CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
BEHAVORIAL HEALTH CARE PROFESSIONAL SERVICES AGREEMENT

County of Monterey,

on behalf of its Health Department,

Clinic Services Bureau

Central California Alliance for Health
Behavioral Health Care Professional Services Agreement

RECITALS

This Behavioral Health Care Professional Services Agreement ("Agreement") is made and entered into as of the Commencement Date specified herein, by and between Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission, a California public entity, operating as Central California Alliance for Health ("Plan"), and the County of Monterey, on behalf of its Health Department, Clinic Services Bureau, a political subdivision of the State of California ("Provider"), with reference to the following facts:

WHEREAS, Plan has entered into or will enter into a contract or contracts with the State of California Department of Health Care Services ("DHCS") or other entities under which the Plan has agreed to arrange for the provision of health care services and benefits to eligible Santa Cruz, Monterey, Merced, San Benito, and Mariposa County Medi-Cal beneficiaries or other covered individuals under the programs identified in Exhibit A hereto.

WHEREAS, Provider desires to participate in Plan's network of contracting providers by providing Covered Services, including Behavioral Health Services, to Members.

NOW THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the parties hereto agree as follows:

ARTICLE I.
DEFINITIONS

Whenever used in this Agreement, the following terms shall have the definitions contained in this Article I. Terms used in this Agreement which are defined by Law shall be interpreted consistent with such Laws.

1.1. Accreditation Organization. Accreditation Organization means any organization engaged in accrediting or certifying Plan or Providers.

1.2. Behavioral Health Services. Behavioral Health Services for the purposes of this contract, encompasses both Behavioral Health Treatment and Mental Health Services as defined in this Agreement.

1.3. Behavioral Health Provider(s). Behavioral Health Provider means any of the following types of individuals that may provide Behavioral Health services: (i) duly licensed professionals as defined in the Medi-Cal Provider Manual, as defined in the Psychological Services section of the Provider Manual, who are licensed or registered in the State of California; (ii) individuals as defined in the Medi-Cal Provider Manual, as defined in the Psychological Services section of the Medi-Cal Provider Manual, that possess a professional licensing waiver from the California Department of Health Care Services; (iii) Qualified autism service providers, professionals or paraprofessionals as described in Health & Safety Code Section 1374.73 (c)(3), (4), (5).

1.4. Behavioral Health Treatment or "BHT". Behavioral Health Treatment means services such as applied behavioral analysis and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without autism spectrum disorder.

1.5. Case Management. Case Management refers to case management activities provided by Plan to help Members with coordination of care, navigating the healthcare system and/or assist with referrals to State programs, community-based resources, and long-term services and supports.

1.6. Complete Claim. Complete Claim shall have the meaning set forth in Title 28 of the California Code of Regulations, Section 1300.71(a)(2).

1.7. Commencement Date. Commencement Date is the date this Agreement becomes effective, as specified in Section 5.1.

1.8. Covered Services. Covered Services are those Medically Necessary health care services, supplies and benefits which are required by a Member pursuant to the coverage provisions of a Program, as further specified in the Program Requirements and in the applicable Member Group Contracts and Membership Contracts. References to Covered Services in this Agreement include Behavioral Health Services.

1.9. Covered Services Documentation. Covered Services Documentation means documentation developed by Participating Providers to support the Covered Services, including Behavioral Health Services, provided hereunder, including, without limitation, claims for payment, discharge summaries, medical records, emergency visit records and diagnostic reports.

1.10. DHCS. DHCS is the State of California Department of Health Care Services, the agency responsible for administering the Medi-Cal program in California.

1.11. Emergency Services. Emergency Services are health care services furnished by a qualified provider and needed to evaluate or stabilize a medical condition, including a psychiatric emergency medical condition (as defined in California Health and Safety Code Section 1317.1(k)(1)), which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (i) placing the health of Member (or in the case of a pregnant Member, the health of the Member or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

1.12. Fiscal Year. Fiscal Year of Plan shall mean each twelve (12) month period beginning January 1st and ending December 31st.

1.13. Law. Law means any and all laws and regulations of the State of California or of the United States and all orders, including instructions, guidance, and other requirements of any government agency which are applicable to this Agreement.

1.14. Medi-Cal Provider Manual. Medi-Cal Provider Manual means the DHCS provider manual.

1.15. Medically Necessary. Medically Necessary means, unless otherwise defined in a Membership Contract, Program Requirement or by Law, or Exhibit D for the In-Home Supportive Services ("IHSS") Program: For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (which includes other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan).

1.16. Member. Member is an individual who is enrolled in a Program and who is determined to be eligible for membership in the applicable Program as of the date of service.

1.17. Member Group Contract(s). Member Group Contract(s) refers to the contracts between the Plan and various government agencies, including the State Medi-Cal Contract, as amended from time to time, under which the Plan has agreed to arrange for the provision of Covered Services to Members.

1.18. Member Payment. Member Payment means an amount (whether expressed as either a percentage of cost or as a specific dollar amount) that a Member is obligated to pay directly to a Participating Provider for a

specific service in accordance with the Program under which he or she is covered and in accordance with any applicable Membership Contract. Member Payments shall include, but not be limited to, those payments commonly referred to as "coinsurance," "copayments," and/or "deductibles."

1.19. Membership Contract(s). Membership Contract(s) refers to the evidences of coverage or member handbooks, as amended from time to time, that the Plan issues to its Members and that include complete descriptions of the terms, conditions and benefits available to Members under applicable Programs.

1.20. Mental Health Emergency. Mental Health Emergency means when the member due to a mental health condition is a current danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient or psychiatric health facility services.

1.21. Mental Health Services. Mental Health Services means assessment, diagnosis, treatment or counseling in a professional relationship to assist an individual or group in alleviating mental or emotional illness, symptoms, conditions or disorders.

1.22. Non-Covered Behavioral Health Services. Non-Covered Behavioral Health Services means those health care services which are not covered Behavioral Health services or are not Medically Necessary services.

1.23. Participating Provider(s). Participating Providers are physicians, medical groups, IPAs, health care professionals, hospitals, facilities and other providers of health care services or supplies that have entered into written contracts directly or indirectly with Plan to provide Covered Services to Members pursuant to a Program.

1.24. Primary Care Physician ("PCP"). PCP is a Participating Provider who supervises, coordinates and provides initial and basic care to certain Members assigned or linked to such PCP. PCP must meet Plan's criteria for participation as a PCP. If the PCP is a physician (Medi-Cal Members may select a Federally Qualified Health Center as their PCP), they must be physicians practicing in the fields of general medicine, internal medicine, family practice, pediatrics, or obstetrics and gynecology, or another specialty approved by Plan and DHCS.

1.25. Program. Program means any health care plan for the provision of Covered Services as more fully described in the Exhibits hereto, the Provider Manual, and any applicable Membership Contract(s), as each may be amended from time to time. The specific Program(s) under which Provider renders Covered Services are set forth on the Schedule of Programs attached as Exhibit A hereto, as may be amended from time to time.

1.26. Program Requirements. Program Requirements are those requirements as established under Law and through any Member Group Contracts and Membership Contracts applicable to specific Programs as summarized in the Exhibits hereto.

1.27. Provider Manual. Provider Manual means that document or series of documents created, maintained, updated and distributed from time to time by Plan that describes the Plan's policies and procedures and provides administrative and Program Requirements for Provider. The Provider Manual is incorporated into this Agreement and made a part hereof.

1.28. Provider Professional(s). Provider Professional(s) are Participating Providers who are licensed professionals, as applicable, and who are shareholders or partners of, employed by or contract with Provider to deliver Covered Services hereunder. Provider Professionals must meet Plan's criteria for participation as a Participating Provider. References to Provider hereunder shall include Provider and its Provider Professionals.

1.29. Quality Management and Improvement ("QI") Program. The QI Program consists of those standards, protocols, policies and procedures adopted by Plan and/or DHCS designed to monitor and improve the quality of clinical care and quality of services provided to Members. A summary of the QI Program is included in the Provider Manual, which may be updated from time to time by Plan.

1.30. Self-Referral Services. Self-Referral Services are those Covered Services, including Emergency Services, that Members may access without a referral as set forth for each Program in the Membership Contracts and Provider Manual. Self-Referral Services are subject to the Plan's UM Program.

1.31. Utilization Management ("UM") Program. The UM Program consists of those standards, protocols, policies and procedures adopted by Plan regarding the management, review and approval of the provision of Covered Services to Members. The UM Program is included in the Provider Manual, which may be updated from time to time by Plan.

1.32. California Children Services Program ("CCS Program"). CCS Program means the program described under California Health and Safety Code section 123800, et seq., and Title 22 of the California Code of Regulations, section 51013, et seq.

1.33. California Children Services ("CCS Services"). CCS Services are Covered Services under the CCS program, that are provided to Medi-Cal Members in accordance with CCS program guidelines (including provider enrollment requirements), and the Provider Manual.

1.34. Substance Use Disorder Services ("MH/SUD"). Substance Use Disorder Services for the IHSS Program are defined in Exhibit D and Exhibit L.

ARTICLE II.
DUTIES OF PROVIDER

2.1. Behavioral Health Care Professional Services. Provider shall provide Behavioral Health Services, in accordance with the terms and conditions set forth in this Agreement, the Provider Manual, the Plan's QI and UM Programs, the applicable Program Requirements, applicable Accreditation Organization standards and the Law. Provider shall verify a Member's eligibility with Plan prior to rendering services other than Emergency Services. Provider shall comply with prospective, concurrent and post-service review requirements as specified in the UM Program. Provider shall ensure that Covered Services that are Behavioral Health Services provided under this Agreement are readily available, accessible, appropriate, and provided in a prompt and efficient manner as required by applicable Law. Provider shall provide the Behavioral Health Services described in the Behavioral Health Services schedule set forth in Exhibit J, Exhibit K, and Exhibit L hereto. [Citation: DHCS APL 19-001 Item 1; Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 13.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867; (and any updated section numbers if amended in the future.)]

2.2 Covered Behavioral Health Services and Excluded Services. Covered Behavioral Health Services are identified in Exhibit E, Medicare Advantage, Dual Eligible Special Needs Plan (D-SNP) Program Requirements for D-SNP Members, Exhibit J, Scope of Behavioral Health Treatment Services and Exhibit K, Scope of Mental Health Services for Medi-Cal Members, Exhibit L Mental Health or Substance Use Disorder Services ("MH/SUD") for IHSS Members, Plan's Member Contract, and in the Provider Manual. References to Covered Services within this Agreement include Covered Behavioral Health Services.

Excluded services for the Medi-Cal Program include, but are not limited to: specialty Mental Health Services including psychiatric crisis and inpatient services and residential treatment services, as well as, residential and outpatient services for alcohol and drug abuse that are managed by the alcohol and drug misuse services department for the applicable county. Additional information on Covered Behavioral Health Services and services that are excluded may be found in the Provider Manual.

2.3. Professional Standards. A primary concern of Provider shall be the quality of Covered Services provided to Members. All Covered Services provided by Provider shall be provided by duly licensed, certified or otherwise authorized professional personnel in accordance with (i) the generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment, (ii) Plan's QI and UM Programs, (iii) applicable rules and regulations of California state licensing boards, (iv) Law, and (v) the standards of Accreditation Organizations.

2.3.1. Licensure of Provider. Provider shall maintain in good standing at all times, and ensure that any and all professionals that provide or assist Provider in the provision of Covered Services hereunder maintain in good standing at all times, any and all licenses, certificates, and/or approvals required under Law and by the Plan.

2.3.2. No Conflicts. Provider is not subject to any agreements or obligations that would interfere with Provider's ability to enter into or perform its obligations under this Agreement in accordance with its terms.

2.3.3. Credentialing. Provider and its Provider Professionals shall meet Plan's credentialing standards as specified in the Provider Manual and must be approved by the Plan before providing Covered Services (other than Emergency Services) to Members. Provider shall respond to requests from Plan for credentialing information. Failure to timely respond to such requests shall be grounds for termination pursuant to Section 5.2 hereto.

2.3.3.1. Provider and Provider Professionals are required to complete screening and enrollment pursuant to DHCS guidelines.

2.3.4. Right to Withdraw. Plan reserves the right to immediately withdraw from Provider any or all Members in the event that Plan determines that the health or safety of Members is endangered by the actions of Provider or if Provider ceases to maintain required licenses, hospital privileges, or ceases to meet Plan's credentialing criteria. For clarity, since references to Provider include Provider and its Provider Professionals, this means that under this provision, Plan may alternatively withdraw Members from individual Provider Professionals.

2.3.5. Change in Status or Information. Provider shall immediately notify Plan in writing of any change in licensure or hospital privilege status, any change in information provided to Plan through the credentialing process, the filing of any disciplinary action by a state licensing board against Provider, the filing of any criminal or medical malpractice lawsuit naming Provider, and any change in address or practice status.

2.4. Access and Availability. Provider shall comply with the access and availability requirements and conditions for each applicable Program as required by Law and as further delineated in the Provider Manual, including but not limited to, prompt scheduling of appointments and availability of Behavioral Health Services.

2.4.1. Acceptance of New Patients. Provider shall notify Plan within five business days when any of the following occur: (A) Provider or any of its Provider Professionals are not accepting new patients, (B) if Provider or any of its Provider Professionals had previously not accepted new patients, that Provider or such Provider Professionals are now currently accepting new patients. Notification under this section shall be provided in a manner approved by Plan or (C) any of the information in Plan's Provider Directory with respect to Provider or any of its Participating Providers or Provider Professionals has changed.

2.5. Acceptance and Transfer of Members. Provider may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients. Provider shall not request or demand the transfer, discharge, or removal of any Member for reasons of the Member's need for, or utilization of, Covered Services, except in accordance with the procedures established by Plan for such action. Provider shall not request or demand the transfer, discharge or removal of any Member while the Member is hospitalized or is in the middle of a course of treatment and Plan has determined that interruption of care would be detrimental to the health of the Member.

2.6. Medical Records. Provider shall maintain all patient medical records relating to Covered Services provided to Members, in such form and containing such information as required by the Provider Manual, QI and UM Programs, Accreditation Organizations, and Law. Medical records shall be maintained in a manner that is current, detailed, organized, and permits effective patient care and quality review by Provider and Plan

pursuant to the QI Program. Medical records shall be maintained in a form and physical location which is accessible to Provider, Plan, government agencies and Accreditation Organizations. Upon request and within the timeframe requested, Provider shall provide to Plan, at Provider's expense, copies of Member medical records for purposes of conducting quality assurance, case management and utilization review, credentialing and peer review, claims processing, verification and payment, resolving Member grievances and appeals, and other activities reasonably necessary for the proper administration of the applicable Program consistent with Law. The provisions of this Section shall survive termination of this Agreement for the period of time required by Law.

2.7. Insurance. Provider shall maintain professional and general liability insurance in the minimum amounts required by Law but not less than one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) aggregate, to apply separately for each Provider Professional who is insured under the policy (or policies) and for a period of seven (7) years following termination. In the event Provider procures a "claims made" policy as distinguished from an occurrence policy, Provider shall procure and maintain prior to termination of such insurance, continuing tail or extended reporting coverage for a period of not less than seven (7) years following such termination or expiration of this Agreement.

Provider, at its sole cost and expense, shall also maintain throughout the term of this Agreement, workers' compensation insurance, with minimum limits as required by Law, and Employer's Liability insurance (if applicable) with the following minimum limits: (1) Bodily Injury by accident: $1,000,000 each accident; (2) Bodily Injury by disease: $1,000,000 each employee; and (3) Bodily Injury by disease: $1,000,000 policy limit.

All insurance required of Provider under this Agreement shall be provided by insurers licensed to do business in the State of California and who have obtained an A.M. Best financial strength rating of A- or better and are classified by A.M. Best as being of financial size category VIII or greater. Provider may substitute comparable self-insurance coverage for the insurance coverage required by this Section only upon the prior written approval of Plan.

A certificate of insurance shall be issued to Plan prior to the Commencement Date and upon each renewal of the insurance coverage specified in this Section. The certificate shall provide that Plan shall receive thirty (30) days prior written notice of cancellation or material reduction in the insurance coverage specified in this Section. Notwithstanding anything to the contrary, if Provider has a claims-made based policy and such policy (or policies) is cancelled or not renewed, Provider agrees to exercise any option contained in the policy (or policies) to extend the reporting period to the maximum period permitted; provided, however, that Provider need not exercise such option if the superseding insurer will accept all prior claims. Notwithstanding any other provision of this Agreement, Provider's failure to provide the certificate of insurance shall be grounds for immediate termination of this Agreement.

2.8. Notice of Charges. Provider shall notify Plan immediately of the issuance of any formal charges, disciplinary actions, or lawsuits against Provider or any professional delivering Covered Services on behalf of Provider by any governmental authority or licensing or Accreditation Organization. Provider shall further notify the Plan immediately of the initiation of any complaint, formal inquiry, investigation, or review with or by any licensing or regulatory authority, peer review organization, hospital committee, or other committee, organization or body which reviews quality of medical care in which complaint, inquiry, investigation, or review directly or indirectly, evaluates or focuses on the quality of care provided by Provider either in any specific instance or in general.

2.9. Administrative Requirements. Provider agrees to perform its duties under this Agreement in accordance with Plan's administrative guidelines, policies, and procedures as set forth in this Agreement, the Provider Manual, the Medi-Cal provider manual and Law. In the event of a conflict between this Agreement and the Provider Manual, the terms of this Agreement shall govern. In the event of a conflict between the Medi-Cal Provider Manual and either this Agreement or the Provider Manual, this Agreement or the Provider Manual, as applicable, will govern.

2.10. Data Requirements.

2.10.1. General Data and Information. Provider shall maintain and provide at no cost to Plan, upon written request, any and all information or data required by Plan, Law, government agencies, or Accreditation Organizations. Provider shall submit such information or data to Plan in the format and within the time periods specified by Plan. Provider shall allow Plan personnel reasonable on-site access to Provider records in connection with Plan's QI Program, UM Program or for other valid purposes. Provider shall accurately and completely maintain all information and data required by this Agreement, including medical records, necessary to characterize the scope and purpose of Covered Services provided to Members for the time period required by Law.

2.10.2. Covered Services Documentation. Upon reasonable request and as required by the Provider Manual, Provider shall provide Plan with Covered Services Documentation at no cost to Plan. Provider will utilize and cooperate with Plan reporting tools for Covered Services Documentation as set forth in the Provider Manual. All Covered Services Documentation shall be provided on a timely basis and shall be supported by information recorded in the applicable Member's medical chart. By signing this Agreement, Provider hereby attests to the accuracy, completeness, and truthfulness of all Covered Services Documentation provided pursuant to this Agreement. Provider shall provide additional attestations as requested by the Plan to support the accuracy, completeness, and truthfulness of the Covered Services Documentation.

2.11. Pharmaceuticals. If Provider is licensed to prescribe drugs and medications, Provider shall prescribe drugs and medications in accordance with all applicable Law, DHCS requirements, drug lists for Medi-Cal Members, and Plan's formulary for IHSS Members.

2.12. HIPAA Compliance. Provider represents and warrants that it is presently and shall remain at all relevant times compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). Provider represents and warrants with respect to all Protected Health Information ("PHI"), (as defined under 45 C.F.R. § 164.501), that it is a Covered Entity under 45 C.F.R. section 164.501 (and not a business associate of Plan), and that it shall use all appropriate safeguards to prevent the use or disclosure of PHI other than as allowed by Law.

2.13. Identification of CCS Eligible Conditions. Provider will comply with Plan's policies and procedures as described in the Provider Manual for the identification, referral and treatment of Members with suspected CCS-eligible conditions.

2.14. Training. Provider and its practitioners and staff shall participate in applicable training programs available through the Plan as required by any applicable Member Group Contract, DHCS guidance, or as required by the Plan to address any Plan policies and procedures. The Plan will notify Provider of any training program that must be completed pursuant to a Member Group Contract and the timeframe for completing (and providing verification of same) for such required training.

2.15. Non-disparagement. Provider will not at any time, publish or communicate to any person or entity or in any public forum any defamatory or disparaging remarks, comments or statements concerning the Plan.

ARTICLE III.
DUTIES OF PLAN

3.1. Plan Communications. Plan shall establish a system of Member identification, communicate the requirements of the Provider Manual to Participating Providers, and identify Participating Providers to Members. Plan shall be responsible for providing applicable notification to Members upon notification of termination of Provider.

3.2. Records. Plan shall maintain and furnish such records and documents as may be required by applicable Law, and shall create, maintain and transmit such records and documents in accordance with generally accepted industry standards and the requirements of applicable Laws.

3.3. Licensure. Plan shall maintain such licenses as are necessary for the performance of its obligations hereunder.

3.4. Limitations. Plan makes no representations or guarantees concerning the number of Members that will be referred to Provider or otherwise access services under this Agreement. Plan shall not be obligated to include Provider in all Participating Provider directories or in all Programs or to utilize or market Provider for all services available from Provider.

3.5. Continuation of Care. In the event this Agreement is terminated due to Plan's insolvency, Plan shall provide for continuation of Covered Services to Members for the duration of the period for which payment has been made by DHCS to Plan, as well as for inpatient admissions until discharge. Plan shall comply with its legal obligations to ensure continuity of care for its Members pursuant to California Law. Payment shall be made pursuant to Section 4.10 of this Agreement.

ARTICLE IV.
COMPENSATION

4.1. Submission of Claims. Provider agrees to submit to Plan all fee-for-service Complete Claims for Covered Services rendered to eligible Members. Complete Claims shall be submitted to the location described in the Provider Manual within one (1) year of the provision of Covered Services and in the format specified in the Provider Manual. Complete Claims will be paid within the timeframe required by Law as applicable to each Program. If Plan is the secondary payor, coordination of benefits claims may be submitted within one hundred eighty (180) days after the primary payor's date of payment or date of contest, denial, or notice, if such period is longer than one (1) year. Plan may deny payment for claims not submitted by Provider within the timeframe set forth above and in accordance with the billing procedures set forth in the Provider Manual. Provider agrees that Plan will be materially damaged by late claim submittals and agrees to waive any right to assert that it is entitled to payment for claims asserted beyond the time periods specified above, unless Provider submits a dispute pursuant to Section 6.5 and Plan determines that Provider has demonstrated good cause for delay.

4.2. Payment. Plan shall pay Provider for Covered Services rendered to eligible Members in accordance with the provisions of this Agreement, including Exhibit H hereto, and the Provider Manual. Provider agrees to accept such amounts paid by Plan, and any applicable Member Payment, as payment in full.

4.3. Adjustments to Payments. Only those charges for Covered Services billed in accordance with the Plan's claims coding standards will be payable. If Plan determines that services rendered are inappropriate or not Medically Necessary, coding practices do not comply with Plan standards, payment is not in accordance with the terms of this Agreement, or services were provided to a patient who was not an eligible Member as of the date of service, Plan may deny, reduce, or otherwise adjust payment to Provider. The Plan may also adjust payment rates as specified in Exhibit H for the following reasons:

Adjustments to Fee Schedules. In the event a government program (including, without limitation, the Medi-Cal Program, as defined in Exhibit B) revises a payment rate or a procedure or revenue code under a Program fee schedule pursuant to which payments are determined under this Agreement, Plan may, in order to ensure payment amounts consistent with the current fee schedule, adopt such adjustments in the same manner and on the same effective date as adopted by the government program.

4.3.1. Audit and Recovery. Plan, or the Plan's third-party designee, shall have the right to conduct periodic audits of all records maintained by the Provider with respect to all payments received by

Provider from Plan for Covered Services rendered to Members during the term of this Agreement. If an audit shows that the Plan has overpaid any claim or if Plan identifies an overpayment through any other process, Plan will send a written request for the reimbursement of the overpayment within one year (365 days) of the date of the claim overpayment as required by applicable Law, unless the overpayment was caused in whole or in part by Provider's fraud or misrepresentation, in which case Plan shall not be limited to 365 days. If Provider does not contest the Plan's request for reimbursement of the overpayment within thirty (30) days in writing or reimburse the Plan, the Plan may offset or recoup the amounts overpaid against amounts due and owing from Plan to Provider. If Provider contests a request for reimbursement, then Provider shall send a written notice to Plan stating the basis for which the claim was not overpaid and the matter shall be resolved in accordance with the Plan's provider dispute resolution process in Section 6.5 of this Agreement and the Provider Manual. This provision shall survive the termination of this Agreement.

4.4. Coordination of Benefits. Provider agrees to comply with the Plan's coordination of benefits ("COB") policies and procedures as specified in this Agreement, the Provider Manual, the Membership Contracts, and any applicable Law.

4.4.1. Member Screening. Provider agrees to screen each Member receiving Covered Services to determine if the Member has Medicare coverage or other health coverage, and agrees to provide such information to Plan upon request.

4.4.2. Plan is Primary. When Plan is primary under the Plan's coordination of benefits rules, Plan shall pay Provider, as set forth in this Agreement, the amount due for Covered Services rendered to Members.

4.4.3. Plan is Secondary. When Plan is secondary under the Plan's coordination of benefits rules, Plan shall pay for Covered Services according to the Plan's policies and procedures as set forth in the Provider Manual. Plan will deny claims from Provider if Provider fails to first make recoveries from other health care coverage sources.

4.4.4. Refund. If, following payment by Plan for Covered Services, Provider discovers that it is entitled to payment or receives payment from another payor that is primary to Plan, Provider shall notify Plan and promptly refund any amount overpaid by Plan.

4.5. Claim Correction Requests and Disputes. If Provider believes Provider is entitled to any payment for a Covered Service from Plan, or for payment in excess of the amount the Plan has paid or indicated it will pay, then Provider shall not directly or indirectly bill for or seek to collect from Plan any such payment or additional payment for Covered Services beyond the amount that Plan has paid or indicated it will pay for such Covered Services except pursuant to either a request for a claim correction submitted to the Claims Department as specified in the Provider Manual, or pursuant to a dispute filed with Plan as specified in Section 6.5 of this Agreement and the Provider Manual.

4.6. Hold Harmless. Provider agrees that, in no event, including but not limited to nonpayment by Plan, insolvency of Plan, breach of this agreement, or denial of claims by Plan due to Provider's failure to properly submit claims, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Member or any person acting on behalf of a Member to whom Covered Services have been provided in accordance with the terms of this Agreement or any Program, or the State of California for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting Member Payments as specifically provided under any applicable Member Group Contract or Membership Contract or from pursuing claims against the applicable primary payor. Failure to comply with this Section shall be deemed a material breach of this Agreement and Provider may be terminated for cause pursuant to Section 5.2.2 of this Agreement as the result of such failure. This provision shall survive the termination of the Agreement, regardless of the reason for termination, including insolvency of Plan. [Citation: DHCS APL 19-001 Item 15; MCP Contract, Exhibit

A, Attachment 6, Provision 13.B.13 and Title 22, CCR, Sections 53250(e)(6) and 53867; (and any updated section numbers if amended in the future.)]

4.7. No Surcharges. Provider understands that surcharges against Members are prohibited and that Plan will take appropriate action if surcharges are imposed. A "surcharge" is an additional fee which is charged to a Member for a Covered Service but which is not a Member Payment as provided for under the applicable Member Group Contract and Membership Contract.

4.8. Reporting of Surcharges and Member Payments. Provider will report to Plan all surcharge and Member Payment monies paid by Member directly to Provider and shall refund all surcharges.

4.9. No Charge for Non-Covered Services. Provider shall not charge a Member for a service which is not a Covered Service unless, in advance of the provision of such service, the Member has been notified by Provider that the particular service will not be covered and Provider obtains a written statement in a form acceptable to the Plan, signed by the Member or the person responsible for paying for services rendered that he or she shall be responsible for payment of charges for such service.

4.10. Payments Following Termination of this Agreement. Following termination of this Agreement and during the continuing care period described in Section 5.10 hereto, Plan shall compensate Provider at the applicable Program payment rates set forth in Exhibit H to this Agreement for providing Covered Services to Members until such Members are assigned by Plan to other Plan Participating Providers, and Provider shall accept these rates as payment in full.

4.11. No Inducement to Deny Covered Services. Provider acknowledges and agrees that this Agreement does not contain any financial incentive or make any payment that acts directly or indirectly as an inducement to limit Medically Necessary health care services.

ARTICLE V.
TERM AND TERMINATION

5.1. Term. The term of this Agreement shall commence on the later of July 1, 2025, or the first of the month following the date that the Plan completes credentialing of Provider (the "Commencement Date"), and shall expire on December 31 of the same year of the Commencement Date. The Plan will provide written notification to Provider of the Commencement Date of this Agreement. Thereafter, the term of this Agreement shall be automatically extended for a one (1) year term on each succeeding January 1 (the "Renewal Date"), unless terminated by either party as provided herein. [Citation: DHCS APL 19-001 Item 4; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.2 and Title 22, CCR, Sections 53250(c)(4) and 53867; (and any updated section numbers if amended in the future.)]

5.2. With Cause Termination of Agreement. Either Plan or Provider may terminate this Agreement for cause as set forth below, subject to the notice requirement and cure period set forth below.

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

5.2.1.1. Non-Payment. Material failure by Plan to make any payments due Provider hereunder within forty-five (45) days of any such payment's due date and Plan's failure to cure such failure to make such payments due to Provider within the cure period provided at Section 5.2.3, below.

5.2.1.2. Breach of Material Term and Failure to Cure. Plan's material breach of any material term, covenant, or condition and subsequent failure to cure such breach as provided in Section 5.2.3, below.

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

5.2.2.1. Breach of Material Term and Failure to Cure. Provider's material breach of any material term, covenant, or condition and subsequent failure to cure such breach as provided in Section 5.2.3, below.

5.2.2.2. Insolvency. Provider becomes insolvent, as reasonably determined by Plan.

5.2.2.3. Failure to Comply with Standards. Provider fails to provide Covered Services in accordance with the standards set forth in this Agreement and Plan's QI Program and UM Program. Plan reserves the right to immediately transfer from Provider any Members and cease referrals of any or all Members in the event the health or safety of Members is endangered by the actions of Provider, or as a result of continuation of this Agreement.

5.2.3. Notice of Termination, Cure Period and Effective Date of Termination. The party asserting cause for termination of this Agreement (the "terminating party") shall provide written notice of termination to the other party specifying the breach or deficiency with sufficient information to allow the receiving party to identify the actions necessary to cure such breach. The party receiving the written notice of termination shall have thirty (30) calendar days from the receipt of such notice to cure the breach or deficiency to the reasonable satisfaction of the terminating party (the "Cure Period"). If such party fails to cure the breach or deficiency to the reasonable satisfaction of the terminating party within the Cure Period or if the breach or deficiency is not curable, the terminating party shall have the right to provide written notice of failure to cure the breach or deficiency to the other party following expiration of the Cure Period. The Agreement shall terminate thirty (30) calendar days following receipt of the written notice of failure to cure or at such later date as may be specified in such notice. During the Cure Period and the period following the Cure Period, Plan may begin transferring Members to other Participating Providers. Notwithstanding the above, in the event Plan provides notice of termination as the result of a breach by Provider and Plan determines the health and safety of Members is endangered by the actions of Provider, Plan shall have the right to terminate the Agreement immediately.

5.3. Automatic Termination Upon Revocation of License or Certificate. This Agreement shall automatically terminate upon the revocation, suspension or restriction of any license, certificate or other authority required to be maintained by Provider or Plan in order to perform the services required under this Agreement or upon the Provider's or Plan's failure to obtain such license, certificate or authority. In addition, this Agreement shall automatically be terminated if: (i) Provider is excluded from participation in the Medicaid or Medicare program or is subjected to sanctions imposed by the Medicare program or the Medicaid program; (ii) Provider's professional liability insurance or any other Provider insurance required under this Agreement is cancelled, non-renewed, or is no longer in effect; (iii) Provider fails to comply with Section 2.3 of this Agreement; or (iv) Provider dies or becomes incapacitated (as reasonably determined by Plan). For clarity, since references to Provider include Provider and its Provider Professionals, this means that under this provision, Plan may alternatively terminate this Agreement as to individual Provider Professionals.

5.4. Termination of Member Group Contract. If any Member Group Contract terminates, this Agreement shall automatically terminate with respect to Members covered under the Member Group Contract on the date the Member Group Contract and any continuing care obligations under the Member Group Contract terminate.

5.5. Termination Without Cause. Either party may terminate this Agreement without cause at any time by giving the other party at least one hundred twenty (120) days prior written notice.

5.6. Termination if No Agreement on Provider Manual Modifications or Material Changes to Agreement. This Agreement may be terminated pursuant to the terms specified in Sections 6.8.2 and 6.8.3.

5.7. Transfer of Medical Records. Following termination of this Agreement, at Plan's request, Provider shall copy all requested Member medical records in the possession of Provider and forward such records to another provider of Covered Services designated by Plan, provided such copying and forwarding is not otherwise objected to by such Members. The cost of copying the Members' medical records shall be borne by Provider. Provider shall maintain the confidentiality of such Member medical records at all times.

5.8. Repayment Upon Termination. Within one hundred eighty (180) calendar days of the effective date of termination of this Agreement, an accounting shall be made by Plan of the monies due and owing either party and payment shall be forthcoming by the appropriate party to settle such balance within thirty (30) calendar days of such accounting.

5.9. Termination Not an Exclusive Remedy. Any termination by either party pursuant to this Article V is not meant as an exclusive remedy and such terminating party may seek whatever action in law or equity as may be necessary to enforce its rights under this Agreement. Notwithstanding the foregoing, the parties agree to waive any and all rights they may have to assert claims for or recover exemplary or punitive damages against the other party.

5.10. Continuing Care Obligations of Provider. If this Agreement is terminated for any reason, Provider shall continue to provide Covered Services, including Behavioral Health Services, to Members, including any Members who become eligible during the termination notice period, beginning on the effective date of termination and continuing until the first to occur of (i) a period of one hundred and twenty (120) days following termination of this Agreement or such longer period required for any Member as required by Law, or (ii) the date Plan provides written notice to Provider that it has made arrangements for all Members to receive services from another Participating Provider of Behavioral Health Services. In addition, Provider will continue to provide Covered Services, including Behavioral Health Services, to any Members who cannot be transferred within the time period specified above for Members who are hospitalized upon the expiration of the continuing care period, for Members who are entitled to continuing care as the result of their condition pursuant to Law, and otherwise in accordance with Plan's legal and contractual obligations to ensure continuity of care for its Members. In all cases, Payment shall be made pursuant to Section 4.10 of this Agreement.

ARTICLE VI.
GENERAL PROVISIONS

6.1. Independent Contractor Relationship. The relationship between Plan and Provider is an independent contractor relationship. Neither Provider nor its employees or agents are employees or agents of Plan. Neither Plan nor its employees or agents are partners, employees or agents of Provider.

6.2. Indemnification. Provider shall indemnify and hold harmless Plan and its directors, officers, employees, affiliates and agents against any claim, loss, damage, cost, expense or liability (including reasonable costs of defense) arising out of or related to the performance or nonperformance by Provider, its employees or agents of any Behavioral Health Services or other services to be performed or arranged by Provider under this Agreement; provided, however, that Provider shall not be responsible for indemnifying Plan for Plan's own acts or omissions.

6.3. Member Grievances. Plan shall be responsible for resolving Member claims for benefits under the Programs and all other claims against Plan. Provider will immediately refer Members to contact Plan or deliver any written complaint to Plan for handling pursuant to Plan's Member Grievance Procedures. Provider shall comply with all final determinations made by Plan through the Member grievance procedures.

6.4. Disputes Between Provider and Member. Any controversies or claims between Provider and a Member arising out of the performance of this Agreement by Provider, other than claims for benefits under the Program, are not governed by this Agreement. Provider and the Member may seek any appropriate legal

action to resolve such controversy or claim deemed necessary. Provider will provide written notice to Plan of any dispute between Provider and Member.

6.5. Disputes Between Plan and Provider. Any claim, dispute, or other matter arising out of, relating to, or in any way connected with this Agreement, shall be addressed through the Plan's provider dispute resolution procedure as set forth in the Provider Manual. Provider will be informed of any changes to the provider dispute procedures including any changes to the procedures for processing and resolving disputes and the location and telephone number where information regarding disputes may be submitted. If the procedure set forth in this Section has been exhausted and such matter is not resolved to the satisfaction of the parties, either party may pursue any available legal remedy. For clarity, Provider shall be required to comply with the claims presentation requirements and all other requirements of the Government Claims Act. Venue shall be in Santa Cruz, Monterey, Merced, San Benito or Mariposa County. Plan retains all immunities applicable to public entities to which it is entitled by law.

6.6. Notice. All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission or electronic transmission (including but not limited to email and/or DocuSign). The addresses, email address or facsimile number specified on the signature page shall be the addresses for delivery or mailing of notice. The parties may change the names, addresses, email addresses and facsimile numbers noted above through written notice in compliance with this Section. Notices shall be effective upon receipt.

6.7. Assignment. Neither this Agreement nor any portion of this Agreement shall be assigned, transferred, or pledged in any way by Provider and shall not be subject to execution, attachment or similar process without the prior written consent of Plan. A change of ownership through the sale of Provider's stock or assets may be deemed an assignment requiring consent pursuant to this Section. [Citation: DHCS APL 19-001 Item 14 and Title 22, CCR, Sections 53250(e)(5) and 53867; (and any updated section numbers if amended in the future.)]

6.8. Amendments. Except as provided in this Section 6.8 (and subsections thereto), no amendments or modifications to this Agreement shall be valid unless made in writing and signed by both Provider and Plan, and unless any required regulatory approvals are obtained.

6.8.1. Legally Required Modifications. The Plan may amend this Agreement at any time in order to comply with Law or any requirements of a private sector Accreditation Organization, as reasonably interpreted by the Plan. Plan shall notify Provider of such legally required modification. Such amendment shall be effective upon written notice to Provider, and shall not require the written consent of Provider.

6.8.1.1. DHCS Member Group Contract Modifications. Plan shall notify Provider of new requirements added to Plan's Member Group Contract with DHCS that are relevant to the Provider's performance under this Agreement in advance of the effective date of the requirement. Such notice shall constitute an amendment to this Agreement and such amendment shall not require Provider's consent. Provider must comply with the new requirement within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. [Citation: DHCS APL 19-001 Item 24; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.15; (and any updated section numbers if amended in the future.)]

6.8.2. Provider Manual Modifications. If Plan materially amends a manual or a policy or procedure document referenced in the Agreement ("Provider Manual Modification"), Plan will provide at least forty-five (45) business days' notice to Provider, and Provider will have the right to negotiate and agree to the change. If the parties cannot agree to the Provider Manual Modification, Provider will have the right to terminate the Agreement prior to the implementation of the Provider Manual Modification.

6.8.3. Material Changes to Agreement. For Providers compensated on a fee-for-service basis, Plan may make a material change to the Agreement by providing a minimum of ninety (90) business days' notice of its intent to change a material term of the Agreement ("Material Change Notice"). Provider shall have the right to negotiate and agree to the change within thirty (30) business days of Provider's receipt of the Material Change Notice ("Right to Negotiate") by providing written notice of such intent within the thirty (30) business day period. Provider shall have the right to terminate the Agreement effective ninety (90) business days following the receipt of the Material Change Notice if (1) Provider does not exercise Provider's Right to Negotiate or no agreement is reached during the ninety (90) business day period and, (2) if Provider provides notice of its intent to terminate prior to the expiration of the ninety (90) business day period. The material change shall become effective ninety (90) business days following the Material Change Notice if Provider does not exercise its Right to Negotiate or does not provide timely notice of its intent to terminate as described above. The parties may agree to the material change at any time during the ninety (90) business day period by mutual written agreement.

6.8.4. Non-Material Amendments to Agreement. The Plan may notify Provider of amendments to non-material change f this Agreement. Such amendments shall be effective upon written notice to Provider, and shall not require the written consent of Provider.

6.8.5. Program Benefit Changes. Program benefit changes shall be effective upon implementation, following receipt of any required regulatory approvals.

6.8.6. This Agreement and amendments hereto shall become effective only as set forth in the DHCS Member Group Contract, as applicable. When required by Law, amendments to this Agreement shall be in writing and submitted by Plan to the DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes, which are neither approved nor disapproved by the DHCS, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later. [Citation: DHCS APL 19-001 Item 3 and Title 22, CCR, Sections 53250(c)(3) and 53867; (and any updated section numbers if amended in the future.)]

6.9. Confidential and Proprietary Information.

6.9.1. Information Confidential and Proprietary to Plan. Provider shall maintain as confidential all information designated in this Section. The information which Provider shall maintain as confidential (the "Confidential Information") consists of: (i) any information containing the names, addresses and telephone numbers of Members which has been compiled by Plan; (ii) the financial arrangements between Plan and any of Plan's Participating Providers, including Provider; and (iii) any other information compiled or created by Plan which is proprietary to Plan and which Plan identifies in writing to Provider.

6.9.2. Non-Disclosure of Confidential Information. Provider shall not disclose or use the Confidential Information for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement. Provider may use the Confidential Information to the extent necessary to perform its duties under this Agreement or upon express prior written permission of Plan. Upon the effective date of termination of this Agreement, Provider shall provide and return to Plan the Confidential Information in their possession in the manner specified by Plan.

6.9.3. Plan Names, Logos and Service Marks. Provider shall obtain the written consent of Plan prior to using Plan's name, product names, logos and service marks in any of Provider's promotional, marketing, or advertising materials or for any other reason.

6.10. Solicitation of Plan Members. Provider shall not engage in solicitation of Members without Plan's prior written consent. Solicitation shall mean conduct by an officer, agent, employee or contractor of Provider or their respective assignees or successors during the term of this Agreement, and during the twelve (12)

months immediately following the effective date of termination of this Agreement which may be reasonably interpreted as designed to persuade Members to disenroll from the Program or discontinue their relationship with Plan. Provider agrees that Plan shall, in addition to any other remedies provided for under this Agreement, have the right to seek a judicial temporary restraining order, preliminary injunction, or other equitable relief against Provider to enforce its rights under this Section in a manner consistent with and to the extent permitted by California law.

6.11. No Restrictions on Discussing a Member's Health Care. Nothing in this Agreement shall be interpreted to discourage or prohibit Provider or its Provider Professionals from discussing a Member's health care including, without limitation, communications regarding treatment options, alternative health plans or other coverage arrangements, unless such communications are for the primary purpose of securing financial gain.

6.12. Invalidity of Sections of Agreement. The unenforceability or invalidity of any paragraph or subparagraph of any section or subsection of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

6.13. Survival. The following provisions of this Agreement shall survive the termination of this Agreement: Sections 2.5, 2.6, 2.9, 2.11, 3.5, Article IV, Sections 5.7, 5.8, 5.9, 5.10, 6.2, 6.4, 6.5, 6.9, 6.10, 6.11 and any other section where survival of termination is required by Law.

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

6.15. Entire Agreement. This Agreement, including all exhibits, attachments, addenda, and amendments hereto and the Provider Manual contains all the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement are null and void and of no further force or effect.

6.16. Incorporation of Exhibits and Attachments. The schedules, exhibits, addenda, and attachments to this Agreement and the Provider Manual are integral parts of this Agreement and are incorporated in full herein by this reference.

6.17. Authority to Bind. Each signatory of this Agreement represents and warrants individually on behalf of themself, and the party on whose behalf they execute this Agreement, that they are duly authorized to execute this Agreement.

ARTICLE VII.
GOVERNING LAW AND REGULATORY REQUIREMENTS

7.1. Governing Law. This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of California, except where preempted by federal law, and the laws of the United States of America. [Citation: DHCS APL 19-001 Item 2; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.4 and Title 22, CCR, Sections 53250(c)(2) and 53867; (and any updated section numbers if amended in the future.)]

7.2. Americans with Disabilities Act of 1990. Provider's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled which includes, but is not limited to ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

7.3. Civil Rights Act of 1964. Provider will comply with Title VI of the Civil Rights Act of 1964 and any implementing regulations that prohibits recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

7.4. Language Assistance. Provider agrees to comply with the Plan's Language Assistance Program as detailed in the Plan's Policies and Procedures and Provider Manual.

7.5. Certification. As required by Title 31 U.S.C. Section 1352, if payments under this Agreement are $100,000 or more, Provider certifies to the best of Provider's knowledge and belief that no federally appropriated funds have been paid or will be paid, by or on behalf of Provider, to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the making, awarding or entering into of this Agreement, and the extension, continuations, renewal, amendment, or modification of this Agreement. If payments under this Agreement are $100,000 or more, Provider shall submit to Plan the "Certification Regarding Lobbying" set forth in the Provider Manual. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Agreement, Provider shall complete and submit to Plan standard form LLL, "Disclosure of Lobbying Activities", in accordance with its instructions. Provider shall file such disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by Provider. Provider shall require that the language of this certification be included in all subcontracts at all tiers which exceed $100,000 and that all subcontractors shall certify and disclose accordingly. All such disclosure forms of subcontractors shall be forwarded to Plan.

7.6. Antifraud Plan. Provider agrees to comply with Plan's antifraud plan, as detailed in the Provider Manual. Provider will immediately notify Plan of (i) investigations of Provider or Provider's employees in which there are allegations relating to fraud, waste, or abuse, and (ii) suspected cases where there is reason to believe that an incident of fraud, waste, or abuse has occurred. Provider acknowledges that Plan may share information about any suspected fraud, waste, or abuse with DHCS. [Citation: MCP Contract, Exhibit E, Attachment 2, Provision 27; (and any updated section numbers if amended in the future.)]

7.6.1. Plan may receive information shared by DHCS, other state and federal agencies, and other Medi-Cal managed care plans in connection with any fraud, waste, or abuse referral and Plan is required to keep such information confidential, until formal criminal proceedings are made public (FWA Confidential Information). Plan would be receiving this FWA Confidential Information as a DHCS business associate in order to facilitate Plan's contractual obligations to maintain a fraud, waste, and abuse prevention program. Plan must receive and maintain this FWA Confidential Information in its capacity as a Medi-Cal managed care plan and will use the FWA Confidential Information only for conducting an investigation into any potential fraud, waste, or abuse activities and in furtherance of any other program integrity activities.

In the event Plan is required to share this FWA Confidential Information with Provider, Provider is required to keep such information confidential. [Citation: MCP Contract, Exhibit A, Attachment III, Provision 1.3.2.D.6; (and any updated section numbers if amended in the future)]

7.7. No Inducement for Referrals. The parties acknowledge and agree that: (1) they intend to comply with the safe harbor requirements set forth in 42 C.F.R. §1001.952(t); (2) in establishing the terms of the Agreement, including the exhibits, addenda and attachments hereto, neither party gave or received remuneration in return for or to induce the provision or acceptance of business (other than business covered by the Agreement) for which payment may be made in whole or in part by a federal health care program on a fee-for-service or cost basis; and (3) neither party will shift the financial burden of the Agreement to the extent that increased payments are claimed from a federal health care program. Plan represents and agrees that it is an eligible managed care organization, as defined in 42 C.F.R. §1001.952(t). Provider represents and agrees that (a) Provider is a first tier contractor under the Agreement, defined as an individual or entity that has a direct contract with Plan, as the managed care organization, to provide or arrange for items or services; and (b) Provider cannot and will not claim payment in any form, directly or indirectly, from a federal health care program for items or services covered under the Agreement for Members enrolled in the Plan, except as provided in 42 C.F.R. §1001.952(t).

7.8 Compliance with Law. Provider and any subcontractor to Provider shall comply with the Program Requirements set forth in the exhibits hereto. Any provisions required to be included in the Agreement by applicable Law, including but not limited to, the Knox-Keene Health Care Service Plan Act of 1975 (Cal. Health & Safety Code Section 1340 et seq.), Cal. Code of Regulations, Tit. 28, Section 1300.43 et seq., Cal. Welfare & Institutions Code Sections 14000 and 14200 et seq., and Cal. Code of Regulations, Tit. 22, Sections 53800 et seq., shall be deemed incorporated herein whether or not expressly set forth in the Agreement, including the exhibits hereto.

IN WITNESS WHEREOF, the undersigned have executed this Agreement effective as of the Commencement Date.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

By:_____

Print Name:_____

Title: _____

Date: _____

COUNTY OF MONTEREY, ON BEHALF OF ITS HEALTH DEPARTMENT, CLINIC SERVICES BUREAU

By: _____

Print Name: _____

Title: _____

Date: _____

Plan Address and Facsimile Number for Notices:

Central California Alliance for Health
ATTN: Provider Services Director
1600 Green Hills Road
Scotts Valley, CA 95066
Facsimile Number: 831-430-5857
Email: pscontracts@ccah-alliance.org

Provider Address and Facsimile Number for Notices:

Street: _____

City, State ZIP: _____

Facsimile Number: (_____)_____

Email*:_____

*Note – by inserting an email address on this line, Provider is consenting to allow Plan to send notices and amendments related to this Agreement electronically per Section 6.6 of this Agreement.

If Provider chooses to opt out of receiving notices and amendments pertaining to this Agreement by email, Provider must initial here and leave email address line blank _____.

APPROVAL SIGNATURE PAGE, (continued)

COUNTY OF MONTEREY,

Approved as to Legal Form:

By: Signed by: Stacy Saetta 696D21D44C4341D... _____

Stacy Saetta, Chief Deputy County Counsel

Date: 4/18/2025 | 9:32 AM PDT _____

Approved as to Fiscal Provisions:

By: DocuSigned by: Jennifer Forsyth 4E7E057875454AE... _____

Auditor-Controller

Date: 4/18/2025 | 1:59 PM PDT _____

EXHIBIT A

SCHEDULE OF PROGRAMS

Provider has been approved to provide Covered Services, including Allied Health Care Professional Services, under the Programs defined below and pursuant to the applicable terms and conditions of the Agreement. The Plan may amend the counties in which each Program operates from time to time, by providing Provider with written notice of such changes.

Medi-Cal Program: is a state- and federally-funded Program pursuant to a contract between the Plan and DHCS for coverage of Members who meet Medi-Cal eligibility requirements, as determined by DHCS. The Medi-Cal Program is, as of the Commencement Date, offered in Merced, Monterey, Santa Cruz, San Benito and Mariposa Counties.

Alliance Care IHSS Health Program: is a state- and federally-funded Program pursuant to a contract between the Plan and the County of Monterey for coverage of Members who meet Alliance Care IHSS Health Program eligibility requirements, as determined by the County of Monterey. As of the Commencement Date, the Alliance Care IHSS Health Program is offered in Monterey County.

Medicare Advantage D-SNP Program: is a state- and federally-funded Program pursuant to a contract between the Plan and CMS for coverage of Members who meet Medicare Advantage, Dual Eligible Special Needs Plan (D-SNP) eligibility requirements, as determined by CMS. The Medicare Advantage D-SNP Program is, as of January 1, 2026, offered in Merced, Monterey, Santa Cruz, San Benito and Mariposa Counties.

EXHIBIT B

MEDI-CAL PROGRAM ATTACHMENT

This Exhibit B sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Medi-Cal Program. In the event of a conflict between the provisions of the Agreement and the provisions of this Exhibit, this Exhibit will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Members enrolled in the Medi-Cal Program.

1. With respect to the Medi-Cal Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the Medi-Cal Member Group Contract and Medi-Cal Member Handbook. Covered Services, including Behavioral Health Services, for Medi-Cal Members are set forth in Title 22 of the California Code of Regulations Section 51301 et seq., and Title 17 of the California Code of Regulations Section 6840 et seq. Information regarding Behavioral Health Services, excluded services, and certain health screening and preventive services for Medi-Cal Members is set forth in the Provider Manual.

2. With respect to the Medi-Cal Program, the term "Medi-Cal Member" shall mean an individual who is enrolled in Plan's Medi-Cal Program and who is determined to be eligible for membership in the Medi-Cal Program. A newborn of a Medi-Cal Member is covered under the mother's membership for the month of birth and the following calendar month. A newborn born in the month immediately preceding the mother's enrollment as a Medi-Cal Member is covered under the mother's membership during the mother's first month of enrollment.

3. Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of this Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Rights to Monitor, as set forth in the DHCS Member Group Contract. [Citation: MCP Contract, Exhibit E, Attachment 2, Provision 20, Audit and Exhibit E, Attachment 2, Provision 21 (and any updated section numbers if amended in the future)] Inspection Rights:

   (A) by DHCS, Centers for Medicaid & Medicare Services ("CMS"), the United States Department of Health and Human Services ("DHHS") Inspector General, the Comptroller General, the United States Department of Justice ("DOJ"), the California Department of Managed Health Care ("DMHC"), and their designees;

   (B) at any time at the Provider's place of business, premises, physical facilities, and equipment where Medi-Cal-related activities or work is conducted, or at such other mutually agreeable location in California;

   (C) in a form maintained in accordance with the general standards applicable to such book or record keeping;

   (D) for a term of at least ten years from the final date of the Agreement period or from the date of completion of any audit, whichever is later, or such longer period as required by Law; and

   (E) including all Covered Services Documentation for a term of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later, or such longer period as required by Law;

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

(G) upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal Program, seek recovery of payments made to the Provider, impose other sanctions provided under the State Plan, and direct Plan to terminate this Agreement due to fraud.

[Citation: DHCS APL 19-001 Item 8; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h) ; (and any updated section numbers if amended in the future.)]

4. Provider shall comply with all applicable monitoring provisions of the DHCS Member Group Contract and any applicable monitoring request by DHCS. [Citation: DHCS APL 19-001 Item 7; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.10, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867; (and any updated section numbers if amended in the future.)]

5. Plan shall share any applicable utilization data Plan receives from DHCS with Provider. Provider agrees to receive and use the utilization data as able for the purpose of Member care coordination. To the extent that Provider is not equipped to receive the utilization data, Plan shall make it available to Provider. Member Payments are not permitted under the Medi-Cal Program. Provider shall not seek reimbursement of any such payments from Medi-Cal Members for any Covered Services provided under this Agreement. [Citation: DHCS APL 19-001 Item 23; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.14 and 42 CFR 438.208; (and any updated section numbers if amended in the future.)]

6. Provider agrees to submit reports as required by Plan. [Citation: DHCS APL 19-001 Item 6; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867; (and any updated section numbers if amended in the future.)]

7. If this Agreement terminates for any reason, Provider will assist the Plan in the transfer of care. Additionally, Provider will assist in the orderly transfer of necessary data and records to the Plan, a successor Plan, or DHCS. Provider will assist in the transition of Members, and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Provider will make available to Plan or DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Members, as determined by the Director of DHCS. In no circumstances will a Medi-Cal Member be billed for this activity.

8. Provider shall notify DHCS in the event the Agreement is terminated or amended. Notice to the Department is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Notice should be mailed to the Department of Health Care Services, Medi-Cal Managed Care Division, County Organized Health Systems MS 4408, P.O. Box 997413, Sacramento, CA 95899. [Citation: DHCS APL 19-001 Item 13; Title 22, CCR, Sections 53250(e)(4) and 53867; (and any updated section numbers if amended in the future.)]

9. Provider agrees that the assignment or delegation of any part of this Agreement shall be void unless prior written approval is obtained from DHCS in those instances where prior approval is required. [Citation: DHCS APL 19-001 Item 14; and Title 22, CCR, Sections 53250(e)(5) and 53867; (and any updated section numbers if amended in the future.)]

10. Prior to commencing services under the Agreement, Provider shall provide Plan with any necessary disclosure statements, including the statements set forth in Title 22 of the California Code of Regulations, Section 51000.35. Provider must also provide written disclosure of any prohibited affiliation under 42 CFR section 438.610. [Citation: MCP Contract Exhibit A, Attachment III, Provision 1.3.5.A; (and any updated section numbers if amended in the future)]

11. Provider, as applicable, shall ensure that Members are informed of the full array of covered contraceptive methods when appropriate and that informed consent is obtained from Members for sterilization consistent with requirements of applicable Law.

12. Provider will comply with the Medi-Cal Minor Consent Services program, as applicable, which generally provides that minors do not need parental or legal guardian consent in order to access these services and Provider is prohibited from disclosing any information relating to Minor Consent Services without the express written consent of the minor Member. Minor Consent Services include treatment for the following:

    a. Sexual assault, including rape;

    b. Drug or alcohol abuse(for children 12 years of age or older);

    c. Pregnancy;

    d. Family planning;

    e. STDs and HIV/AIDS (in children 12 years of age or older); and

    f. Non-specialty mental health services (NSMHS) (for children 12 years of age or older) who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924. [Citation: MCP Contract Exhibit A, Attachment III, Provision 5.2.8.D; (and any updated section numbers if amended in the future)]"

13. For Medi-Cal Members under the age of 21, the term "Medically Necessary" includes those standards set forth in Title 22 of the California Code of Regulations Sections 51340 and 51340.1.

14. Provider will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of payment and other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state the Provider's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

15. Provider will, in all solicitations or advancements for employees placed by or on behalf of Provider, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

16. Provider will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the state, advising the labor union or workers' representative of the Provider's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

17. Provider will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

18. Provider will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

19. In the event of the Provider's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Provider may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

20. By signing this Agreement, Provider agrees that if any performance under this Agreement or any subcontract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC Section 263a (CLIA) and the regulations thereto.

21. Provider shall comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act; and all other laws regarding privacy and confidentiality.

22. Provider shall comply with Plan's policies and procedures as described in the Provider Manual relating to the identification of Members that may be eligible for other Programs.

23. Provider shall make no claim for recovery of the value of Covered Services rendered to Members when such recovery would result from an action involving the tort or Workers Compensation liability of a third party, casualty liability coverage, or any other third-party liability which could result in recovery by the Medi-Cal Member of funds for which DHCS has lien rights under Welfare and Institutions Code Section 14124.70. Provider shall identify and notify Plan of cases in which such an action could result in recovery by the Member. Provider shall notify Plan immediately upon the discovery of such cases and shall provide any requested information promptly to Plan. DHCS retains the right to such third-party tort and workers' compensation liability, and casualty liability recoveries with respect to Medi-Cal Members as set forth in Welfare and Institutions Code Section 14124.70 and following.

24. Provider agrees to timely gather, preserve and provide to DHCS, CMS, Attorney General's Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in Provider's possession, in accordance with the DHCS Member Group Contract's requirements for records related to recovery for litigation. [Citation: DHCS APL 19-001 Item 16; Citation: MCP Contract, Exhibit A, Attachment 6, Provision 13.B.10; MCP Contract, Exhibit E, Attachment 2, Provision 26, Records Related to Recovery for Litigation; (and any updated section numbers if amended in the future.)]

25. To the extent that Provider is at risk for non-contracting Emergency Services, Provider shall be subject to the applicable provisions in the DHCS Member Group Contract relating to same. In such instances, Provider shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has

stabilized sufficiently to permit discharge. The attending emergency physician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on Plan. Emergency Services shall not be subject to authorization by Plan. [Citation: DHCS APL 19-001 Item 5; (and any updated section numbers if amended in the future.)]

26. Provider shall maintain and make available to DHCS, upon request, copies of all sub-subcontracts and ensure that all sub-subcontracts are in writing. Provider shall make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to the DHCS Member Group Contract available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. Provider shall retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the DHCS Member Group Contract period or from the date of completion of any audit, whichever is later. [Citation: DHCS APL 19-001 Item 10; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.7; (and any updated section numbers if amended in the future.)]

    a. Provider is fully responsible for all duties and obligations set forth in this Agreement. However, Provider may enter into subcontracts or sub-subcontracts with other individuals, groups, or entities to fulfill its obligations and duties under the Agreement. Such individuals, groups, or entities may be a combination of network provider, subcontractor, and/or downstream subcontractor, in which case they would need to comply with the requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements (as defined in the DHCS Member Group Contract) as required in the DHCS Member Group Contract, as applicable. Subcontractors and Downstream Subcontractors may enter into agreements to fulfill their obligations and duties under the Agreement, in which case they would need to comply with the requirements of Downstream Subcontractor Agreements or Network Provider Agreements, as required in the DHCS Member Group Contract, as applicable. [Citation: MCP Contract Exhibit A, Attachment III, Provision 3.1.1.A; Exhibit A, Attachment I, Provision 1.0; (and any updated section numbers if amended in the future)]

27. In the event of a termination of the DHCS Member Group Contract or this Agreement, Provider agrees to assist Plan in the transfer of care of Members, in accordance with the phaseout requirements referenced in the DHCS Member Group Contract and in ensuring, to the extent practicable, continuity of Member-provider relationships. In doing so, Provider will make available to Plan and DHCS, as applicable, information maintained by Provider necessary for efficient case management of Members. In no circumstances will a Member be billed for this activity. Plan shall remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members prior to the expiration or termination of the DHCS Member Group Contract. [Citation: DHCS APL 19-001 Item 11; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.11. & DHCS APL 19-001 Item 12; MCP Contract, Exhibit E, Attachment 2, Provision 15; (and any updated section numbers if amended in the future.)]

28. As required under Plan's Language Assistance Program referenced in Section 7.4 of this Agreement, Provider agrees to provide interpreter services for Members at all Provider sites. Provider also agrees to comply with language assistance standards developed pursuant to Health & Safety Code § 1367.04. [Citation: DHCS APL 19-001 Item 17; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.17. & DHCS APL 19-001 Item 30; (and any updated section numbers if amended in the future.)]

29. Provider agrees to participate and cooperate in Plan's QI Program. [Citation: DHCS APL 19-001 Item 19 (and any updated section numbers if amended in the future.)]

30. If Provider is delegated any quality improvement functions as defined in the DHCS Member Group Contract, the provisions required in the Member Group Contract with DHCS regarding: (i) quality improvement responsibilities and specific delegated functions; (ii) oversight, monitoring, and evaluation processes; (iii) reporting requirements and approval processes; and (iv) action/remedies if Plan's obligations are not met, are specifically stated in Plan's delegation agreements and are hereby incorporated by reference into this Provider Agreement. [Citation: DHCS APL 19-001 Item 20; MCP Contract, Exhibit A, Attachment 4, Provision 6.A; (and any updated section numbers if amended in the future.)]

31. Provider agrees to comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including but not limited to, all applicable Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, All Plan Letters ("APLs") and contract provisions. [Citation: DHCS APL 19-001 Item 21; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.5; (and any updated section numbers if amended in the future.)]

32. Provider agrees that Plan may terminate this Agreement, revoke the delegation of activities or obligations, or specify other remedies, in instances where DHCS or Plan determines that Provider has not performed satisfactorily. [Citation: DHCS APL 19-001 Item 22; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.12, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867; (and any updated section numbers if amended in the future.)]

33. Provider will submit complete, accurate, reasonable, and timely provider data and/or encounter data needed by Plan in order for Plan to meet its provider data and/or encounter data reporting requirements to DHCS. [Citation: DHCS APL 19-001 Item 25; MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates. & DHCS APL 19-001 Item 26; Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates; (and any updated section numbers if amended in the future.)]

34. Provider is prohibited from balance billing any Member. [Citation: DHCS APL 19-001 Item 27; MCP Contract, Exhibit A, Attachment 8, Provision 6; (and any updated section numbers if amended in the future.)]

35. Provider, or Plan at Provider's request, will provide cultural competency, sensitivity, health equity, and diversity training to all employees and staff at key points of contact with Members. [Citation: DHCS APL 19-001 Item 28; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.16; (and any updated section numbers if amended in the future.)]

36. Notwithstanding anything to the contrary, Provider is entitled to, and Plan shall ensure that, all protections afforded to it under the Health Care Provider's Bill of Rights including, but not limited to the right to submit a grievance in accordance with Plan's formal process to resolve Provider grievances and to access Plan's dispute resolution mechanism referenced in Section 6.5 of this Agreement and pursuant to Health and Safety Code § 1367(h)(1). [Citation: DHCS APL 19-001 Items 18, 29 and 31; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.20; Health & Safety Code §1375.7; Health & Safety Code §1367 (h)(1) (and any updated section numbers if amended in the future.)]

37. Provider agrees to (i) report to Plan when it has received an overpayment, (ii) return the overpayment to Plan within 60 calendar days of the date the overpayment was identified, and (iii) notify Plan in writing of the reason for the overpayment in accordance in accordance with the Member Group Contract and 42 CFR § 438.608(d)(2). [Citation: MCP Contract, Exhibit A, Attachment 6, Provision 13.B.19, Exhibit E, Attachment 2, Provision 34; 42 CFR § 438.608(d)(2).]

38. Plan has established a Member Emergency Preparedness Plan to address its Members' needs during an Emergency, including for Members in long-term care facilities, skilled nursing facilities, or other institutional settings; and for Members with disabilities, limitations in activities of daily living, and/or cognitive impairments. For the purposes of this Agreement, a "Member Emergency Preparedness Plan" means a required subsection of the Plan's Emergency Preparedness and Response Plan that details the required coordination between Plan and its Members, Network Providers, Subcontractors, and Downstream Subcontractors to ensure Member access to health care services in the event of an Emergency. As part of this Member Emergency Preparedness Plan, Provider is required to:

    a. Annually submit evidence of adherence to CMS Emergency Preparedness Final Rule 81 FR 63859;

    b. Advise Plan as part of the Network Provider's Emergency plan; and

    c. Notify Plan within 24 hours of an Emergency if Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency.

[Citation MCP Contract Exhibit A, Attachment III, Provision 6.3.C.3; (and any updated section numbers if amended in the future)]

39. If DHCS, DMFEA, or US DOJ, or any other authorized state or federal agency, determines there is a credible allegation of fraud against Provider or any of Provider's subcontractors or downstream subcontractors, Plan will immediately suspend payments to Provider for which a state or federal agency determines there is a credible allegation of fraud. Provider must immediately suspend payments to any subcontractor or downstream subcontractor for which a state or federal agency determines there is a credible allegation of fraud (42 CFR § 438.608(a)(8)). In addition, Plan may conduct additional monitoring, temporarily suspend and/or terminate Provider. [Citation: MCP Contract Exhibit A, Attachment III, Provision 1.3.4.D; (and any updated section numbers if amended in the future)]

EXHIBIT C

COVERED TAX IDENTIFICATION NUMBER(S)

The Tax Identification Number(s) ("TIN(s)") listed below are the only TINs that apply to this Agreement. Any update to the TINs in this Exhibit C must be requested by Provider with a minimum of 60 days prior written notice given. Such requests are subject to the approval of the Plan and will require memorialization via an amendment to this Agreement.

TIN(s):
946000524

EXHIBIT D

ALLIANCE CARE IHSS HEALTH PROGRAM ATTACHMENT

The Alliance Care IHSS Health Program is regulated in part by DMHC. As such, there are certain DMHC-required terms that apply to IHSS Members. The IHSS program also has its own programmatic requirements. This Exhibit D sets forth those IHSS and DMHC requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Alliance Care IHSS Health Program. In the event of a conflict between the provisions of the Agreement and the provisions of this Exhibit, this Exhibit will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Members enrolled in the IHSS Program.

1. With respect to the Alliance Care IHSS Health Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the IHSS Member Group Contract. Covered Services, including Referral Services for IHSS Members are set forth in Sections 2699.6700 through 2699.6707 of Title 10 of the California Code of Regulations, and are also described in the Alliance Care IHSS Health Program Evidence of Coverage and the Plan's Provider Manual. Covered Services also includes those services specified by Title 28, California Code of Regulations, section 1300.74.72.01.

2. With respect to the Alliance Care IHSS Health Program, and pursuant to Health and Safety Code section 1374.72, "mental health and substance use disorders" (MH/SUD) means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

3. With respect to the Alliance Care IHSS Health Program, "medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

   (i) In accordance with the generally accepted standards of mental health and substance use disorder care.

   (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

   (iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider

4. Discrimination: The term "discrimination" as used in this Exhibit D, means the illegal denial of equal employment opportunity, harassment (including sexual harassment and violent harassment), disparate treatment, favoritism, subjection to unfair or unequal working conditions, and/or other discriminatory practice by any Monterey County official, employee or agent, due to an individual's race, color, ethnic group, national origin, ancestry, religious creed, sex, sexual orientation, age, veteran's status, cancer-related medical condition, physical handicap (including AIDS) or disability. The term also includes any act of retaliation.

5. The County of Monterey and DMHC may examine, monitor, and audit all records, documents, conditions, and activities of Provider related to the provision of Alliance Care IHSS Health Program Covered Services. Provider agrees to submit to an examination and audit of the State Auditor pertaining to matters connected

with the performance of the IHSS Member Group Contract or provision of Alliance Care IHSS Health Program Covered Services for a period of three years after the final payment under the IHSS Member Group Contract.

6. Plan shall establish and follow its own written procedures for the prompt and fair resolution of discrimination complaints made against Plan by Provider.

7. During the performance of this Agreement, Plan and Provider shall comply with all Laws which prohibit discrimination, including but not limited to the following:

   i. California Fair Employment and Housing Act;

   ii. California Government Code Sections 11135-11139.5 and 22 CCR Sections 98000-98413;

   iii. Federal Civil Rights Acts of 1964 and 1991;

   iv. The Rehabilitation Act of 1973, and all guidelines and interpretations issued pursuant thereto;

   v. 7 Code of Federal Regulations (CFR) Part 15 and 28 CFR Part 42;

   vi. Title II of the Americans with Disabilities Act of 1990 (P.L. 101-336), 42 U.S.C. Sections 12101 et seq. and 47 U.S.C. Sections 225 and 611, and any federal regulations issued pursuant thereto (see 24 CFR Chapter I; 28 CFR Parts 35 and 36; 29 CFR Parts 1602, 1627, and 1630; and 36 CFR Part 1191);

   vii. Unruh Civil Rights Act, California Civil Code Section 51 et seq., as amended;

   viii. Chapter 2.80 of the Monterey County Code;

   ix. Age Discrimination in Employment Act 1975, as amended (ADEA), 29 U.S.C. Sections 621 et seq.;

   x. Equal Pay Act of 1963, 29 U.S.C. Section 206(d);

   xi. California Equal Pay Act, Labor Code Section 1197.5;

   xii. California Government Code Section 4450;

   xiii. The Dymally-Alatorre Bilingual Services Act; California Government Code Section 7290 et seq.;

   xiv. The Food Stamp Act of 1977, as amended and in particular Section 272.6.;

   xv. California Code of Regulations, Title 24, Section 3105A (e); and

   xvi. Removal of Barriers to Inter-Ethnic Adoption Act of 1996, Section 1808

8. Upon request by the County of Monterey, Provider will give any written assurances of compliance with the Civil Rights Act of 1964 and 1991, the Rehabilitation Act of 1973 and/or the Americans with Disabilities Act of 1990, as may be required by the federal government in connection with the IHSS Member Group Contract as may be required by Law.

9. Provider agrees to comply with the Elder Abuse and Dependent Adult Civil Protection Act, and will comply with its provisions which define a mandated reporter, and requires that reports of abuse or neglect be made by a mandated reporter when, in his or her professional capacity, or within the scope of his or her employment, he/she observes or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, isolation, financial abuse, or neglect. Provider will require any Participating Provider,

employee, consultant, and agent performing services under the Agreement and this Exhibit D, who are mandated reporters under the Elder Abuse and Dependent Adult Civil Protection Act, to sign statements indicating that they know of and will comply with the reporting requirements of the Act.

10. With respect to the Alliance Care IHSS Health Program, Plan affirmatively agrees to provide coverage of health care benefits for preventing, diagnosing, and treating mental health conditions and substance use disorders as medically necessary for an enrollee in accordance with current generally accepted standards of MH/SUD care pursuant to Rule 1300.74.72.01 and that Plan will not apply criteria other than those set forth in Rule 1300.74.721(c) unless the circumstances in section 1374.721(c)(1) or (c)(2) apply.

EXHIBIT E (Effective 1/1/2026)

MEDICARE ADVANTAGE, DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP) PROGRAM REQUIREMENTS

This Exhibit sets forth Medicare Advantage, D-SNP Program requirements that are required to be included in the Agreement with respect to the provision of any health care services under a Medicare Advantage Part C plan, including any D-SNP plan. All citations in this Exhibit are to the applicable sections of law. This Exhibit will automatically be modified to conform to subsequent changes in law or government program requirements.

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA").

1. Defined Terms. For purposes of the Medicare Advantage D-SNP Program, the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

   "Business Day" means any day except Saturday, Sunday, or a legal holiday**.**

   "Calendar Day" or "day" means all seven (7) days of the week; when a deadline or timeframe provided herein ends on a Calendar Day, the last day of the designated period shall be included unless it is a Saturday, Sunday, or a legal holiday, in which event the designated period shall run until the end of the next day which is not a Saturday, Sunday or a legal holiday.

   "Care Coordination" means the coordination of Covered Person care services including recruitment, outreach, psychosocial assessment, service planning, assisting the Covered Person in arranging for appropriate services, including but not limited to, resolving transportation issues, education, counseling, and follow-up, and monitoring to ensure services are delivered and continuity of care is maintained.

   "Centers for Medicare and Medicaid Services ("CMS")" the agency within the Department of Health and Human Services that administers the Medicare program.

   "Clean Claim" means a claim for Covered Services provided to a Covered Person that can be accurately processed without obtaining additional information from the provider of the service or from a third party. In regard to Covered Persons, this means (i) a claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with 42 CFR §422.310(d)) or particular circumstance requiring special treatment that prevents timely payment and (ii) a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare. Any physician incentive reimbursement plan operated by Plan and applicable to Provider under this Exhibit shall be in compliance with 42 C.F.R. §422.208 and any other federal or state laws applicable to physician incentive plans. Provider agrees to furnish Plan with any information necessary for Plan to meet the physician incentive disclosure obligations under 42 CFR §422.210.

   "Covered Person" is a Member who has been assigned one or more Medicare identification numbers, is enrolled in both Medicare and Medi-Cal, and who is enrolled in the Plan's Medicare Advantage D-SNP Program.

   "Covered Services" means the services covered under Medicare Part A and Part B provided to Covered Persons pursuant to the Plan Contract.

   "Downstream Entity" any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

"Encounter" means the basic unit of service used in accumulating utilization data and/or a face-to-face contact between a Covered Person and Provider resulting in a service to the Covered Person.

"First Tier Entity" any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

"Generally Accepted Standards of Medical Practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and are required when applicable; or physician specialty society recommendations (or clinical treatment guidelines/guidance) and/or the general consensus of physicians practicing in relevant clinical areas.

"Medically Necessary" or "Medical Necessity" means any health care service, intervention, or supply (collectively referred to as "service") that a Provider (or psychologist, when applicable), exercising prudent clinical judgment, would provide to an Covered Person for the purpose of preventing, evaluating, diagnosing, or treating an illness (including mental illnesses and substance use disorders), injury, disease, condition, or its symptoms, in a manner that is: (i) in accordance with Generally Accepted Standards of Medical Practice; (ii) clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the Covered Person's illness, injury, disease, or condition; (iii) in accordance with medical necessity "guidelines/ references" in the Plan MA Provider Manual; (iv) not primarily for the convenience of the Covered Person or Provider; (v) not more costly than an alternative service or sequence of services that is at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that Covered Person's illness, injury, disease, or condition; (vi) the service is not contraindicated; and (vii) the Provider's Medical Records include sufficient documentation to justify the service.

"Medical Records" means the document that records all of the medical treatment and services provided to the Covered Person.

"Medicare Advantage ("MA")" an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

"Medicare Advantage Organization ("MAO")" a public or private entity organization and licensed by a state as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

"MA Provider Manual" means the provider manual and any billing manuals, developed by Plan which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Program-specific, Plan-specific, and CMS-specific requirements, as may be amended from time to time by Plan.

"MA Provider Network" means those Participating Providers affiliated or contracted with the Plan who are authorized to provide services to Covered Persons.

"Plan Contract" or "Contract" means the contract between Plan and CMS to arrange for medical care to Medicare Covered Persons, including any amendments thereto.

"Potential Enrollee" means a Medicare recipient or Medicare-eligible individual who is subject to mandatory enrollment or who may voluntarily elect to enroll with the Plan but is not yet enrolled.

"Prior Authorization" means a service authorization requested by the Covered Person, or by a provider on Covered Person's behalf, for coverage of a service, whether for a new authorization period or within an existing authorization period, before such service is provided to the Covered Person.

"State" means the State of California.

"Subcontract" means any written agreement for any services necessary to fulfill the requirements of the Contract between Plan and any other individual, entity, facility, or organization not in the Provider Network and/or not considered to be a Participating Provider; and any agreement between Provider and any other individual, entity, facility or organization to perform any service, in whole or in part, for which Plan has contracted with Provider.

"Subcontractor" means any individual, entity, facility or organization not in the MA Provider Network and/or a Participating Provider that has entered into a Subcontract with Plan or with any Subcontractor for any portion of the work under the Contract; or any individual, entity, facility or organization that has entered into a Subcontract with Provider.

2. Medicare Advantage D-SNP Program.

2.1 Medicare Advantage D-SNP Program. This Exhibit is incorporated into the Agreement between Provider and Plan. It supplements the Agreement by setting forth specific terms and conditions that apply to the Exhibit with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation. This Exhibit applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicare Advantage D-SNP Program.

2.2 Participation. Any services or other activity performed in accordance with a contract or written agreement by Provider must be consistent and comply with Plan's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]. \Except as otherwise provided in this Exhibit or the Agreement, Provider and all Participating Providers under the Agreement will participate as Participating Providers in the Medicare Advantage D-SNP Program and will provide to Covered Persons enrolled in the Plan, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Exhibit, those Covered Services that are provided by Participating Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Participating Providers to, comply with and abide by the provisions of this Exhibit and the Agreement (including the MA Provider Manual).

2.3 Exhibit. This Exhibit constitutes the Medicare Advantage D-SNP Program Exhibit and Exhibit H contains the Compensation Schedule for the Medicare Advantage D-SNP Program.

2.4 Construction. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect as a result of this Exhibit. In the event of a conflict between the provisions of the Agreement and the provisions of this Exhibit, this Exhibit will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by the Medicare Advantage D-SNP Program. To the extent Provider or any Participating Provider is unclear about its or their respective duties and obligations, Provider or the applicable Participating Provider shall request clarification from the Plan.

3. Term. This Exhibit will become effective as the date on which this Exhibit is added to the Agreement (the "MA Program Effective Date") and shall be coterminous with the Agreement unless a Party terminates the participation of the Participating Provider in this Medicare Advantage D-SNP Program in accordance with the applicable provisions of the Agreement or this Exhibit.

4. CMS Mandated Regulatory Requirements. Provider and Plan shall comply with the following mandatory provisions for provider agreements as set forth below. Any additional regulatory requirements that may apply to Covered Persons enrolled in or covered by this Medicare Advantage D-SNP Program may be set forth in the MA Provider Manual or Plan policy and are incorporated herein by this reference.

4.1 Agreement Subject to Review and/ or Approval. The Agreement is subject to the review and/or approval of CMS and if implemented prior to such review, the parties agree to incorporate into the Agreement

any and all modifications required by CMS for approval or, alternatively, to terminate the Agreement with respect to the Medicare Advantage D-SNP Program if so directed by CMS, effective forty-five (45) Calendar Days subsequent to notice. The Agreement, including this Exhibit, and Compensation Schedule, is the sole Agreement between the parties regarding the arrangement established therein.

4.1.1 Amendment Subject to Review and/or Approval. Any amendment to the material terms (e.g., scope of services, risk or shared savings/ loss payment terms, etc.) of the Exhibit may be subject to the review and/ or approval of CMS.

4.1.2 Approval of Provider Subcontracts and Amendments. Provider shall not subcontract any aspect of a service or task required by the Exhibit unless the service or task is expressly identified in an exhibit to the Exhibit.

4.1.3. Disclosure of Information. Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 CFR Part 455, Subpart B, and provide such information on request to Plan, CMS and the United States Department of Health and Human Services (HHS). Provider agrees to inform Plan and CMS in writing of any material change in ownership or control, federal tax identification number, or Provider business addresses, at least thirty-five (35) Calendar Days prior to making such changes.

4.1.4 Audits. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of Provider related to CMS' contract with Plan through 10 years from the final date of the final contract period of the contract entered into between CMS and Plan or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]. Provider will also submit to and cooperate with periodic audits and readiness reviews of Plan and Provider to be performed by CMS and/or HHS as may be required by CMS Administrative Code Chapter 11, Section 100.4. Such audits and readiness reviews shall be carried out in such a manner as to cause minimal disruption to the business and care/services of the Provider. Provider will comply with the requirements of the audits as related to the services the Provider performed and readiness reviews and will make all records, including pertinent books, financial records, Medical Records, meeting minutes, forms, statements and other information reasonably pertaining to its performance under the Agreement, on a selected or sample basis as requested for these audits and reviews, available to CMS, its designee and/or HHS or its designee. All Covered Person information, including protected health information obtained during these audits and reviews, shall be safeguarded in accordance with state and federal laws and regulations.

4.1.5. Interviews of Provider's Employees and Subcontractors. Investigators and internal and external auditors of CMS, HHS, the State and federal governments and/or Plan may conduct interviews of Provider, Provider's employees, Subcontractors and their employees, witnesses, and Potential Enrollees or Covered Persons without the Provider's representative or Provider's legal counsel present unless the person voluntarily requests that the representative be present. Provider's employees, Subcontractors and their employees, witnesses, and Potential Enrollees or Covered Persons must not be coerced by Provider or Provider's representative to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in the Agreement limits a person's right to counsel of their choice. Requests for interviews are to be complied with, in the form and the manner requested. Provider will ensure by contract or other means that its employees and Subcontractors over whom the Provider has control cooperate fully in any investigation conducted by CMS and/or State and federal authorities.

4.1.6. Compliance with Laws and Requirements. Provider agrees to comply with all applicable Law and any requirements governing or regulating Medicare Advantage Programs and the Plan, Plan

Contract, procedures and requirements promulgated by HHS, and all state and federal laws, rules and regulations now in effect or that may be in effect during the term of the Agreement. The Agreement includes, adopts, and incorporates by reference as if set forth therein all applicable provisions of the Medicare Advantage Program as reflected in CMS Medicare Managed Care Manual, Chapter 11, Section 100.4, 42 C.F.R. Part 422 and all state and federal laws, rules and regulations now in effect or that may be in effect during the term of the Agreement. Provider agrees to comply with all state and federal laws, rules and regulations relating to the preparation and filing of cost reports, audit requirements, and the inspection and monitoring of facilities, quality, utilization, and records. Provider is responsible for ensuring that employees, Subcontractors, agents, and representatives acting on behalf of the Provider comply with all applicable requirements of the above authorities.

4.1.7. Interference with Delivery of Services and Care Coordination Prohibited. Provider shall not interfere with the delivery of services or care coordination benefits for any Covered Person whether or not the Provider is providing such care.

4.1.8. Discrimination Against Enrollees Prohibited. Provider shall not discriminate against Potential Enrollees or Covered Persons on the basis of health status or the need for health care services or on the basis of race, color, national origin, gender, age, disability, political or religious affiliation or belief, or any other basis for which discrimination is prohibited by Law.

4.1.9. Sole Responsibility of Plan for Provider Payments. Provider understands and agrees that as between Covered Persons and Plan, Plan shall be solely responsible for all payments, charges or costs relating to Plan's Covered Services for Covered Persons.

4.2. Provider's Responsibilities and Obligations

4.2.1. Credentialing Standards. Plan reviews the credentials of medical professionals affiliated Provider. Provider must comply with Plan's credentialing requirements.

4.2.2. Eligibility. Provider represents the Provider or Provider's employees is/are not excluded or debarred from participation in any program under Title XVIII (Medicare), any program under Title XIX (Medicaid), under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC § 1320a-7) or Executive Order 12549 or any other exclusion authority. Provider also has not been excluded or debarred from participation in any other state or federal health care program and has not had their license or certificate to provide medical services revoked or suspended.

4.2.3. Submission of Claims and Encounter Data. Provider agrees to submit Clean Claims or Encounter data to Plan or its designee for Covered Services provided by Provider to Covered Persons under the Agreement in accordance with Plan's billing guidelines and procedures. Provider agrees to submit such Clean Claims or Encounter data to Plan or its designee within one year from the date services are provided, as required by CMS. Provider certifies that information submitted regarding Clean Claims or Encounter data will be true, accurate, complete and that such information can be verified by source documents from which data entry is made by the Provider. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and/or federal laws. All Clean Claims or Encounters submitted by Provider must be for Medically Necessary Covered Services actually rendered by Provider. Physician Providers must submit Clean Claims for services rendered by physician extenders employed by a physician in accordance with Plan's rules regarding physician extenders found in Plan's MA Provider Manual.

4.2.4. Financial Liability. Covered Persons will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4.2.4.1 For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4.2.5. False Claims Act Requirements. Providers that receive annual Medicare payments of at least five million dollars ($5,000,000) must establish written policies for all employees that provide information about the False Claims Act, any state laws pertaining to civil or criminal penalties for false claims and statements, whistleblower protections under such laws, and the Provider's policies and procedures for detecting fraud, waste, and/ or abuse in accordance with Section 1902(a)(68) of the Social Security Act. Affected Providers must also include this information in an employee handbook.

4.2.6. Quality and Utilization Management. Provider agrees to participate in quality improvement activities, quality reporting, care coordination activities, grievance procedures, continuing medical education requirements of the applicable licensing board and other policies and programs required by Plan. Provider agrees to comply with all applicable performance standards and quality measures established by Plan.

4.2.7. Behavioral Health. Provider shall comply with Plan's behavioral health program, if applicable.

4.2.8. Transition of Covered Persons. Provider agrees to cooperate in all respects with other health care providers to assure maximum health outcomes for Covered Persons previously under the treatment or care of the Provider who are transitioning to another health care provider or Program.

4.2.9. Medical Records. Provider shall maintain standard Medical Records for Covered Persons as may be reasonably requested to fulfill the purposes of the Agreement and as required under state and federal laws and regulations. Provider shall retain such Medical Records for ten (10) years after the later of (i) the date of service rendered to the Covered Person or (ii) the date of final adjudication of any claim submitted for payment for such service. Medical Records must be legible, signed, and dated. Medical Record information must be protected by the Provider as required under state and federal laws and regulations. Provider shall provide a copy of a Covered Person's Medical Record upon reasonable request by such Covered Person in accordance with state and federal law and shall facilitate the transfer of a copy of the Covered Person's Medical Record to another health care provider at the Covered Person's request.

4.2.10. Employee Review. Provider shall have a process in place for conducting comparisons of the Provider's employee files, prior to employment and monthly thereafter, against the Excluded Parties List System (EPLS), the List of Excluded Individuals/Entities (LEIE) and CMS's suspended providers list and provide a report, in a format established by Plan, of the result of the comparison to the Plan each quarter. Any employee of the Provider confirmed to be an excluded party, as defined in this section, must be terminated immediately upon confirmation, and reported to Plan within one Business Day of the termination.

4.2.11. Provider Training. Provider shall participate in trainings as required by the Plan and/or CMS, and delivered by the Plan on an annual basis. Provider must attest in writing to the fact that they attended the training and understood the material.

4.2.12 Out-of-Area Renal Services. Payment for temporarily out-of-area renal dialysis services, for emergency and urgently needed services and for maintenance and post-stabilization care services shall be made consistent with the requirements of 42 CFR § 422.100(b)(1)(iv)

pertaining to the approval and deemed approval for post-stabilization services and 42 CFR § 422.113, as may be amended or updated from time to time.

4.2.13 Disenrollment Information. Provider agrees to furnish Plan with any information necessary for Plan to comply with its disclosure responsibilities regarding Medicare Advantage Covered Person disenrollment, Medicare Advantage Covered Persons satisfaction, and health outcomes under 42 C.F.R. §§ 422.504(f)(2)(iv)(A), 422.504(f)(2)(iv)(B), and 422.504(f)(2)(iv)(C).

4.2.14 Plan Medicare Advantage D-SNP Administration. Provider agrees to furnish Plan with all information necessary for Plan to comply with its disclosure responsibilities under 42 C.F.R. §§ 422.64, 422.504(a)(4), and 422.504(f)(2) so that CMS may (a) administer and evaluate the Medicare Advantage Program and (b) establish and facilitate a process for current and prospective Medicare Advantage beneficiaries to exercise choice in obtaining Medicare services.

4.2.15 Plan Insolvency. Provider agrees that in the event of Plan's insolvency or other cessation of operations, Covered Services to Covered Persons will continue through the period for which the premium has been paid to Plan by CMS, and Covered Services to any Covered Person confined in an inpatient Provider hospital on the date of insolvency or other cessation of operations will continue until such person's discharge, as required under 42 C.F.R. § 422.504(g)(2)(ii).

4.2.16 Subcontracts. Provider acknowledges that Provider is subject to 45 C.F.R. Part 76 and 42 C.F.R. §§ 422.752(a)(8). Neither Provider nor Plan may employ or subcontract with an individual or with an entity that employs or contracts with an individual, who is excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act or from participation in a federal health care program for the provision of any of the following:
(i) health care;
(ii) utilization review;
(iii) medical social work; or
(iv) administrative services.

4.3. Plan's Responsibilities and Obligations

4.3.1. Provider Contract Disputes Procedures. Plan shall adhere to the procedures set forth in CMS Administrative code Chapter 29 with respect to any Provider contract disputes.

4.3.2. Participation in Covered Person Grievances and Appeals. Plan shall not take punitive action against Provider for advocating on behalf of the Covered Person in any grievance system, appeal process or utilization management process, or individual authorization process to obtain necessary health care services.

4.3.3. Advice to Covered Persons. Plan shall not prohibit, or otherwise restrict, Provider from acting within the lawful scope of practice, or from advising or advocating on behalf of a Covered Person, for the following:

4.3.3.1. The Covered Person's health status, medical care or treatment options, including any alternative treatment that may be self-administered.

4.3.3.2. Any information the Covered Person needs in order to decide among all relevant treatment options.

4.3.3.3. The risks, benefits and consequences of treatment or non-treatment.

4.3.3.4. The Covered Person's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

5. Oral Interpretation Services. Provider shall inform Potential Enrollees and Covered Persons the Plan offers oral interpretation services, free of charge, for those whose primary language is any foreign language.

6. Written Materials. Provider shall notify Covered Persons the Plan offers written information in prevalent languages and how to access those services.

7. Ensuring Accurate Provider Information. Provider acknowledges that Plan is required to submit a monthly update with any changes to the MA Provider Network directory and thus Provider shall notify Plan in a timely fashion regarding changes to specialty, office locations, or contact information.

8. Provider Access. Provider, as applicable, must meet the CMS and State standards for timely access to care and services, which hours of operation shall be no less than the hours of operation offered by Provider to enrollees in commercial health plans, or hours of operation that are comparable to Medicare fee-for-service if Provider serves only Medicare recipients, and taking into consideration the urgency of the need for such services.

9. Access for Covered Persons with Disabilities. Both parties shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing or arranging for health care benefits, neither Party shall directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Covered Persons who are qualified disabled individuals covered by the provisions of the ADA.

10. Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Providers shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with Plan's formulary or preferred drug list when prescribing medications for Covered Persons.

11. Subcontracts. Provider and Plan shall identify any aspect of service in this Exhibit that may be subcontracted by Provider in an exhibit to the Agreement.

12. Confidentiality. Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (a) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (b) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (c) maintaining the records and information in an accurate and timely manner, and (d) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]. Provider shall comply with Plan's policies governing access to, duplication and dissemination of all such information. Confidential information of any kind must not be sold to any third party, nor may it be distributed or used by Provider in any way except as authorized by the Contract or approved in writing by Plan. Provider shall establish and implement procedures consistent with confidentiality requirements set forth in this Exhibit and the Plan Contract.

13. Out-of-State Providers. All out-of-State Providers must follow the enrollment procedures of Plan.

14. Physician Incentive Plans. Provider acknowledges that all Physician Incentive Plans ("PIPs") must be in compliance with 42 CFR § 422.208 and § 422.210 and therefore Plan may not make any payments directly or indirectly under a PIP to Provider as an inducement to reduce or limit Medically Necessary services furnished to a Covered Person. In addition, Provider, if participating in Plan's PIP, shall maintain adequate stop-loss insurance coverage, including amount and type of stop-loss insurance protection to individual Providers and conduct annual Covered Person satisfaction surveys. Provider shall provide proof of such stop-loss protection upon request from Plan.

15. Generally Accepted Standards of Medical Practice. At Plan's request, Provider must submit written documentation to comply with Generally Accepted Standards of Medical Practice as defined in this Exhibit.

16. Prior Authorizations. During the term of the Agreement and any continuation period, Provider shall follow established written policies and procedures for the initial and continuing coverage and authorization of Covered Services. Plan shall have in effect mechanisms to assure consistent application of review criteria for Prior Authorization decisions and consult with the requesting Provider when appropriate.

17. Cultural Competency. Provider shall cooperate with Plan's efforts to promote the delivery of services in a culturally competent manner to all Covered Person, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

18. Protecting Health Information. Provider shall use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular Covered Person, in accordance with the confidentiality requirements in 45 CFR parts 160 and 164.

19. General Laws and Regulations. Provider shall comply with the following statutes and regulations, as they currently exist and as may hereafter be amended:
    - CMS Medicare Managed Care Manual Guidelines 100.4 - Provider and Supplier Contract Requirements (Rev. 83, Issued 04-25-07, Effective Date 04-25-07)
    - Age Discrimination Act of 1975, as amended, 42 USC § 6101, et seq.;
    - Age Discrimination in Employment Act of 1967, 29 USC § 621-634;
    - Americans with Disabilities Act of 1990 (ADA), 42 USC § 12101, et seq.;
    - Byrd Anti-Lobbying Amendment, 31 USC § 1352, 45 CFR § 2543.87;
    - Clean Air Act, 42 USC § 7401, et seq.;
    - Debarment and Suspension 45 CFR § 74 Appendix A (8) and Executive Order (E.O.) 12549 and 12689;
    - Equal Employment Opportunity, E.O. 11246, as amended by E.O. 11375, amending E.O. 11246 and as supplemented by 41 CFR Part 60;
    - Equal Pay Act of 1963, 29 USC § 206(d);
    - Federal Water Pollution Control Act, as amended, 33 USC § 1251, et seq.;
    - Immigration Reform and Control Act of 1986, 8 USC 1324b;
    - Rights to inventions made under a contract or agreement, 45 CFR § 2543.85;
    - Section 504 of the Rehabilitation Act of 1973, as amended, 29 USC § 794;
    - Title VI of the Civil Rights Act of 1964, as amended, 42 USC § 2000d, et seq.;
    - Title VII of the Civil Rights Act of 1964, 42 USC § 2000e; and
    - Title IX of the Education Amendments of 1972, as amended, 20 USC § 1681.

20. Electronic Data Interchange. Provider must submit claims through electronic data interchange (EDI) required by Plan that allows for automated processing and adjudication of claims.

EXHIBIT F

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EXHIBIT G

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EXHIBIT H

COMPENSATION SCHEDULE

1. Payment in Full. Provider agrees to accept payment rendered pursuant to this Exhibit H, and any applicable Member Payment, as payment in full for any Covered Services, including CCS Services, provided by Provider to a Member, as well as any necessary administrative services. Payment may be subject to adjustment as described in Section 4.3 of this Agreement, and is subject to the Coordination of Benefits rules set forth in Section 4.4 of this Agreement.

2. Definitions. The following definitions are applicable to this Exhibit H:

   a. "Medi-Cal Rate" shall mean the current applicable Medi-Cal rate, as published by the California Department of Health Care Services in effect at the time Covered Services are rendered. Medi-Cal Rate does not include those payment rates, including, but not limited to, those procedure codes on the Medi-Cal fee schedule, created for DHCS's Target Rate Increase program pursuant to Welfare and Institutions Code section 14105.201.

   b. "Medi-Medi Members" shall mean Members covered by both Medicare and Medi-Cal that are not Covered Persons under the Medicare Advantage D-SNP Program.

   c. "Medicare Rate" shall mean one hundred percent (100%) of the applicable National Medicare Fee Schedule in effect at the time the Covered Service was rendered, for the location where the Covered Service was provided as identified by the zip code of the place of service on the claim with the following criteria:
      (i) Covered Services provided in Santa Cruz, Monterey, Merced, San Benito, and Mariposa Counties will be paid based on the CMS locality applicable for each county respectively; and
      (ii) Covered Services provided in a county not listed above will be paid based on the CMS locality specific for Santa Cruz County.

   d. "Medicare Crossover Claims" shall mean claims for Covered Services provided to Medi-Medi Members for which Medicare is the primary payer and Medi-Cal is the secondary payer.

   e. "Medicare Crossover Claim Rate" shall mean eighty percent (80%) of the applicable National Medicare Fee Schedule percentage as listed by Provider Type in table 3 a. i, in effect at the time the Covered Service was rendered for the location where the Covered Service was provided as identified by the zip code of the place of service on the claim, less any adjustments implemented by CMS (including but not limited to the sequestration reduction initially provided for in the Budget Control Act of 2011 as such amount may be amended or changed from time to time or incentives), with the following criteria:
      (i) Covered Services provided in Santa Cruz, Monterey, Merced, San Benito, and Mariposa Counties will be paid based on the CMS locality applicable for each county respectively; and
      (ii) Covered Services provided in a county not listed above will be paid based on the CMS locality specific for Santa Cruz County.

   f. "Standard Claims" shall mean claims for Covered Services, including CCS Services, provided by Provider to Medi-Cal or IHSS Members that are not Medicare Crossover Claims.

3. Payment for Behavioral Health Services provided to Medi-Cal and IHSS Members

   a. Fee-for-Service Payment. Plan shall pay Provider for Covered Services provided to Medi-Cal and IHSS Members as set forth below in subsections i. and ii.

      i. Standard Claims. Plan will pay Provider for Standard Claims at the Medicare Rate specified in the table below when billed with the Modifier identified for the applicable Provider Type. If there is no Medicare Rate for the Covered Service provided, Plan will pay Provider at one hundred and fifty percent (150%) of the Medi-Cal Rate.

Provider Type					
Rate Structure	**Physician (MD, incl. psychiatrist/DO)**	**PhD/PsyD (Psychologist)**	**NP/PA**	**Master's (LCSW / LMFT / LPCC)**	**Registered Psychological Associate, Associate CSW, Associate Marriage and Family Therapist, Associate Professional Clinical Counselor**
	100% of the Medicare Rate	100% of the Medicare Rate	85% of the Medicare Rate	75% of the Medicare Rate	75% of the Medicare Rate
Modifier	AF	AH	AS	AJ or HO	HL

ii. Medicare Crossover Claims. Plan will pay Provider for Covered Services that are Medicare Crossover Claims provided to Medi-Medi Members at the Medicare Crossover Claim Rate.

iii. Physician Administered Drugs or "PAD". In the event PAD is provided to a Member by an applicable licensed Behavioral Health Provider, Plan will pay Provider for Covered Services that are PAD provided to Medi-Cal Members at one hundred percent (100%) of the Medi-Cal Rate in effect at the time the Covered Service was provided.

4. Payment for Behavioral Health Treatment ("BHT").

   a. Fee-for-Service Payment. Plan shall pay Provider for the following CPT Codes for Covered Services that are BHT services provided to Medi-Cal and IHSS Members as set forth in the table below:

CPT Code	Contracted Rate
H0031	$26.88
H0032	$27.50
H0046	$21.50
H2014	$10.75
H2019	$13.75
S5111	$21.50

5. Payment for Covered Services Provided to Medicare Advantage D-SNP Members, **effective January 1, 2026**. Plan will pay Provider for Covered Services provided to Covered Persons at the Medicare Rate specified in the table below, less any adjustments implemented by CMS (including but not limited to the sequestration reduction initially provided for in the Budget Control Act of 2011 as such amount may be amended or changed from time to time, deductibles, coinsurance, etc.), when billed with the Modifier identified for the applicable Provider Type.

Provider Type					
Rate Structure	**Physician (MD, incl. psychiatrist/DO)**	**PhD/PsyD (Psychologist)**	**NP/PA**	**Master's (LCSW / LMFT / LPCC)**	**Registered Psychological Associate, Associate CSW, Associate Marriage and**

					Family Therapist, Associate Professional Clinical Counselor
	100% of the Medicare Rate	100% of the Medicare Rate	85% of the Medicare Rate	75% of the Medicare Rate	75% of the Medicare Rate
Modifier	AF	AH	AS	AJ or HO	HL

6. Supplemental Payments

   a. Sign-On Bonus: Provider will receive a Sign-On bonus for every rendering Behavioral Health Provider who submits a completed credentialing application, per the standards outlined in the Provider Manual, to Plan under this Agreement. Payments will be made to Contractor no later than three months following the end of the quarter in which completed credentialing application was received by Plan.

      i. Completed Credentialing Application received on January 16, 2025 through March 1, 2025 - Provider will receive a one-time only Sign-On bonus per every rendering provider at four hundred dollars ($400) each.

      ii. Completed Credentialing Applications received after March 2, 2025 through June 30, 2027 – Provider will receive a one-time only Sign-On bonus per every rendering provider at three hundred dollars ($300) each.

      iii. If the Behavioral Health Provider for whom a sign on bonus was paid, is terminated on or before December 31, 2027 by Provider or Plan, Plan may recover Sign-On Bonus dollars from Provider through the process described in Section 4.3.1.

EXHIBIT I

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EXHIBIT J

SCOPE OF BEHAVIORAL HEALTH TREATMENT ("BHT") SERVICES

SECTION 1: OVERVIEW

Behavioral Health Treatment Services described in this Exhibit are an Early and Periodic Screening Diagnostic and Treatment ("EPSDT") benefit that are applicable to all Members with Medi-Cal under the age of 21, unless otherwise indicated.

Provider shall provide coverage of BHT Services for Members diagnosed or suspected of diagnosis of Autism or Autism Spectrum Disorder or other developmental conditions for whom a physician, surgeon or psychologist determined that BHT Services are medically necessary. The coverage shall meet professionally recognized standards of care and shall be subject to the requirements of sections 1374.72 and 1374.73 of the Health & Safety Code, as well as all applicable Law.

SECTION 2: DEFINITIONS

Capitalized Terms used in this Exhibit and not defined below shall have the meanings ascribed to them in the body of the Agreement.

Autism Spectrum Disorder ("ASD") is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified, and Asperger syndrome. These conditions are now all called ASD in the Diagnostic and Statistical Manual of Mental Disorders: DSM-V.

EPSDT. The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in Medi-Cal, and is set forth in the Social Security Act (SSA) Section 1905 and 42 USC, Section 1396 (d)(1),(2).

SECTION 3: MEDICAL NECESSITY CRITERIA

Per federal and State law, an EPSDT service is considered medically necessary to correct or ameliorate defects, and physical and/or mental illnesses and conditions. BHT Services therefore will be considered medically necessary to prevent or minimize the adverse effects of behaviors presented as a result of a diagnosed or suspected Autism Spectrum Disorder diagnosis or other developmental conditions.

Provider shall adhere to all applicable federal and State laws pertaining to EPSDT benefits to ensure that medical necessity decisions are made accordingly; including verifying and coordinating services provided by other overlapping entities such as a Local Education Agency (LEA), Regional Center or County Mental Health to ensure that Members are receiving all medically necessary non-duplicative BHT Services.

SECTION 4: REFERRALS

Plan will receive and evaluate all requests for BHT services. Plan will consider referrals from, including, but not limited to, parents or guardians, medical or behavioral health providers, and regional centers. BHT providers will receive approved referrals from Plan only.

SECTION 5: COVERED BEHAVIORAL HEALTH TREATMENT SERVICES

Covered benefits are subject to change based upon any future changes in regulatory requirements. Benefits shall be covered by Plan based upon the current regulatory requirements in effect at the time of service. This Exhibit also incorporates all applicable provisions of the Medi-Cal Manual in effect at the time of service.

Provider shall provide BHT Services to Plan's Members according to EPSDT and BHT criteria. These include but are not limited to:

- Medically necessary, as defined for the EPSDT population;

- Provided and supervised in accordance with an approved behavioral treatment plan that is developed by a BHT service provider who meets the requirements of California's Medicaid state plan;
- Provided by a qualified autism provider or a provider who meets the requirements contained in California's Medicaid state plan or licensed provider acting within the scope of their licensure.

SECTION 6: NON-COVERED BEHAVIORAL HEALTH TREATMENT SERVICES

Provider shall not render the following services as Medi-Cal does not cover the following as BHT services under the EPSDT benefit, including but not limited to:

- Services rendered when continued clinical benefit is not expected, unless the services are determined to be medically necessary.
- Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
- Treatment where the sole purpose is vocationally or recreationally based.
- Custodial care. For purposes of BHT services, custodial care: (i) is provided primarily to maintain the member's or anyone else's safety; and (ii) could be provided by persons without professional skills or training.
- Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
- Services rendered by a parent, legal guardian, or legally responsible person.
- Services that are not evidence-based behavioral intervention practices.

SECTION 7: COORDINATION OF SERVICES

Provider shall follow all Plan's guidelines, Policies and Procedures, and Plan's Provider Manual.

SECTION 8: TIMELY ACCESS STANDARDS

Provider must provide BHT services in accordance with timely access standards, pursuant to Welfare and Institutions Code section 14197 and Plan's existing contract with DHCS.

SECTION 9: BEHAVIORAL HEALTH TREATMENT PLAN ("BHT PLAN")

Provider must follow the BHT Plan as specified in the DHCS guidelines and Plan's Policies and Procedures, and Provider Manual.

EXHIBIT K

SCOPE OF MENTAL HEALTH ("MH") SERVICES FOR MEDI-CAL MEMBERS

SECTION 1: OVERVIEW

Provider will be responsible to provide Medically Necessary covered outpatient mental health services to Plan Members who are diagnosed or suspected to be diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders ("DSM") that results in mild to moderate distress or impairment of mental, emotional, or behavioral function; or members that are diagnosed or suspected to be diagnosed with a mental health disorder that exclude them from County Mental Health or substance abuse services.

Covered services will be rendered by the Provider to identify and treat a mental health condition that has been diagnosed or is suspected to be diagnosed with a mental health disorder, and such services shall be consistent with the diagnosis and treatment of the condition and professionally recognized standards of care.

Mental Health Services will be provided by Licensed Mental Health Professionals (as specified in the Psychological Services Medi-Cal Provider Manual) for Members with potential mental health disorders, in accordance with Sections 29 and 30 of Senate Bill X1.1 of the First Extraordinary Session (Hernandez & Steinberg, Chapter 4, Statutes of 2013) which added Sections 14132.03 and 14189 to the Welfare and Institutions Code.

SECTION 2: DEFINITIONS

Capitalized terms used in this Exhibit and not defined below shall have the meanings ascribed to them in the body of the Agreement.

County Mental Health shall mean the department within the Counties of Santa Cruz, Monterey, Merced, Mariposa or San Benito that is charged with providing certain Specialty Mental Health Services to Members, as described herein. County Mental Health ("CMH") may also be referred to as "Mental Health Plan" or "MHP".

Licensed Mental Health Care Provider(s)/Professional(s) shall mean duly licensed or registered in the State of California or licensed waivered professionals as specified in the Medi-Cal Provider Manual, Psychological Services and all applicable regulations and guidelines, including but not limited to Welfare and Institutions Code section 5751.2 regarding DHCS' authority to waive professional licensure requirements for mental health providers.

Mental Health Plan ("MHP") shall refer to an entity that contracted with DHCS to provide directly or arrange and pay for Specialty Mental Health Services to beneficiaries in a county. The MHP in this contract will refer to either the Counties of Santa Cruz, Monterey, Merced, Mariposa or San Benito that is charged with providing Specialty Mental Health Services to Members, as described herein.

SECTION 3: MEDICAL NECESSITY CRITERIA

For mild to moderate mental health covered services for adults, medically necessary services are defined as reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. These include services to:

- Diagnose a mental health condition and determine a treatment plan;
- Provide medically necessary treatment for mental health conditions (excluding couples and family counseling for relational problems) that result in mild or moderate impairment; and
- Refer adults to County Mental Health for Specialty Mental Health Services when a mental health diagnosis covered by the County Mental Health Plan results in significant impairment.

For children under age 21, medically necessary mental health services is defined as services to correct or ameliorate defects and physical mental illnesses and conditions discovered by the screening services, whether or not such services or items are covered under the State plan (42 USC Section 1396d(r)(5). Provider is required to provide and cover

medically necessary mental health services, except for SMHS listed in CCR, Title 9, Section 1810.247 for beneficiaries that meet the medical necessity criteria for SMHS as specified in CCR, Title 9, Sections 1820.205, 1830.205, or 1830.210 that must be provided by a MHP.

SECTION 4: INITIATION OF SERVICES

Provider shall follow all Plan guidelines, Policies and Procedures, and Plan's Provider Manual for initiation of services.

SECTION 5: SCREENING AND INITIAL ASSESSMENT

Provider shall follow all Plan guidelines, Policies and Procedures, and Plan's Provider Manual for all screening and initial assessment procedures.

SECTION 6: COVERED OUTPATIENT MENTAL HEALTH SERVICES

Covered benefits are subject to change based upon any future changes in regulatory requirements. Benefits shall be covered by Plan based upon the current regulatory requirements in effect at the time of service. This Exhibit also incorporates all applicable provisions of the Medi-Cal Manual in effect at the time of service.

Outpatient Mental Health Services that are covered by Plan is specified by the State plan (or All Plan Letters under the directives of DHCS) and excludes Specialty Mental Health Services.

SECTION 7: CARE COORDINATION

Provider shall follow all Plan guidelines, Policies and Procedures, and Plan's Provider Manual for all care coordination.

EXHIBIT L

SCOPE OF MENTAL HEALTH OR SUBSTANCE USE DISORDER ("MH/SUD") SERVICES FOR IHSS MEMBERS

SECTION 1: OVERVIEW

Provider will be responsible to provide Medically Necessary covered outpatient mental health or Substance Use Disorder Services to Plan's IHSS Members who are diagnosed or suspected to be diagnosed with a MH/SUD.

Covered Services will be rendered by the Provider to identify and treat a mental health condition that has been diagnosed or is suspected to be diagnosed with a MH/SUD, and such services shall be consistent with the diagnosis and treatment of the condition and professionally recognized standards of care.

Mental health or Substance Use Disorder Services will be provided by Licensed Mental Health Professionals.

SECTION 2: DEFINITIONS

Capitalized terms used in this Exhibit and not defined below shall have the meanings ascribed to them in the body of the Agreement.

Licensed Mental Health Care Provider(s)/Professional(s) shall mean a mental health provider/professional that is duly licensed or registered in the State of California.

"Mental Health or Substance Use Disorder" or "MH/SUD" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

SECTION 3: MEDICAL NECESSITY CRITERIA

For MH/SUD services, "medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.
(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.
(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider

SECTION 4: INITIATION OF SERVICES

Provider shall follow all Plan guidelines, Policies and Procedures, and Plan's Provider Manual for initiation of services.

SECTION 5: SCREENING AND INITIAL ASSESSMENT

Provider shall follow all Plan guidelines, Policies and Procedures, and Plan's Provider Manual for all screening and initial assessment procedures.

SECTION 6: COVERED MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Covered benefits are subject to change based upon any future changes in regulatory requirements. Benefits shall be covered by Plan based upon the current regulatory requirements in effect at the time of service. This Exhibit also incorporates all applicable DMHC All Plan Letters or other applicable DMHC directives in effect at the time of service.

SECTION 7: CARE COORDINATION

Provider shall follow all Plan guidelines, Policies and Procedures, and Plan's Provider Manual for all care coordination.