name, identification number, contact information, a clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which Provider believes that the claim was not overpaid and the request for reimbursement of the

Claims Overpayment amount is not correct. Provider's notice must be sent to Blue Shield 's provider appeals unit at the address listed in the Provider Manual. Blue Shield shall review and make a decision with respect to Provider's appeal ("Final Claims Overpayment Determination"), and Blue Shield shall notify Provider of the Final Claims Overpayment Determination in writing within forth-five (45) business days of the date Blue Shield receives Provider's written notice. In the event Blue Shield 's Final Claims Overpayment Determination upholds the Claims Overpayment, Provider must reimburse Blue Shield within thirty (30) business days from the date Provider receives the Final Claims Overpayment Determination.

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

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

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

## IV. REPRESENTATIONS AND WARRANTIES OF PROVIDER

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

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

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

practice;

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

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

(e) provide evidence to Blue Shield of compliance with the forgoing requirements set forth in this Section 4.1.

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

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

4.4 **Disclosures.**

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

(b) Provider shall notify Blue Shield immediately in writing of the occurrence of any of the following events: (i) Provider or any licensee affiliated with Provider no longer meets any of the Blue Shield credentialing criteria set forth in the Provider Manual; (ii) Provider or any licensee affiliated with Provider is excluded or suspended from participation in, ceases to be certified by, or is sanctioned by any state or federal healthcare program, including, without limitation, Medicare or Medi-Cal; (iii) Provider's liability insurance (or that of any licensee affiliated with Provider) is canceled, terminated, not renewed, or materially modified; (iv) a petition is filed to

declare Provider bankrupt or for reorganization under the bankruptcy laws of the United States or a receiver is appointed over all or any portion of Provider's assets; or (vi) any act of nature or other event or circumstance which has, or reasonably could be expected to have, a material adverse effect on Provider's ability to perform its obligations under this Agreement.

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

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

4.6 **Compliance With State and Federal Law.** Provider will comply with applicable state and federal laws and regulations. If this Agreement applies to Medicare Members, provider acknowledges that payments made by Blue Shield are, in whole or in part, derived from federal funds. Provider agrees to comply with all applicable Medicare laws, regulations and CMS instructions including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and to require his/her/its subcontractors to do the same. If, (a) absent this Agreement, Provider would not be obligated to comply with any such laws, or (b) there is a new interpretation of or change to existing law that imposes new obligations on Provider, and (c) Provider reasonably determines that compliance with such laws would represent a material cost to Provider, Blue Shield shall meet with Provider in good faith to discuss the additional costs and possible additional compensation. If Blue Shield and Provider are unable to reach agreement regarding additional compensation, then Provider may terminate this Agreement upon sixty (60) days' notice to Blue Shield.

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

## V. MAINTENANCE AND INSPECTION OF RECORDS

5.1 **Records.**

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

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

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

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

5.2 **Site Evaluations.** Provider shall permit Government Officials and Blue Shield to conduct periodic site evaluations, inspections, and onsite audits of their facilities. Blue Shield shall provide Provider five (5) business days' advance notice (or fewer if mutually agreed upon by

the parties) of any proposed site evaluation or inspection by Blue Shield. If Government Officials or Blue Shield finds any deficiencies in such facilities, Provider shall have thirty (30) days to correct such deficiencies which are identified by such Government Official or Blue Shield, unless the Government Official requires that such deficiency be corrected within a shorter timeframe.

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

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

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

5.6 **Onsite Audits.** Provider shall permit Government Officials and Blue Shield to conduct periodic onsite audits of their records. Blue Shield shall provide Provider five (5) business days' advance notice (or fewer if mutually agreed upon by the parties) of any proposed onsite audit by Blue Shield. Audits will be performed on-site or otherwise and may involve statistically valid sampling techniques of Provider that are deemed necessary to include, but not limited to, medical practice audits, medical necessity reviews, data validation reviews, billing and claims payment audits, coding audits and quality improvement audits. Further, provider agrees to participate in any corrective action plan required by Blue Shield. Based on such review, Blue Shield may deny payment, reject claims, and/or review claims on a retrospective basis and recover any overpayments, consistent with the requirements set forth in Section 1300.71(b)(5) of Title 28 of the California Code of Regulations. Provider may not bill for services rendered by a practitioner if such services are subject to billing

independently by practitioner, another provider, and/or another entity subject to another agreement or arrangement with Blue Shield.

## VI. INDEPENDENT RELATIONSHIP

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

## VII. TERM & TERMINATION

7.1 **Term.** This Agreement shall be effective as of the date of execution by Blue Shield and shall remain in effect for one (1) year. Thereafter, this Agreement will automatically renew for successive one (1) year terms, unless and until terminated or modified in accordance with the terms set forth herein. Either party may terminate this Agreement without cause effective upon the annual renewal date by giving the other party written notice of non-renewal at least one hundred twenty (120) days' prior written notice of termination. Any termination pursuant to this Section 7.1 shall become effective the first day of the calendar month following the expiration of the notice period. Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination.

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

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

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

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

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

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

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

7.5 **Termination of Individual Physician in Group.** If Provider is a group of licensed providers and grounds for termination of any individual provider arise pursuant to Sections 7.2 or 7.3 hereof, then Blue Shield may, at its sole election, elect to terminate only the participation of such individual provider under this Agreement rather than the entire Agreement.

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

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

terms of this Agreement.

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

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

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

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

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

(g) All written, printed, or electronic communications to Members concerning the termination of this Agreement shall comply with Health & Safety Code Section 1373.65(f) and CAA Section 113, as applicable.

## VIII. RESOLUTION OF DISPUTES

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

The term "Claims Determination" as used in this Agreement means the acknowledgement, adjudication, adjustment, denial, contest, payment, and/or any other action by Blue Shield

following Provider's submission of a claim for reimbursement under this Agreement, including without limitation Blue Shield's failure to pay or otherwise take required action with respect to such claims.

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

(b) This Section 8.1 does not in any way modify the provisions of Section 9.1 relating to arbitration of disputes that cannot be resolved through the Appeal Process. However, if Provider fails to submit a Provider Appeal within the timeframes set forth in the Provider Manual, and complete the Appeal Process, Provider shall be deemed to have waived its right to any remedies and to further pursue any dispute arising out of or relating to a Claims Determination. Without limiting the foregoing, in such instance, Provider may neither initiate a demand for arbitration pursuant to Section 8.1 and Section 8.1 of this Agreement nor pursue additional payment from the Member.

8.2 **Arbitration of Disputes.** Any dispute between Provider and Blue Shield shall be settled by final and binding arbitration in San Francisco, Los Angeles, San Diego or Sacramento, California, whichever city is closest to Provider, including any dispute arising out of or related to (a) a Claims Determination (as defined in Section 8.1 of this Agreement) or a Claims Overpayment or Final Claims Overpayment Determination (as such terms are defined in Section 3.12 of this Agreement) that exceeds the jurisdiction of Small Claims Court and that was reviewed through, but not resolved by, the Appeal Process set forth in Section 8.1 of this Agreement, and (b) other disputes that were reviewed through, but not resolved by, the dispute resolution process set forth in Section 8.4 of this Agreement. The parties agree that (a) timely pursuit and completion of the Appeal Process set forth in Section 8.1 of this Agreement shall be a condition precedent to submitting a demand for arbitration for disputes arising out of or related to Claims Determinations, and (b) timely notice that Provider contests a Claims Overpayment and completion of the Final Claims Overpayment Determination as set forth in Section 3.12 of this Agreement shall be a condition precedent to submitting a demand for arbitration of disputes arising out of or related to Claims Overpayment and Final Claims Overpayment Determinations, and (c) timely pursuit and completion of the dispute resolution process set forth in Section 8.4 of this Agreement shall be a condition precedent to submitting a demand for arbitration of other disputes. Arbitration shall be conducted by and under the Commercial Rules of the American Arbitration Association. The arbitrator shall be a retired judge of the State of California, unless otherwise agreed to by the parties. The arbitration decision shall be binding on both parties. The arbitrator shall be bound by applicable Laws and Regulations and shall issue written findings of fact and conclusions of law. The arbitrator shall have

no authority to award damages or provide a remedy that would not be available to such prevailing party in a court of law nor shall the arbitrator have the authority to award punitive, incidental, or consequential damages, or to add to, modify, or otherwise refuse to enforce any agreements between the parties. The parties acknowledge that arbitration of a dispute under this Agreement may require the disclosure or exchange of confidential or sensitive information. Therefore, the parties agree to enter into protective orders, including without limitation limiting certain discovery documents to "attorney's eyes only" to the extent possible in view of the context and nature of the dispute and documents to be disclosed. The parties further agree that any and all discovery information disclosed or exchanged as part of an arbitration proceeding shall be used solely within the arbitration of the dispute between the parties and shall not be used for any other purpose. Within thirty (30) days following the date of a final arbitration award, each party shall return or destroy any documents of the other party that were subject to a protective order. The cost of the arbitration shall be shared equally by Provider and Blue Shield; provided, however, that each party shall be responsible for its own attorneys' fees and costs. Notwithstanding any other term of this Agreement to the contrary, for purposes of clarity, the parties agree that arbitration shall not apply to, and the arbitrator shall have no authority to conduct arbitration or to issue a decision with respect to, any class arbitration or other claim brought by Provider on behalf of the general public under a statute or regulation that allows an individual to sue on behalf of the Attorney General or other federal, state or municipal actor, or in any other representative capacity, or to any claims of medical malpractice, breach of privacy or HIPAA obligations, or intellectual property claims.

8.3 **Limitation of Actions.** A demand for arbitration pursuant to Section 8.2 must be filed within three hundred sixty-five (365) days of the date of the final appeal decision in the Appeal Process or the Final Claims Overpayment Determination, as applicable, notwithstanding any other communication between the parties that may take place, or payment(s) that may be made, subsequent to the final appeal decision in the Appeal Process or the Final Claims Overpayment Determination, as applicable, related to the lack of action or alleged breach that is the subject of the dispute. A demand for arbitration pursuant to Section 8.4 must be filed within three hundred sixty-five (365) days of the date the dispute arose, notwithstanding any meet and confer or other communication between the parties that may take place related to the dispute. Should the aggrieved party fail to file a demand for arbitration of the dispute within the timeframes set forth herein, the aggrieved party shall have waived its rights and remedies with respect to the dispute and any alleged breach, it shall have no right to pursue any remedy with respect to such dispute and alleged breach, including, without limitation, initiation of any arbitration or civil action in state or federal court, and, if the aggrieved party is Provider, Provider shall have no right to pursue payment of any disputed amounts from the Member. Pursuit by Provider of a dispute through the applicable process described in this Article XI shall neither modify nor relieve Provider of any obligations to continue providing services to Members in compliance with all terms of this Agreement.

In the event Provider, intentionally or unintentionally, initiates a demand for arbitration pursuant to Section 8.2 of this Agreement regarding the alleged underpayment of a claim

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

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

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

(b) Blue Shield and Provider shall meet and confer in good faith to resolve the dispute within no more than sixty (60) days following the date of the receiving party's documented receipt of the dispute notice. In order for a meet and confer to satisfy the requirement set forth herein, an actual meeting must take place between employees of the parties, each of whom has the authority to resolve the dispute. The meet and confer may occur either in person, on the telephone, or through other electronic means that enable each of the participants to hear the other participants, as mutually agreed. The meet and confer meeting and all related communications between the parties, and any documents prepared or collected in connection with, or exchanged as part of the meet and confer process shall be treated as confidential protected compromise and settlement negotiations subject to applicable State law. The parties further acknowledge that the meet and confer requirement is intended to achieve an informal resolution to disputes between parties with an ongoing business relationship. Therefore, unless otherwise mutually agreed by the parties in advance of the meet and confer, neither party is allowed to have legal counsel present at the meeting or to substitute legal counsel for the party's employee(s) attending the meet and confer. If Provider and Blue Shield are unable to reach agreement and resolve the dispute through the meet and confer process required under this Section 8.4, then either party can initiate the demand for arbitration as

permitted by Section 8.2, subject to Section 8.3 of this Agreement.

## IX. GENERAL PROVISIONS

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

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

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

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

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

Shield are unable to resolve Provider's objection(s) to the parties' mutual satisfaction within thirty (30) days of Provider's notice, then, within sixty (60) days of Provider's notice, Provider may elect to terminate this Agreement upon ninety (90) days' prior written notice to Blue Shield. Unless Provider so terminates this Agreement, such Legally Required Amendment shall be deemed accepted by Provider and an amendment to this Agreement.

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

9.7 **Assignment and Subcontracting.** Neither party shall assign, transfer, or subcontract any of its rights, interests, duties, or obligations under this Agreement, whether by sale, assignment, negotiation, pledge or otherwise, without the prior written consent of the other party. Without limiting the foregoing, the following events shall constitute an assignment of this Agreement for purposes of this Section 9.7: (a) the sale, transfer or other disposition of all or substantially all of the issued and outstanding voting securities or interests of Provider or Provider's direct or indirect corporate parent; (b) the merger, consolidation or other reorganization of Provider if, immediately following such transaction, either Provider or its member(s) shareholders or other equity holders (as existing immediately preceding such transaction) do not own a majority of all classes of the issued and outstanding membership interests or voting securities of the surviving, consolidated or reorganized entity; and (c) the issuance of any class of voting securities or interests by Provider (or its successor) if, immediately following such transaction, Provider's shareholders or other equity holders existing immediately preceding such issuance do not own a majority of all classes of the issued and outstanding voting securities or interests of Provider. Subject to the foregoing, this Agreement shall be binding on and shall inure to the benefit of the parties and their respective heirs, successors, assigns and representatives.

9.8 **Directory and Use of Names.** Blue Shield maintains a directory of Blue Shield Providers participating in Blue Shield that is made available to Members. Provider agrees that the following information may be included in Blue Shield's marketing materials, Blue Shield publications provided to current or potential Members and subscriber groups, and in other written or electronic information sources: (a) Provider's name, practice location or locations, and contact information, including open and closed panel status for PCPs; (b) type of practitioner; (c) National Provider Identifier number; (d) California license number and type of license; (e) area of specialty, including board certification, if any; (f) Provider's office email address, if available; (g) For physicians, surgeons, and podiatrists, the admitting privileges, if any, at hospitals contracted with the insurer; and (h) such other types of information regarding

Provider that are reasonable to include in directories, marketing materials, or publications. The Plans shall maintain said directory pursuant to state and federal law, including, but not limited to, Section 116 of the Consolidated Appropriations Act of 2021, Health and Safety Code 1367.27 and 42 C.F.R. Section 438.10. Blue Shield may engage a vendor or vendors that performs some or most of Blue Shield's provider directory maintenance tasks of behalf of Blue Shield ("Directory Vendor"). Blue Shield shall identify any such Directory Vendor to Provider and, throughout the term of this Agreement, Provider shall maintain a participation agreement with such Directory Vendor to facilitate exchange of directory data about Provider. With respect to provisions of this Agreement pertaining to Blue Shield's provider directory, Provider shall be equally obligated to respond and otherwise cooperate with either Directory Vendor or Blue Shield itself, as Blue Shield directs. Provider may identify himself/herself/itself as a participating/contracting provider with Blue Shield in all Benefit Programs and Tiered/Narrow Products in which he/she/it participates.

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

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

available to the parties for notices or communications required or permitted under this Agreement.

9.11 **Other Payors.** Blue Shield may contract with employers, insurance companies, associations, health and welfare trusts or other organizations to provide administrative services for plans provided by those entities which are not underwritten by Blue Shield. In addition, Blue Shield may extend this Agreement to managed care arrangements established by Blue Shield subsidiaries, or by persons or entities utilizing the Managed Care Network which Blue Shield has established pursuant to agreements with CareTrust Networks and Blue Shield of California Life & Health Insurance Company. All such entities shall be referred to as **"Other Payors"**. Blue Shield shall require that: (a) the health programs of Other Payors include provisions to encourage the use of Blue Shield contracting providers, and (b) Other Payors comply with performance standards relating to timely processing of claims which meet or exceed the time requirements set forth in California law. Provider agrees that, if Blue Shield is not the underwriter of the health plan for the Other Payor, Provider shall look solely to Other Payor for payment for services. The identity of Other Payors shall be disclosed in the Provider Manual. If, despite reasonable efforts, Provider is unable to obtain appropriate payment from an Other Payor, Provider may notify Blue Shield and Blue Shield shall undertake reasonable efforts to assist Provider in obtaining proper payment. If, within fifteen (15) days following notification to Blue Shield, Provider still has not obtained payment from the Other Payor, then Provider may immediately terminate this Agreement.

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

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

9.14 **Free Exchange of Information.** No provision of this Agreement shall be construed to prohibit, nor shall any provision in any contract between Provider and its employees or

subcontractors prohibit, the free, open and unrestricted exchange of any and all information of any kind between health care providers and Members regarding the nature of the Member's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Member's health plan, and the Member's right to appeal any adverse decision made by Provider or Blue Shield regarding coverage of treatment which has been recommended or rendered. Moreover, Provider shall not be penalized nor sanctioned in any way for engaging in such free, open and unrestricted communication with a Member nor for advocating for a particular service on a Member's behalf.

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

9.16 **Counterparts**. This Agreement may be executed in one or more counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

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

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

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

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

(d) No Gag Clauses; Compliance with Transparency Requirements. Nothing in this Agreement may be construed to restrict Blue Shield from disclosing information

required by applicable state or federal law or regulation including, without limitation, the federal Transparency in Coverage Rule, the federal Consolidated Appropriations Act of 2021, and, where applicable, the implementing regulations thereof, including without limitation 26 C.F.R Section 54.9815-2715A2; 26 C.F.R Section 54.9815-2715A3; 29 C.F.R. Section 2590.715-2715A2; 29 C.F.R. Section 2590.715-2715A3; 45 C.F.R. Section 147.211; and 45 C.F.R. Section 147.212, as they may be amended from time to time. Without limiting the foregoing, nothing in this Agreement or otherwise shall directly or indirectly restrict Blue Shield, or group health plans Blue Shield insures or administers with respect to their applicable Members, from:

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

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

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

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

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

agrees to be bound by the same prohibitions set forth herein with respect to such practitioners.

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

**BLUE SHIELD OF CALIFORNIA**

Signature: _____

Print Name: Patty Gonzalez

Title: Vice President, Provider Partnerships and Network Management

Date: _____

**TEHAMA COUNTY HEALTH SERVICES**

Signature: Jayme S Bottke

Print Name: Jayme S. Bottke

Title: Executive Director

Date: 5-8-25

blue of california

**EXHIBIT A**
**Independent Provider Agreement**

**PROVIDER INFORMATION**

| | |
|---|---|
| Tehama County Health Services Agency Clinic | |
| Provider Name | License number (if individual) |
| | TIN: 94-6000543 NPI:1043427388 |
| License Type (if individual) | IRS (TIN) and NPI Number |
| Type of Service Provided (e.g., pediatric/infertility/multi-specialty | |

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

**1.**

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

***OR***

**2.**

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

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

☒ Commercial PPO/EPO (Blue Shield Network A)
☒ Commercial PPO/EPO (Blue Shield Network B)
☒ Commercial PPO/EPO (Blue Shield Network C)
☒ Medicare Advantage PPO
☒ Commercial HMO
☒ Medicare Advantage HMO

Addresses for Notice:

If to Blue Shield:

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

If to Provider:

| **PROVIDER** | | | |
|---|---|---|---|
| *Name of Provider* | Tehama County Health Services Agency | | |
| *Address Line 1* | Po Box 400 | | |
| *Address Line 2* | | | |
| *City, State, Zip* | Red Bluff, CA 96080 | | |
| *Title* | Clinic Director | | |
| *Phone Number* | 530-527-8491 ext. 3563 | *Fax Number* | 530-529-3881 |
| *Practice Email Address* | Laura.Fierce@tchsa.net | | |

**EXHIBIT B**
**Independent Provider Agreement**

**COMPENSATION RATES**

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

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

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

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

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

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

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

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

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

(e) Commercial HMO:

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

(f) Medicare Advantage:

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

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

**EXHIBIT C**
**Independent Provider Agreement**

**MEDICARE ADVANTAGE REGULATORY EXHIBIT**

This Exhibit C sets forth the requirements established by CMS, in addition to those set forth elsewhere in the Agreement, applicable to the Covered Services provided by the contracting entity named in the Agreement (["Party Type"] or "Provider") and its Downstream Entities to the extent Provider is supporting Medicare Advantage Benefit Programs and Prescription Drug Plans on behalf of Blue Shield. Unless otherwise provided in this Exhibit C or in the Agreement, capitalized terms have the same meaning as set forth in 42 C.F.R. Part 422. In the event of a conflict between this Exhibit C and the remainder of the Agreement, this Exhibit C shall govern.

**1. Interpretation and relationship to the Agreement**

i. **Conflicts.** To the extent there is a conflict between the terms of this Exhibit C and any terms of the Agreement, the terms of this Exhibit C shall govern with regard to Medicare Advantage Benefit Programs. Otherwise, the provisions of the Agreement also apply with regard to Medicare Advantage Benefit Programs.

**ii.** **Interpretation.** The terms of the Agreement, as amended herein, as they relate to Medicare Advantage Benefit Programs, shall be interpreted in a manner consistent with applicable requirements under Medicare law.

**2. Compliance with CMS Agreement.** Provider shall perform Covered Services and other obligations under the Agreement and this Exhibit C in a manner that is consistent and compliant with Blue Shield's contract with CMS to act as a Medicare Advantage Organization ("***CMS Agreement***"). A copy of the CMS Agreement shall be made available to Provider upon request. Provider shall comply with applicable Laws and Regulations. Without limiting the above, Provider shall comply with Laws and Regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. § 3729 et. seq.) and the Anti-Kickback Statute (Section 1128B(b) of the Social Security Act); and Health Insurance Portability and Accountability Act of 1996 as amended ("HIPAA") administrative simplification rules at 45 C.F.R. Parts 160, 162, and 164. Additionally, Provider agrees to comply with Blue Shield's policies and procedures related to its Medicare Advantage Benefit Programs. Blue Shield shall monitor the parties' performance under the Agreement on an ongoing basis. **42 C.F.R. 422.504(i)(3)(iii); 42 C.F.R. § 422.504(h); 42 C.F.R. 422.504(i)(4)(iii).**

**3. Downstream Entities.** Provider shall ensure that Provider's Downstream Entities agree in writing to comply with all applicable provisions of the Agreement and this Exhibit C pursuant to 42 C.F.R.422.504(i)(4)(v). For purposes of this Exhibit C, a Downstream Entity is any person or entity that Provider has entered into a written arrangement with that is involved with the Medicare Advantage Benefit Program.

**4.** **Access to Records.** Provider shall permit the Department of Health and Human Services ("DHHS"), the Comptroller General, or their designees to audit, evaluate, collect, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of Provider related to the CMS Agreement (collectively, the "***Records***"). Provider agrees to make available its premises, physical facilities and equipment, records relating to Medicare Advantage Members, and any additional relevant information that CMS may require. The right of DHHS, the Comptroller General, or their designees to inspect, evaluate, and audit the Records for any particular contract period under the CMS Agreement shall exist for a period of ten (10) years from the later of (i) the final date of the contract period for the CMS Agreement, or (ii) the date of completion of any audit (the "***Audit Period***"). Provider shall keep and maintain accurate and complete Records throughout the term of the Agreement and the Audit Period. Provider further agrees that DHHS, the Comptroller General or their designees have the right to audit, evaluate, collect, and inspect any Records directly from Provider. **42 C.F.R. §§ 422.504(d)-(e); 422.504(h)(2); 422.504(i)(2)(i) and (ii).**

**5.** **Delegated Activities.** To the extent activities or responsibilities of Blue Shield under the CMS Agreement are delegated to Provider pursuant to the Agreement ("***Delegated Activities***"), Provider agrees that (i) this Agreement shall specify the Delegated Activities and required reporting requirements; (ii) the performance of the Delegated Activities and responsibilities thereof shall be subject to monitoring on an ongoing basis by Blue Shield; and (iii) in the event that Blue Shield or CMS determines that Provider has not satisfactorily performed any Delegated Activity or responsibility, then Blue Shield shall have the right, at any time, to revoke the Delegated Activities by terminating the Agreement in whole or in part, and Blue Shield shall have the right to institute corrective action plans or seek other remedies or curative measures as contemplated by the Agreement. Provider shall not further delegate any activities or requirements without the prior written consent of Blue Shield. **42 C.F.R. §§ 422.504(i)(4)(ii)-(iii).**

**6.** **Oversight and Accountability.** Provider acknowledges that Blue Shield shall oversee and monitor Provider's performance on an ongoing basis. Provider further acknowledges that Blue Shield is accountable to CMS for the functions and responsibilities described in the CMS Agreement and regulatory standards.

**7.** **Member Health Records.** Provider will comply with Blue Shield's confidentiality and Medicare Advantage Member record accuracy requirements, including: (i) abiding by all Laws and Regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information, (ii) ensuring that medical information is released only in accordance with applicable Laws and Regulations, or pursuant to court orders or subpoenas, including, but not limited to, HIPAA and all rules and regulations promulgated thereunder, (iii) maintaining the records and information in an accurate and timely manner, and (iv) ensuring that Medicare Advantage Members have timely access to the records and information that pertain to them. **42 C.F.R. § 422.118 42 C.F.R. § 422.504(a)(13).**

**8.** **Confidentiality.** Provider agrees to comply with all applicable Laws and Regulations

regarding confidentiality, privacy and security of member information. Provider further agrees that all information about a Medicare Advantage Member shall be treated as confidential so as to comply with all applicable Laws and Regulations and applicable court decisions, including, but not limited to, HIPAA, and all rules and regulations promulgated thereunder. In addition, Provider agrees to abide by the confidentiality requirements established by Blue Shield and the Medicare Advantage program as set forth at 42 CFR §422.118

**9.** **Hold Harmless.** Provider shall in no event, including, without limitation, non-payment by Blue Shield, insolvency of Blue Shield, or breach of this Agreement, bill, charge, collect a deposit from, seek compensation or remuneration from, or have any recourse against any Medicare Advantage Member or any person (other than Blue Shield) acting on behalf of any Medicare Advantage Member for Covered Services provided pursuant to this Agreement. Provider shall not hold a Medicare Advantage Member liable for, nor maintain any action at law or equity against a Medicare Advantage Member to collect sums that are the legal obligation of Blue Shield. Upon notice of any such action, Blue Shield may terminate this Agreement and take all other appropriate action consistent with the terms of this Agreement to eliminate such charges. Provider's obligations under this Section shall survive the termination of this Agreement with respect to Covered Services provided during or after the term of this Agreement. This Section 9 supersedes any oral or written contrary agreement between Provider and any Medicare Advantage Member or Medicare Advantage Member representative. **42 C.F.R. § 422.504(i)(3)(i); 42 C.F.R. § 422.504(g)(1)(i).**

**10.** **Excluded Individuals/Program Integrity.** Provider acknowledges and agrees that it is not excluded and shall not employ or contract for the provision of services pursuant to this Agreement with any individual or entity (hereafter, "Excluded Person") whom Provider knows is excluded from participation in the Medicare or Medicaid programs under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such Excluded Person currently is employed by or under contract with Provider. Provider shall review the Office of Inspector List of Excluded Individuals and Entities and the System for Award Management exclusion list and verify on a monthly basis or as often as required by CMS guidelines, that individuals or entities it employs or contracts for the provision of Covered Services pursuant to this Agreement are in good standing. Provider shall promptly after discovery disclose to Blue Shield any exclusion, or other event that makes a Provider employee, contractor or Downstream Entity ineligible to perform work related to federal health care programs. **42 CFR § 422.752(a)(8).**

Provider agrees to be bound by the provisions set forth at 2 C.F.R. Part 376.

**11.** **Federal Funds.** Provider acknowledges that payments it receives from Blue Shield pursuant to this Agreement are, in whole or part, from Federal funds. Therefore, Provider and its Downstream Entities are subject to certain Laws and Regulations that are applicable to individuals and entities receiving Federal funds, which may include, but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with

Disabilities Act; the Rehabilitation Act of 1973; and any other regulations applicable to recipients of Federal funds. Provider also agrees to comply with applicable sections of Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of DHHS (45 CFR Part 92

**12.** **Compliance-Training, Education and Communications.** In accordance with, but not limited to 42 C.F.R. §§ 422.503(b)(4)(vi)(C), Provider agrees and certifies that its employees, Downstream Entities, and agents who provide services under this Agreement shall participate in applicable compliance training, education and/or communications as reasonably requested by Blue Shield or its designee annually or as otherwise required by applicable Laws and Regulations. Provider shall annually take the compliance training made available by CMS, and Blue Shield shall accept the certificate of completion of the CMS training as satisfaction of the training requirement.

**13.** **Offshore Subcontractors.** In no event shall Provider employ or contract with a person or entity pursuant to which Medicare Advantage Member Protected Health Information will be sent or accessed offshore without the prior written consent of Blue Shield. For purposes of this Section 13, "*offshore*" refers to outside the fifty United States, the District of Columbia, and the United States territories (*i.e.*, American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands).

**14.** **Compliance Reporting.** Provider shall report to Blue Shield any suspected or actual violations of this Exhibit C, or any applicable Laws and Regulations, committed by Provider or Provider's employees, contractor, Downstream Entities, or agents who provide services under this Agreement. Provider shall report such suspected or actual violations as promptly as reasonably practical and in no event later than seventy-two (72) hours after discovery. Provider shall have a no-tolerance policy for retaliation or retribution for good faith reporting of suspected or actual Medicare Advantage Benefit Program compliance violations. Provider shall publicize the non-compliance reporting methods and its non-retaliation policy to its employees, contractors, Downstream Entities, and agents who provide services under this Agreement.

**15.** **Marketing Activities.** Provider shall comply with all applicable provisions of Subpart V of 42 C.F.R. Part 422, CMS' Medicare Marketing Guidelines then in effect for the particular contract year, which are published annually, and the following in regards to the marketing activities it performs on behalf of Medicare Advantage Benefit Programs:

(a) Provider shall only use marketing materials that Blue Shield has represented have been approved by or deemed approved by CMS. Provider shall ensure that any social media posts, Member Advantage Member-facing websites, or mobile apps that Provider uses to market Medicare Advantage Benefit Programs have been approved by or deemed approved by CMS, to the extent required by the Medicare Marketing Guidelines. All marketing and advertising materials must be submitted to Blue Shield's Medicare Compliance department for review and approval.

(b) Provider shall only develop and use marketing materials that meet CMS requirements in regards to font size, references to studies/data and star ratings, product testimonials, references to hours of operation, the appearance of a TTY number, and the appearance of disclaimers. Marketing materials shall not be materially inaccurate or misleading, shall not claim that Medicare Advantage Benefit Programs are recommended or endorsed by CMS, DHHS, or Medicare, and shall not include any other statements that CMS prohibits from appearing in marketing materials.

(c) Provider shall not market a plan year's Medicare Advantage Benefit Program to Medicare Advantage Members or potential Medicare Advantage members prior to October 1 of the preceding year.

(d) Provider shall not discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability or geographic location. Provider shall not target potential Medicare Advantage Members from higher income areas or state or imply that Medicare Advantage Benefit Programs are only available to seniors rather than to all Medicare beneficiaries.

(e) Provider's call centers shall abide by CMS call center requirements. Provider shall only use sales and enrollment scripts that have been approved by or deemed approved by CMS. Provider's informational, sales, and enrollment scripts shall comply with CMS requirements.

(f) Provider shall ensure that its sales agents are licensed and appointed with Blue Shield in accordance with CMS requirements and applicable Laws and Regulations. Provider shall ensure that its sales agents are trained on Medicare marketing rules and tested annually on those rules prior to those agents selling Medicare Advantage Benefit Programs.

(g) Provider shall ensure that the compensation paid to its sales agents complies with applicable agent compensation requirements.

(h) Provider shall not market through unsolicited direct contact, including by sending unsolicited text messages or email communications to Medicare Advantage Members or prospective Medicare Advantage members.

**16.** **Credentialing.** If Provider is delegated for credentialing and recredentialing, Provider shall credential its physicians and other licensed professionals who provide services to Medicare Advantage Members under this Agreement. Provider agrees to comply with all aspects of the Blue Shield's credentialing and recredentialing policies and procedures and all applicable Medicare Advantage credentialing requirements. Provider agrees that the credentialing process will be reviewed and approved by Blue Shield and that Blue Shield will audit the credentialing process on an ongoing basis.

**17.** **Physician Selection.** Provider agrees that if Blue Shield delegates the selection of

providers, contractors, or subcontractor to Provider, Blue Shield retains the right to approve, suspend, or terminate any such arrangement.

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