blue of california

Fremont Hospital

Provider Agreement

Behavioral Health Services

Acute Psychiatric Hospital

June 1, 2025

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

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BLUE SHIELD OF CALIFORNIA
BEHAVIORAL HEALTH SERVICES
ACUTE PSYCHIATRIC HOSPITAL AGREEMENT

This Acute Psychiatric Hospital Agreement (this "Agreement") is entered into by and between California Physicians' Service, dba Blue Shield of California, a California nonprofit corporation ("Blue Shield") and BHC Fremont Hospital, Inc., dba Fremont Hospital, a corporation ("Provider"). This Agreement shall be effective June 1, 2025 (the "Effective Date").

RECITALS

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

B. Provider owns and operates an acute psychiatric hospital and is duly licensed and qualified to provide inpatient and outpatient behavioral health services to Members.

C. Provider and Blue Shield desire that Provider provide inpatient and outpatient behavioral health services to Members, in accordance with the terms of this Agreement.

I. DEFINITIONS

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

1.1 **Agreement Year:** is the twelve (12)-month period beginning on the Effective Date, and each twelve (12)-month period beginning on each annual anniversary date of the Effective Date thereafter.

1.2 **Allowed Charges:** are charges billed by Provider, in accordance with Provider's Charge Master, for Provider Services furnished pursuant to this Agreement, less those charges, if any, disallowed by Blue Shield pursuant to Section III (General Notes) of Exhibit C and Exhibit C-1 hereto.

1.3 **Authorization/Authorized:** is the approval of Blue Shield, or its delegate, for the provision of Covered Services, obtained in accordance with, and as further described in, the Provider Manual and Section 2.6 of this Agreement.

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

1.5 **Blue Shield Providers:** are those licensed health care providers, including, without limitation, institutional providers, that have entered into agreements with Blue Shield to provide Covered Services to Members.

1.6 **Case Rate:** is a rate of reimbursement paid by Blue Shield for certain Provider Services identified in Exhibit C and Exhibit C-1 hereto, furnished during a single inpatient or outpatient admission, and, except as otherwise set forth in Exhibit C and Exhibit C-1, constitutes payment in full for all Provider Services provided by Provider during such admission.

1.7 **Charge Master:** is the uniform schedule of charges, in either electronic or printed form, represented by Provider to be its gross billed charges for all Provider procedures, services, supplies and drugs that are billed and charged on a UB-04 billing form or its electronic billing equivalent, regardless of payor type.

1.8 **Charge Master Year:** is the twelve (12)-month period beginning on [Charge Master Year], and each twelve (12)-month period beginning on each annual anniversary date of [Charge Master Year] thereafter.

1.9 **Copayment:** is any copayment, deductible, coinsurance and/or amounts in excess of the maximum benefit for which a Member is financially responsible in connection with the receipt of Covered Services, as specifically described in the Health Services Contract and/or Evidence of Coverage applicable to the Member and in effect as of the date of service.

1.10 **Covered Services:** are Medically Necessary health care services, supplies and drugs that a Member is entitled to receive pursuant to the Health Services Contract and/or Evidence of Coverage applicable to the Member.

1.11 **Emergency Services:** are Covered Services required to address an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the Member's health in serious jeopardy, or in the case of a pregnant woman, the health of the woman or her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. For Blue Shield Medicare Advantage Members, Emergency Services also include any other services defined as emergency services in Title 42 of the Code of Federal Regulations, Section 422.113.

1.12 **Evidence of Coverage:** is the document issued to a Member, pursuant to California law,

that describes the benefits, limitations and other features of the Benefit Program in which the Member is enrolled.

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

1.14 **Inpatient:** is a Member who: (a) is admitted to Provider as a registered bed patient with the expectation of staying overnight, and (b) is receiving services ordered by and under the direction of a physician or other health care provider with appropriate medical staff privileges at Provider.

1.15 **Inpatient Services:** are Provider Services provided to an Inpatient, including: (a) all Provider Services provided to a Member on the same date as the commencement of the Member's admission as an Inpatient, if related to the condition for which the Member is admitted; and (b) transportation services required for treatment of the Member following admission as an Inpatient at Provider and until discharge.

1.16 **Medically Necessary or Medical Necessity:** means, with respect to the provision of medical services, supplies and drugs: (a) required by a Member; (b) provided in accordance with recognized professional medical and surgical practices and standards; (c) appropriate and necessary for the symptoms, diagnosis, or treatment of the Member's medical condition; (d) provided for the diagnosis and direct care and treatment of such medical condition; (e) not furnished primarily for the convenience of the Member, the Member's family, or the treating provider or other provider; (f) furnished at the most appropriate level that can be provided consistent with generally accepted medical standards of care; (g) with respect to Inpatient Services, could not have been provided in a physician's office, the Outpatient department of a hospital, or in another less acute facility without adversely affecting the Member's condition or the quality of medical care rendered; and (h) consistent with Blue Shield Medical Policy and Blue Shield Medication Policy.

1.17 **Member:** is an individual who is eligible for and enrolled in a Benefit Program to which this Agreement applies (as identified in Exhibit B) or a health benefit plan of an Other Payor (as defined in Section 11.1 hereof).

1.18 **Outpatient Services:** are Provider Services other than Inpatient Services.

1.19 **Per Diem Rate:** is a rate of reimbursement paid by Blue Shield on a per-day basis for certain Inpatient Services identified in Exhibit C and Exhibit C-1 hereto, and, except as otherwise set forth in Exhibit C and Exhibit C-1, constitutes payment in full for all Provider Services provided by Provider during each such day.

1.20 **Per Visit Rate:** is a rate of reimbursement paid by Blue Shield on a per-visit basis for certain Outpatient Services identified in Exhibit C and Exhibit C-1 hereto, and, except as otherwise set forth in Exhibit C and Exhibit C-1, constitutes payment in full for all

Outpatient Services provided by Provider during each such visit.

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

1.22 **Provider Manual:** is the set of manuals developed by Blue Shield that set forth the operational rules and procedures applicable to Provider and the performance of services hereunder, and such other documents used by Blue Shield to determine reimbursement rates under the terms of this Agreement, including, without limitation, Blue Shield's ICD-10 Service Category Code File.

1.23 **Provider Services:** are those Covered Services that Provider is licensed to provide.

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

II. OBLIGATIONS OF PROVIDER

2.1 **Provider Services.** Provider shall provide Provider Services to Members, as directed by Members' treating physicians or as otherwise Medically Necessary, in accordance with the terms of this Agreement. Notwithstanding anything in this Agreement to the contrary, this Agreement shall not apply to or govern the provision of provider services to Members enrolled in HMO programs (including, without limitation, Medicare Advantage) for which Provider receives capitation payments pursuant to a separate capitated provider agreement, if any, between Provider and Blue Shield.

2.2 **Location and Availability.**

(a) Provider Services shall be provided and made reasonably available at the location(s) set forth in Exhibit A hereto. Subject to bed availability and compliance with its admission criteria, Provider will accept Authorized admissions of Members twenty-four (24) hours a day.

(b) Provider shall cooperate and comply with Blue Shield's language assistance program, as set forth in the Provider Manual. Nothing in this Section shall be construed as a delegation to Provider of Blue Shield's obligations pursuant to Section 1300.67.04 of Title 28 of the California Code of Regulations or Section

2538.3 of Title 10 of the California Code of Regulation.

2.3 **Licensure & Accreditation.** At all times during the term of this Agreement, Provider shall be licensed by the state of California, certified under Title XVIII of the Social Security Act, and accredited by The Joint Commission or an alternative CMS-approved accreditation agency applicable to Provider and approved by Blue Shield.

2.4 **Standards for Provision of Care.** Provider shall maintain its facilities and equipment in accordance with all applicable legal requirements. Provider shall comply with all federal and state laws, licensing requirements, and professional standards, and provide its services in accordance with generally accepted Provider practices and standards prevailing in the applicable professional community at the time of treatment. Consistent with Title 10 of the California Code of Regulations, Section 2240.4, Provider's primary consideration shall be the quality of the health care services rendered to Members.

2.5 **Quality Improvement/Case Management/Utilization Management Programs.**

(a) Provider shall comply with Blue Shield's Medical Policy and Blue Shield Medication Policy. Without limiting the foregoing, Provider shall cooperate fully with and participate in Blue Shield's Quality Improvement and Utilization Management Programs, including its Authorization procedures, as set forth in this Agreement and as described in the Provider Manual. Provider shall comply with the decisions of the Blue Shield Quality Improvement and Utilization Management Programs. If Provider disputes any such decision, Provider shall comply with the decision pending resolution of the dispute through the Appeal Process described in Article IX of this Agreement.

(b) Provider shall cooperate fully with Blue Shield with regard to Healthcare Effectiveness Data and Information Set ("HEDIS") measurements, audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring, and quality improvement studies and initiatives.

(c) Provider shall maintain a quality management program pursuant to which Provider will review, on a prospective, concurrent, and retrospective basis, the quality, appropriateness, and level of care furnished to Medicare Advantage Members. Such quality management program shall include, without limitation, an annual evaluation, annual quality management goals, proposed quality management studies, a description of Provider's quality management committee, and the frequency with which such committee holds meetings. Provider shall notify Blue Shield of any changes to such quality management program, which changes shall be subject to prior approval by Blue Shield.

2.6 **Service Authorization.** Provider shall comply with the Authorization procedures and requirements set forth in the Provider Manual and this Section 2.6. Provider understands and agrees that, except in the case of Emergency Services or as otherwise provided in the

Provider Manual, Provider Services must be Authorized in advance by Blue Shield or its delegate in order for Provider to be eligible for payment hereunder. In the case of Emergency Services, Provider shall obtain Authorization from Blue Shield or its delegate as soon as possible following stabilization of the Member, but in no event later than twenty-four (24) hours after providing post-stabilization services, or the next occurring non-holiday weekday, whichever is later. Blue Shield will not retroactively deny Provider's claims on the basis of Medical Necessity for services reviewed and Authorized pursuant to the Quality Improvement and Utilization Management Program, provided that Provider submitted full and accurate information to Blue Shield for review under its Quality Improvement and Utilization Management Program. If Provider fails to obtain Authorization, as required, or if Provider provides services outside of the scope of the Authorization obtained, then Blue Shield, or its delegate, shall have no obligation to compensate Provider for such services; Provider will be deemed to have waived payment for such services and shall not seek payment from Blue Shield, its delegate, or the Member.

2.7 **Cooperation with Discharge Planning.** Provider shall cooperate fully with Blue Shield or its delegate in planning and implementing the discharge of Members from Provider's facility(ies), including, without limitation, providing Blue Shield's on-site discharge planning coordinator(s) reasonable access to Provider's facility(ies) and Members.

2.8 **Physician Access.** Provider shall provide each Member's treating physician such access to Provider's facilities as may be appropriate to provide professional services to the Member, in accordance with the bylaws, rules, and regulations established by Provider with the approval of Provider's governing board. Members' physicians shall not be denied staff membership or clinical privileges on the basis of sex, race, age, religion, color, national origin, sexual orientation, disability, or any other criteria lacking professional justification, nor will such privileges be arbitrarily delayed. If a Member requires the care of a specialist physician, and no such physician who is a Blue Shield Provider has active privileges at Provider, Provider shall consider, in as rapid a manner as possible, taking into consideration possible emergency situations, requests from qualified persons for temporary privileges at Provider, and shall grant such temporary privileges, provided such persons meet and conform to the requirements of Provider's medical staff bylaws and rules and regulations for temporary privileges.

2.9 **Submission of Physician Hospital Privilege Roster.** Provider shall provide Blue Shield with an updated physician privilege roster, preferably in electronic format, at least annually, as well as upon Blue Shield's request, which shall not exceed two (2) requests annually.

2.10 **Provider Manual.** Provider shall comply with the Provider Manual, the terms of which are incorporated herein by reference. Blue Shield may, in its sole discretion, periodically modify the Provider Manual. Blue Shield will notify Provider forty-five (45) working days prior to the effective date of any change to the Provider Manual. If Provider reasonably concludes that a change to the Provider Manual is material, Provider shall notify Blue Shield, in writing, prior to the effective date of the change. Following receipt of Provider's

notice, Provider and Blue Shield shall confer in good faith regarding the change. If Provider and Blue Shield are unable to reach agreement regarding the change within thirty (30) days of Provider's notice, then, within sixty (60) days of Provider's notice, Provider may elect to terminate this Agreement for cause pursuant to Section 10.3 hereof, and the Provider Manual change to which Provider objected shall not be effective as to Provider during the termination notice period. To the extent of any conflict between this Agreement and the Provider Manual, the terms of this Agreement shall govern.

2.11 **Disclosures.** Provider shall immediately notify Blue Shield in writing of the occurrence of any of the following events: (a) loss or restriction of any license or certification required in order for Provider to provide Provider Services; (b) loss of any accreditation required by Section 2.3; (c) Provider is excluded or suspended from participation in, ceases to be certified by, or is sanctioned by any state or federal healthcare program, including, without limitation, Medicare or Medi-Cal; (d) Provider's liability insurance is canceled, terminated, not renewed, or materially modified; (e) Provider becomes a defendant in a lawsuit filed by a Member or is required or agrees to pay damages to a Member for any reason; (f) any changes to the hospital-based physicians or physician groups providing services at Provider; (g) any labor action or work stoppage that may materially impact Provider's operations; (h) a petition is filed to declare Provider bankrupt or for reorganization under the bankruptcy laws of the United States or a receiver is appointed over all or any portion of Provider's assets; or (i) any act of nature or other event or circumstance which has or reasonably could be expected to have a materially adverse effect on Provider's ability to perform its obligations under this Agreement. In addition, Provider shall provide Blue Shield with no fewer than ninety (90) days' prior written notice of any proposed material change in the ownership of Provider, or the sale of all or substantially all of the assets of Provider.

2.12 **Directory Information Validation.** Blue Shield or its vendor(s), on behalf of itself and its affiliates accessing services under this Agreement, shall regularly send Provider a notice in accordance with Section 116 of the Consolidated Appropriations Act of 2021 and Health and Safety Code Section 1367.27(l) to validate Provider information in order to maintain the directory of Blue Shield Providers described in Section 3.1 of this Agreement. If, after following the process described in the Provider Manual, Blue Shield or its vendor(s) has not received a response from Provider, Blue Shield may delay payment or reimbursement in accordance with 1367.27 of the California Health and Safety Code.

III. OBLIGATIONS OF BLUE SHIELD

3.1 **Directory & Use of Names.**

(a) Blue Shield maintains a directory of Blue Shield Providers that is made available to Members and/or Blue Shield Providers. Blue Shield shall maintain said directory pursuant to state and federal law, including, but not limited to, Section 116 of the

Consolidated Appropriations Act of 2021, California Health and Safety Code 1367.27 and 42 C.F.R. Section 438.10. Blue Shield may engage a vendor or vendors that performs some or most of Blue Shield's provider directory maintenance tasks on behalf of Blue Shield ("Directory Vendor"). Blue Shield shall identify any such Directory Vendor to Provider and, throughout the term of this Agreement, Provider shall maintain a participation agreement with such Directory Vendor to facilitate exchange of directory data about Provider. With respect to provisions of this Agreement pertaining to Blue Shield's provider directory, Provider shall be equally obligated to respond and otherwise cooperate with either Directory Vendor or Blue Shield itself, as Blue Shield directs.

(b) Provider may identify itself as a Blue Shield Provider.

(c) Except as provided in Sections 3.1(a) and (b), neither party shall use the other party's name, trademark(s), or service mark(s), without the other party's prior written consent, which consent shall not be unreasonably withheld.

3.2 **Administrative Services .** Blue Shield shall perform those services incident to the administration of a health care service plan, including, without limitation, processing enrollment applications and adjudicating claims for Covered Services that are the payment responsibility of Blue Shield.

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

IV. ELIGIBILITY OF BLUE SHIELD MEMBERS

4.1 **Identification Cards & Verification.** Blue Shield shall issue identification cards to Members, as set forth in the Provider Manual. Production of such identification cards shall be indicative of, but not conclusive of, a person's status as a Member. Blue Shield shall provide or shall make available to Provider, in formats that may be accessed by Provider electronically or telephonically, information regarding Member status.

4.2 **Verification of Eligibility.** Provider shall verify the eligibility of Members in accordance with the Provider Manual. If Provider fails to verify Member eligibility in accordance with the Provider Manual, Blue Shield shall have no obligation to compensate Provider for any services provided to patients who are not Members at the time such services are rendered. Provider shall be entitled to reasonably rely on verification of Member eligibility provided by Blue Shield. If Provider provides Authorized Provider Services in reasonable reliance upon verification of a patient's eligibility provided by Blue Shield, and such patient is

subsequently determined not to have been a Member at the time services were provided, Blue Shield shall compensate Provider for such Authorized Provider Services at the rates set forth herein, less amounts, if any, due to Provider from any other health care service plan, insurer or third party payor (including Medicare) by which such patient is covered.

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

V. BILLING, COMPENSATION & CHARGE MASTER OBLIGATIONS

5.1 **Claims Submission.** Provider shall bill Blue Shield for Provider Services as follows:

(a) Provider shall bill Blue Shield according to Provider's Charge Master.

(b) Provider shall bill Blue Shield once for every thirty (30) consecutive days that a Member receives Provider Services. If Provider provides Provider Services to a Member for a period fewer than thirty (30) consecutive days (including any such time period following a thirty (30)-day period for which Provider has already billed Blue Shield), then Provider shall bill Blue Shield for such shorter period of time.

(c) Provider shall submit claims to Blue Shield within ninety (90) days following the end of each period described in Section 5.1(b) or, if Blue Shield is not the primary payor under the coordination of benefits rules described in Section 5.2(e), the date payment or denial is received by Provider from the primary payor. Blue Shield may deny payment for any claims not received by Blue Shield within one hundred eighty (180) days of the end of any such period or date. If Provider fails to submit a claim in a timely fashion, as set forth in this Section 5.1, Provider waives its right to any remedies and to pursue the claim further, and may not initiate a demand for arbitration or other legal action against Blue Shield or bill the Member for Provider Services for which Blue Shield so denied payment; provided, however, that Blue Shield shall, upon submission of a Provider Appeal by Provider, consider good cause for late submission of a claim denied as untimely.

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

(e) In the adjudication of claims for payment hereunder, Blue Shield may request from Provider, and Provider shall provide to Blue Shield, such records as Blue Shield reasonably deems necessary to confirm that individually billed services(s) were rendered and/or were Medically Necessary.

(f) Notwithstanding the foregoing provisions of this Section 5.1, if Provider provides Provider Services to a Member and such Provider Services are the financial responsibility of a Blue Shield Provider who is capitated by Blue Shield for such Provider Services, Provider shall submit billings for such Provider Services to, and seek payment from, such capitated Blue Shield Provider, in accordance with procedures set forth in the Provider Manual. If Provider is unable to obtain payment from such capitated Blue Shield Provider, Provider shall notify Blue Shield. Blue Shield shall, within sixty (60) days, seek to resolve the non-payment by the capitated Blue Shield Provider. If a capitated Blue Shield Provider is financially responsible for Provider Service provided hereunder, and such Blue Shield Provider does not have an agreement with Provider relating to the payment for such Provider Services, Provider shall accept as payment from such Blue Shield Provider (or from Blue Shield on behalf of the Blue Shield Provider) the reimbursement rates set forth in this Agreement.

5.2 **Compensation Amounts.** Blue Shield shall pay Provider in accordance with the following:

(a) In exchange for Provider Services provided to Members enrolled in a Blue Shield commercial Benefit Program, Blue Shield shall pay Provider the lesser of: (i) the percentage of Provider's Allowed Charges specified in the table below, and (ii) the reimbursement rates set forth in this Agreement, in either case, less any applicable Copayment.

	EFFECTIVE 06/01/2025	EFFECTIVE 06/01/2026	EFFECTIVE 06/01/2027
Percentage of Allowed Charges - Inpatient	100%	100%	100%
Percentage of Allowed Charges - Outpatient	100%	100%	100%

(b) In exchange for Provider Services provided to Members enrolled in a Blue Shield Medicare Advantage Benefit Program, Blue Shield shall pay Provider the lesser of: (i) the percentage of Provider's Allowed Charges, as specified in the table below, (ii) the reimbursement rates set forth in this Agreement, and (iii) the reimbursement established by the Medicare program for such services, in any case, less any applicable Copayment.

	EFFECTIVE 06/01/2025	EFFECTIVE 06/01/2026	EFFECTIVE 06/01/2027
Percentage of Allowed Charges - Inpatient	100%	100%	100%
Percentage of Allowed Charges - Outpatient	100%	100%	100%

(c) If, after the Effective Date, Provider adds to its license a new category of service or service unit, the terms of this Agreement will apply to such new category of service

or service(s) furnished by such new unit. Provider shall accept as payment the lesser of: (i) one hundred percent (100%) of Provider's Allowed Charges for such service(s), and (ii) the outpatient rates set forth in Exhibit C and Exhibit C-1, until such a time as Blue Shield and Provider have negotiated and agreed upon a separate reimbursement rate for such service(s).

(d) Payment for Provider Services shall be made by Blue Shield within the timeframes mandated by applicable state or federal law, following receipt of all reasonably necessary information. Provider shall accept electronic payment for Provider Services and receive related explanations of payments ("EOPs") via electronic funds transfer ("EFT") and electronic remittance advice ("ERA"), respectively.

(e) Coordination of benefits, benefit determinations under the Medicare Secondary Payor rules, and Workers' Compensation recoveries shall be conducted by Provider in accordance with the procedures set forth in the Provider Manual. Notwithstanding Section 5.1 or the foregoing provisions of this Section 5.2, if Blue Shield is not the primary payor under coordination of benefit rules, Provider shall not make any demand for payment from Blue Shield until all primary sources of payment have been pursued. In such cases, Blue Shield's financial obligation for Provider Services shall be limited to the amount, if any, which, when added to the amount obtained by Provider from all primary payors, equals the amount of compensation to which Provider is entitled under this Agreement for such Provider Services. Coordination of benefits, benefit determinations under the Medicare Secondary Payor rules, and Workers' Compensation recoveries shall be conducted by Provider in accordance with the procedures set forth in the Provider Manual. Notwithstanding Section 5.1 or the foregoing provisions of this Section 5.2, if Blue Shield is not the primary payor under coordination of benefit rules, Provider shall not make any demand for payment from Blue Shield until all primary sources of payment have been pursued. In such cases, Blue Shield's financial obligation for Provider Services shall be limited to the amount, if any, which, when added to the amount obtained by Provider from all primary payors, equals the amount of compensation to which Provider is entitled under this Agreement for such Provider Services.

(f) Provider agrees to accept payment pursuant to this Section 5.2, together with applicable Copayments payable by a Member, and coordination of benefit collections and third party recoveries allowed under this Agreement, as payment in full for Provider Services.

5.3 **Copayments.** Provider shall collect and retain, as additional compensation, the Member's applicable Copayment for Provider Services provided by Provider. Copayments for Provider Services shall be calculated based on the lesser of: (i) the applicable Charge Master rate, and (ii) the applicable reimbursement rates set forth in Exhibit C and Exhibit C-1 hereto. Provider shall not waive a Member's Copayment obligation. Notwithstanding the foregoing, Provider acknowledges that cost sharing for Members eligible for both

Medicare and Medicaid/Medi-Cal ("Dual Eligible Members") is limited to the cost sharing limits established by Medicaid/Medi-Cal. With respect to Provider Services provided to Dual Eligible Members, Provider shall accept payment by Blue Shield as payment-in-full for such Provider Services, or will separately bill the appropriate State source for any amounts above the Medicaid/Medi-Cal cost sharing limits.

5.4 Claims Overpayments and Recoveries.

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

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

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

(d) If Provider does not reimburse Blue Shield for an Uncontested Claims Overpayment within the thirty (30) business day period, then, beginning as of the first calendar day following the expiration of the thirty (30) business day period, Blue Shield may commence offsetting the amount of the Uncontested Claims Overpayment from Provider's then-current claims. If Blue Shield exercises its offset rights under this Section 5.4(d), Blue Shield shall provide Provider a detailed written explanation identifying the specific Claims Overpayments that have been offset against the specific current claims.

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

(f) In the event Provider desires to dispute the Final Claims Overpayment Determination, Provider must timely follow the dispute resolution process set forth in Section 9.2 (subject to Section 9.3) of this Agreement.

(g) If Provider fails to timely reimburse Blue Shield for a Final Claims Overpayment Determination that Provider has not timely submitted to dispute resolution under Section 9.2 (subject to Section 9.3) of this Agreement, then the Final Claims Overpayment Determination shall be treated as an Uncontested Claims Overpayment. Beginning as of the first calendar day following the expiration of the date Provider had to dispute the Final Claims Overpayment Determination under Section 9.2 (subject to Section 9.3) of this Agreement, Blue Shield may commence offsetting the amount of the Uncontested Claims Overpayment from Provider's then-current claims. If Blue Shield exercises its offset rights under this Section 5.4(g), Blue Shield shall provide Provider a detailed written explanation identifying the specific Claims Overpayments that have been offset against the specific current claims.

(h) In the event Provider fails to provide Blue Shield notice that Provider contests a Claims Overpayment within the timeframe and in the manner set forth herein, and/or if Provider fails to timely initiate the dispute resolution process referenced in Section 5.4(f) above, Provider shall have no right to pursue any further appeal or remedy with respect to the Claims Overpayment or the Final Claims Overpayment Determination, including, without limitation, initiation of any arbitration or civil action in state or federal court, and Provider shall have no right to pursue payment of any disputed amounts from the Member.

5.5 **Payments to Subcontractors.** If Provider subcontracts with any individual or entity to provide Covered Services on behalf of Provider, Provider shall process claims from and

pay such individual or entity for such Covered Services in compliance with the timeliness requirements set forth in applicable state and federal law.

5.6 BlueCard Claims.

(a) If and for so long as Provider is contracted with both Blue Shield and another licensee of the Association (as defined in Section 12.12) in the State of California, Provider shall use best efforts to increase the number of claims for Provider Services reimbursable through the BlueCard Program (as defined in the Provider Manual) sent to Blue Shield. Blue Shield will provide education and/or reference materials to Provider reasonably necessary to inform Provider of the relevant processes associated with the BlueCard Program and assist Provider in identifying BlueCard Program Members.

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

(c) Nothing in either Section 5.6(a) or 5.6(b) shall be construed to require Provider to submit to Blue Shield for processing claims for Provider Services furnished to a Member enrolled in a benefit plan having an exclusive arrangement with another licensee of the Association in the State of California, it being expressly understood that claims for Provider Services furnished to a Member enrolled in a benefit plan having an exclusive arrangement with a particular licensee of the Association in the State of California should be sent to and processed by such licensee.

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VI. PROTECTION OF MEMBERS

6.1 Non-discrimination. Except as otherwise provided in this Agreement, Provider shall provide Provider Services to Members in the same manner, in accordance with the same standards, and with the same level of availability as Provider provides services to its other patients. Provider shall not discriminate against any Member in the provision of Provider Services on the basis of race, sex, gender, gender identity, gender expression, color, religion, national origin, ancestry, age, marital status, physical or mental handicap, health

status, disability, need for medical care, utilization of medical or mental health services or supplies, sexual preference or orientation, veteran's status, health insurance coverage, status as a Member, or other unlawful basis, including, without limitation, the filing by a Member of any complaint, grievance, or legal action against Provider.

6.2 Charges to Members.

(a) Except as expressly set forth in this Agreement, in no event, including, without limitation, nonpayment by Blue Shield or Blue Shield's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, impose a surcharge on, seek compensation, remuneration, or reimbursement from, or have any recourse against, a Member, or any individual responsible for such Member's care, for Covered Services. Without limiting the foregoing, Provider shall not seek payment from a Member, or any individual responsible for such Member's care, for Covered Services for which payment was denied by Blue Shield because the bill or claim for such Covered Services was not timely or properly submitted. If Blue Shield receives notice of a violation of this Section 6.2, it shall have the right to take all appropriate action, including, without limitation, reimbursing the Member for the amount of any payment made and offsetting the amount of such payment from any amounts then or thereafter owed by Blue Shield to Provider.

(b) Provider shall not bill or collect from a Member, or any individual responsible for such Member's care, any charges in connection with non-Covered Services, non-Authorized services, or services determined not to be Medically Necessary, unless Provider has first obtained a written acknowledgment from the Member, or the individual responsible for the Member's care, that such services are not Covered Services, not Authorized, or not Medically Necessary, as the case may be, and that the Member, or the individual responsible for the Member's care, is financially responsible for the cost of such services. Such acknowledgment shall be obtained prior to the time such services are provided to the Member, shall specify the specific services for which the Member, or the individual responsible for the Member's care, is agreeing to accept financial responsibility, and shall otherwise satisfy the applicable requirements set forth in the Provider Manual.

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

(d) The provisions of this Section 6.2 shall: (i) survive the expiration or termination for any reason of this Agreement; (ii) be construed to be for the benefit of Members; and (iii) supersede any oral or written contrary agreement (now existing or hereafter

entered into) between Provider and the Member.

(e) The provisions of this Section 6.2 shall be incorporated into every written contract between Provider and any subcontractor providing Provider Services hereunder.

(f) This Section 6.2 shall not be modified without the prior approval of the appropriate government regulatory agency.

6.3 **Third Party Liens.** If a Member seeks and obtains a recovery from a third party or a third party's insurer for injuries caused to that Member, and only to the extent permitted by the Member's Evidence of Coverage and by state and federal law, Provider shall have the right to assert a third party lien for and to recover from the Member the reasonable value of Covered Services provided to the Member by Provider for the injuries caused by the third party. Provider's pursuit and recovery under third party liens shall be conducted in strict accordance with the procedures set forth in the Provider Manual. Blue Shield shall similarly have the right to assert a lien for and recover for payments made by Blue Shield for such injuries. Provider shall cooperate with Blue Shield in identifying such third party liability claims and in providing such information, within such time frames, as set forth in the Provider Manual.

6.4 **Benefits Determination.** Blue Shield reserves the right to make all final decisions regarding Benefit Program coverage. Provider shall refer Members who have inquiries or disputes regarding such coverage to Blue Shield for response or resolution. Notwithstanding the foregoing, this Section does not, and shall not be construed to, prohibit any physician from providing any medical treatment, or other advice that such physician believes to be in the best interest of the patient.

6.5 **Member Complaints & Grievances.** Provider shall promptly notify Blue Shield of receipt of any claims, including, without limitation, professional liability claims, filed or asserted by a Member against Provider. Provider shall cooperate with Blue Shield in identifying, processing, and resolving all Member grievances and other complaints in accordance with Blue Shield's complaint/grievance process and time limits set forth in the Provider Manual, as well as in accordance with such time limits as required by state and/or federal law. Provider shall comply with Blue Shield's resolution of any such complaints or grievances and any specific findings, conclusions or orders of the California Department of Managed Health Care ("DMHC") (or any successor agency).

6.6 **Medical Necessity Assistance.** In all cases where Blue Shield or its delegate is making or has made a determination regarding the Medical Necessity of a medical service requested or provided to a Member, Provider shall, upon the request of Blue Shield or its delegate, assist Blue Shield and/or its delegate in determining or verifying the Medical Necessity of such service, provide relevant medical records to Blue Shield and/or its delegate, and participate in any grievance, arbitration, and/or other proceedings in which such Medical Necessity determination is an issue. In addition, Provider shall cooperate with and abide by the Medical Necessity determination of any external review entity to which Blue Shield

is either obligated by law to submit such disputes or with which Blue Shield has implemented a program to submit such disputes to external review.

6.7 **Free Exchange of Information.** No provision of this Agreement shall be construed to prohibit, nor shall any provision in any contract between Provider and its employees or subcontractors prohibit, the free, open and unrestricted exchange of any and all information of any kind between health care providers and Members regarding the nature of the Member's medical condition, available health care treatment options and alternatives and their relative risks and benefits, whether or not covered or excluded under the Member's Benefit Program, and the Member's right to appeal any adverse decision made by Provider or Blue Shield regarding coverage of treatment that has been recommended or provided. Provider shall neither penalize nor sanction any health care provider in any way for engaging in such free, open, and unrestricted communication with a Member or for advocating for a particular service on a Member's behalf.

6.8 **Insurance.**

(a) Provider shall maintain professional liability (malpractice) insurance and general liability insurance coverage in the minimum amount of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) annual aggregate. If Provider maintains a "claims made" malpractice insurance policy, Provider shall keep such policy in effect for at least five (5) years following the expiration or termination for any reason of this Agreement or purchase extended reporting coverage (tail insurance) sufficient to ensure that insurance coverage in the amount set forth in this Section 6.8(a) is maintained for claims which arise from services provided by Provider during the term of this Agreement.

(b) Provider shall maintain Workers' Compensation insurance covering all employees of Provider.

(c) Provider shall notify and provide evidence to Blue Shield at the time of any amendment, change, or modification to such insurance coverage, and at any other time upon reasonable request by Blue Shield.

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

VII. MEDICAL RECORDS & CONFIDENTIALITY

7.1 **Medical Records.** Provider shall prepare and/or maintain complete, timely and accurate medical and other records with respect to services provided to Members, in the same manner as for other patients of Provider. Provider will require that all physicians treating

Members at Provider's facility(ies) create and maintain, in an accurate and timely manner, for each Member who has obtained care from such physician, a medical record that is organized in a manner that contains such demographic and clinical information as is necessary, in the opinion of the Blue Shield medical director and the Provider medical director, to adequately document the medical problems of, and medical services provided to, the Member. Such records shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the physician. Such records shall be in such a form as to allow trained health professionals, other than the physician, to readily determine the nature and extent of the Member's medical problem and the services provided and to permit peer review of the care provided. Such records shall, upon request, and without unreasonable delay, be made available without charge to Blue Shield and its designated agents. Failure to provide such records shall be deemed a material breach of the Agreement. Without limiting the foregoing, Provider shall, without charge, transmit Member's medical records information to a Member's other providers, to Government Officials (as defined in Section 8.1(a)), and to Blue Shield for purposes of utilization management, quality improvement, and other Blue Shield administrative purposes. Provider shall secure from the Member, upon admission or prior to providing services, a release of medical information, if such a release is required by law.

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

7.3 **Member Access to Records.** Provider shall ensure that Members have access to their medical records, in accordance with the requirements of state and federal law.

VIII. COOPERATION WITH AUDITS & CERTIFICATIONS

8.1 **Disclosure of Records.**

(a) Provider shall comply with all provisions of the Omnibus Reconciliation Act of 1980 regarding access to books, documents, and records. Without limiting the foregoing, Provider shall maintain such records and provide such information to Blue Shield and to the DMHC (or any successor agency), the Department of Health and Human Services ("DHHS"), CMS, any Quality Improvement Organization

("QIO") with which CMS contracts, the U.S. Comptroller General, their designees and any other governmental officials entitled to such access by law (collectively, "Government Officials") as required by law and as necessary for compliance by Blue Shield with state and federal laws governing Blue Shield. Provider shall grant to Blue Shield and/or Government Officials, upon request and within a reasonable amount of time, access to and copies of the medical records, books, charts, papers, and computer or other electronic systems relating to Provider's provision of health care services to Members, the cost of such services, and payment received by Provider from the Member (or from others on the Member's behalf), and to the financial condition of Provider. Such records described herein shall be maintained at least six (6) years from the date of service or in the case of financial records of Provider, six (6) consecutive fiscal years, and, if this Agreement is applicable to Blue Shield's Medicare Advantage program, ten (10) years from the end of the final contract period between Blue Shield and CMS or the completion of any audit of Blue Shield or its subcontractors by DHHS, the General Accounting Office or their designees (or for a particular record or group of records, a longer time period when CMS or DMHC requests such longer record retention and Provider is notified of such request by Blue Shield), and in no event for a shorter period than as may be required by the Knox-Keene Act and the regulations promulgated thereunder. All books, documents, and records of Provider shall be maintained in accordance with the general standards applicable to such book, document, or record keeping and shall be maintained during any audit or investigation by Government Officials. The obligation to retain records is not terminated upon termination of the agreement, whether by rescission or otherwise.

(b) Provider shall, on request, disclose to Government Officials the method and amount of compensation or other consideration to be received by it from Blue Shield or payable by Provider to its subcontractors. Provider shall maintain and make available to Government Officials: (i) its subcontracts; and (ii) compensation/financial records relating to such subcontracts and compensation from Blue Shield.

(c) Upon forty-eight (48) hours' prior notice, Provider shall make any records of its quality improvement and utilization review activities pertaining to Members and provider credentialing files available to Blue Shield's Quality and Utilization Review Committee. Such sharing of records shall be in accordance with, and limited as required by, Section 1157 of the California Evidence Code and Section 1370 of the California Health and Safety Code, and shall not be construed as a waiver of any rights or privileges conferred on either party by those statutes.

(d) Provider shall permit Blue Shield, or its delegate, at Blue Shield's sole cost and expense, and with reasonable prior notice to Provider, to audit the books and records of Provider as they relate to Provider's services, billings, claims payments, and reporting pursuant to this Agreement.

8.2 **Site Evaluations.** Provider shall permit Government Officials and Blue Shield to conduct periodic site evaluations and inspections of its facilities and records. If a Government Official or Blue Shield finds any deficiencies in such facilities or records, Provider shall correct such deficiencies within thirty (30) days of receipt of notice from such Government Official or Blue Shield, unless the Government Official requires that such deficiency be corrected within a shorter timeframe.

8.3 **Accreditation Surveys.** Provider shall cooperate in the manner described in Sections 8.1 and 8.2 hereof with respect to surveys and site evaluations relating to accreditation of Blue Shield by the National Committee For Quality Assurance ("NCQA") or any other accrediting organization. Provider further agrees to promptly implement any changes Blue Shield deems reasonably required as a result of any such survey.

8.4 **Performance/Compliance Monitoring.** Provider shall cooperate with Blue Shield in the performance of any monitoring, studies, evaluations, analyses or surveys of Provider's performance of services hereunder, required by Government Officials, accrediting organizations, or the Association (as defined in 12.12). Nothing in this Agreement shall prohibit Blue Shield from using, releasing, and/or publishing Provider performance data.

IX. RESOLUTION OF DISPUTES

9.1 **Claims Dispute Resolution Process .** The parties agree that the terms and conditions set forth in this Section 9.1 shall apply to all disputes relating to or arising out of a Claims Determination.

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

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

(b) This Section 9.1 does not in any way modify the provisions of Section 9.2 relating to arbitration of disputes that cannot be resolved through the Appeal Process. However, if Provider fails to submit a Provider Appeal within the timeframes set forth in the Provider Manual, and complete the Appeal Process, Provider shall be

deemed to have waived its right to any remedies and to further pursue any dispute arising out of or relating to a Claims Determination. Without limiting the foregoing, in such instance, Provider may neither initiate a demand for arbitration pursuant to Section 9.2 and Section 9.3 of this Agreement nor pursue additional payment from the Member.

9.2 **Arbitration of Disputes** Any dispute between Provider and Blue Shield shall be settled by final and binding arbitration in San Francisco, Los Angeles, San Diego or Sacramento, California, whichever city is closest to Provider, including any dispute arising out of or related to (a) a Claims Determination (as defined in Section 9.1 of this Agreement) or a Claims Overpayment or Final Claims Overpayment Determination (as such terms are defined in Section 5.4 of this Agreement) that exceeds the jurisdiction of Small Claims Court and that was reviewed through, but not resolved by, the Appeal Process set forth in Section 9.1 of this Agreement, and (b) other disputes that were reviewed through, but not resolved by, the dispute resolution process set forth in Section 9.4 of this Agreement. The parties agree that (a) timely pursuit and completion of the Appeal Process set forth in Section 9.1 of this Agreement shall be a condition precedent to submitting a demand for arbitration for disputes arising out of or related to Claims Determinations, and (b) timely notice that Provider contests a Claims Overpayment and completion of the Final Claims Overpayment Determination as set forth in Section 5.4 of this Agreement shall be a condition precedent to submitting a demand for arbitration of disputes arising out of or related to Claims Overpayment and Final Claims Overpayment Determinations, and (c) timely pursuit and completion of the dispute resolution process set forth in Section 9.4 of this Agreement shall be a condition precedent to submitting a demand for arbitration of other disputes. Arbitration shall be conducted by and under the Commercial Rules of the American Arbitration Association. The arbitrator shall be a retired judge of the State of California, unless otherwise agreed to by the parties. The arbitration decision shall be binding on both parties. The arbitrator shall be bound by applicable Laws and Regulations and shall issue written findings of fact and conclusions of law. The arbitrator shall have no authority to award damages or provide a remedy that would not be available to such prevailing party in a court of law nor shall the arbitrator have the authority to award punitive, incidental, or consequential damages, or to add to, modify, or otherwise refuse to enforce any agreements between the parties. The parties acknowledge that arbitration of a dispute under this Agreement may require the disclosure or exchange of confidential or sensitive information. Therefore, the parties agree to enter into protective orders, including without limitation limiting certain discovery documents to "attorney's eyes only" to the extent possible in view of the context and nature of the dispute and documents to be disclosed. The parties further agree that any and all discovery information disclosed or exchanged as part of an arbitration proceeding shall be used solely within the arbitration of the dispute between the parties and shall not be used for any other purpose. Within thirty (30) days following the date of a final arbitration award, each party shall return or destroy any documents of the other party that were subject to a protective order. The cost of the arbitration shall be shared equally by Provider and Blue Shield; provided, however, that each party shall be responsible for its own attorneys' fees and costs. Notwithstanding any other term of this Agreement to the contrary, for purposes of clarity, the parties agree that

arbitration shall not apply to, and the arbitrator shall have no authority to conduct arbitration or to issue a decision with respect to, any class arbitration or other claim brought by Provider on behalf of the general public under a statute or regulation that allows an individual to sue on behalf of the Attorney General or other federal, state or municipal actor, or in any other representative capacity, or to any claims of medical malpractice, breach of privacy or HIPAA obligations, or intellectual property claims.

9.3 **Limitation of Actions.** A demand for arbitration pursuant to Section 9.2 must be filed within three hundred sixty-five (365) days of the date of the final appeal decision in the Appeal Process or the Final Claims Overpayment Determination, as applicable, notwithstanding any other communication between the parties that may take place, or payment(s) that may be made, subsequent to the final appeal decision in the Appeal Process or the Final Claims Overpayment Determination, as applicable, related to the lack of action or alleged breach that is the subject of the dispute. A demand for arbitration pursuant to Section 9.4 must be filed within three hundred sixty-five (365) days of the date the dispute arose, notwithstanding any meet and confer or other communication between the parties that may take place related to the dispute. Should the aggrieved party fail to file a demand for arbitration of the dispute within the timeframes set forth herein, the aggrieved party shall have waived its rights and remedies with respect to the dispute and any alleged breach, it shall have no right to pursue any remedy with respect to such dispute and alleged breach, including, without limitation, initiation of any arbitration or civil action in state or federal court, and, if the aggrieved party is Provider, Provider shall have no right to pursue payment of any disputed amounts from the Member. Pursuit by Provider of a dispute through the applicable process described in this Article XI shall neither modify nor relieve Provider of any obligations to continue providing services to Members in compliance with all terms of this Agreement.

In the event Provider, intentionally or unintentionally, initiates a demand for arbitration pursuant to Section 9.2 of this Agreement regarding the alleged underpayment of a claim for reimbursement for which Provider has failed to complete the Appeal Process within the time requirements of Section 9.1 of this Agreement, or regarding any other dispute for which Plan has failed to complete the dispute resolution process under Section 9.4 of this Agreement, then, upon notice from Blue Shield, Provider shall immediately dismiss the demand for arbitration as to any such claims and will reimburse Blue Shield for its reasonable costs and attorneys' fees associated with its defense of such untimely and/or unappealed claims.

9.4 **Dispute Resolution Process for Disputes Unrelated to Claims Determinations.** The parties agree that this Section 9.4 shall apply to controversies or disagreements between the parties arising out of or relating to the interpretation of the terms of this Agreement or a party's performance of or failure to perform its obligations under this Agreement. The parties further acknowledge and agree that this Section 9.4 shall not apply to controversies or disagreements that arise out of or relate to a Claims Determination, or to Claims Overpayments, or to Final Claims Overpayment Determinations, or to any claims of medical malpractice, breach of privacy or HIPAA obligations, or intellectual property

claims.

(a) The aggrieved party shall notify the other party, in writing, of a dispute under this Section 9.4 within one hundred eighty (180) days of the date the dispute arose. The dispute notice shall provide a description of the dispute that includes sufficient detail to reasonably enable the receiving party to evaluate the dispute and prepare to meet and confer with the aggrieved party, the date the dispute arose, reference(s) to any Agreement term(s) applicable to the dispute, supporting documentation, and proposed resolution(s) to the dispute.

(b) Blue Shield and Provider shall meet and confer in good faith to resolve the dispute within no more than sixty (60) days following the date of the receiving party's documented receipt of the dispute notice. In order for a meet and confer to satisfy the requirement set forth herein, an actual meeting must take place between employees of the parties, each of whom has the authority to resolve the dispute. The meet and confer may occur either in person, on the telephone, or through other electronic means that enable each of the participants to hear the other participants, as mutually agreed. The meet and confer meeting and all related communications between the parties, and any documents prepared or collected in connection with, or exchanged as part of the meet and confer process shall be treated as confidential protected compromise and settlement negotiations subject to applicable State law. The parties further acknowledge that the meet and confer requirement is intended to achieve an informal resolution to disputes between parties with an ongoing business relationship. Therefore, unless otherwise mutually agreed by the parties in advance of the meet and confer, neither party is allowed to have legal counsel present at the meeting or to substitute legal counsel for the party's employee(s) attending the meet and confer. If Provider and Blue Shield are unable to reach agreement and resolve the dispute through the meet and confer process required under this Section 9.4, then either party can initiate the demand for arbitration as permitted by Section 9.2, subject to Section 9.3 of this Agreement.

X. TERM & TERMINATION

10.1 **Term.** This Agreement shall become effective as of the Effective Date and shall continue in effect for one (1) year thereafter (the "Initial Term"), unless earlier terminated as set forth in this Agreement. Unless either party notifies the other party at least ninety (90) days prior to the expiration of the Initial Term, this Agreement shall automatically renew for additional terms of one (1) year each, unless and until terminated as set forth in this Agreement.

10.2 **Termination Without Cause.** During the Initial Term, neither party may terminate this Agreement without cause. Thereafter, either party may terminate this Agreement without cause by giving to the other party at least ninety (90) days' prior written notice of

termination. Any termination pursuant to this Section 10.2 shall become effective the first day of the calendar month following the expiration of the notice period.

10.3 Termination for Cause.

(a) Either party may terminate this Agreement for material cause, following written notice and the opportunity to cure described in Section 10.3(b). The following shall constitute material cause for termination:

(i) *By Provider:* (A) revocation of Blue Shield's license necessary for the performance of this Agreement; (B) breach by Blue Shield of any material term, covenant, or condition of this Agreement; or (C) failure of Blue Shield and Provider to agree upon any material change to the Provider Manual in accordance with Section 2.10.

(ii) *By Blue Shield:* (A) commencement of any voluntary or involuntary proceedings by or against Provider, or a parent, affiliate or subsidiary thereof, under any bankruptcy, reorganization, insolvency or other similar law of any jurisdiction; (B) any substantial deterioration in the financial condition of Provider or a parent, affiliate or subsidiary thereof; (C) failure by Provider to provide Provider Services consistent with the standards and/or procedures set forth in this Agreement and in the Provider Manual; (D) fraudulent billing or repeated billing in violation of the policies and/or procedures set forth in the Provider Manual; (E) revocation, termination, or restriction of any type of any license required in order for Provider to provide Provider Services pursuant to this Agreement; (F) breach by Provider of any material term, covenant, or condition of this Agreement, including, without limitation, repeated failure to comply with procedures set forth in the Provider Manual; or (G) a pattern or repeated failure of Provider to alert Blue Shield to a change in the information for Provider required to be in the directory of Blue Shield Providers pursuant to Health & Safety Code Section 1367.27.

(b) A party seeking to terminate this Agreement pursuant to Section 10.3(a) shall notify the other party in writing of the nature of the cause and shall provide the non-terminating party thirty (30) days from the receipt of such notice to cure or otherwise eliminate such cause. If, within such thirty (30) days, the non-terminating party does not remedy the breach, to the reasonable satisfaction of the terminating party, this Agreement shall terminate at the end of the thirty (30) day period.

10.4 Immediate Termination. Notwithstanding any provision of this Agreement to the contrary, Blue Shield may immediately terminate this Agreement, upon written notice to Provider, if: (i) Provider is excluded from participation in Medicare; (ii) Provider enters into a "private contract" with a Member for the provision of services, contrary to Medicare

regulations applicable to Blue Shield; (iii) Provider fails to maintain all insurance required herein; (iv) after consulting with Provider, Blue Shield determines, in good faith, that continuation of this Agreement may reasonably be expected to jeopardize the health, safety, or welfare of Members; or (v) after consulting with Provider, Blue Shield reasonably determines that Provider is likely to be financially unable to provide Provider Services in a competent and timely manner.

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

(a) Termination shall not affect: (i) those rights and obligations that have accrued and remain unsatisfied prior to the termination of this Agreement; (ii) those rights and obligations that expressly survive termination of this Agreement; or (iii) any rights or obligations that may arise following termination with respect to any occurrence prior to termination. All such rights and obligations shall continue to be governed by the terms of this Agreement.

(b) Following termination, Provider shall comply with all applicable requirements of the Knox-Keene Act and the Consolidated Appropriations Act, 2021, and the regulations promulgated thereunder, including, without limitation, those set forth in California Health & Safety Code Section 1373.65 and CAA Section 113.

(c) Following termination, Provider shall continue providing Provider Services that are Continuity of Care Services to Members who, as determined by Blue Shield, qualify for Continuity of Care Services at the rates and under terms in effect immediately prior to the date of termination.

(d) Following termination, Provider shall, at Blue Shield's option, continue providing Provider Services to Members (other than Members entitled to Continuity of Care Services) undergoing medical treatment upon the date of termination of this Agreement, at the rates and under the terms in effect immediately prior to the date of termination, for the duration of the Health Services Contracts through which such Members are enrolled with Blue Shield and for which dues or subscription charges are paid to Blue Shield, or until such time as Blue Shield has arranged for an alternative source of services for each such Member from other Blue Shield Providers. Notwithstanding the above, Blue Shield shall be liable for Covered Services rendered by Provider to Member who retains eligibility under Blue Shield or by operation of law under the care of Provider at the time of such termination until Covered Services are completed unless Blue Shield makes reasonable and medically appropriate provision to assume services.

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

10.6 **Termination Not an Exclusive Remedy.** The termination of this Agreement by either party pursuant to this Article X is not an exclusive remedy. The terminating party shall retain and may exercise whatever rights it may have in law or equity as may be necessary to enforce its rights under this Agreement.

10.7 **Survival.** This Section 10.7 and the following Sections of this Agreement shall survive the expiration or termination for any reason of this Agreement: Sections 5.1, 5.2, 5.3, 5.4, 6.1, 6.2, 6.5, 6.6, 7.1, 7.2, 7.3, 8.1, 9.1, 9.2, 9.3, 10.5, 12.11,12.13, 12.14, 12.15 and 12.16.

XI. OTHER PAYORS

11.1 **Other Payors.** Blue Shield may contract with employers, insurance companies, associations, health and welfare trusts, or other organizations to provide administrative services for plans provided by those entities that are not underwritten by Blue Shield (including both local and Blue Cross/Blue Shield National Accounts Programs). In addition, Blue Shield may extend this Agreement to managed care arrangements established by Blue Shield subsidiaries, or by persons or entities using the network Blue Shield has established pursuant to agreements with CareTrust Networks and Blue Shield of California Life & Health Insurance Company. All such entities shall be referred to as "Other Payors". Blue Shield shall require that the health programs of Other Payors include provisions to encourage the use of Blue Shield Providers (including Provider).

11.2 **Responsibility for Payment.** Provider agrees to look solely to Other Payors for payment for services furnished to Members of such Other Payor. If Provider is unable to obtain payment from any Other Payor, Blue Shield shall, upon notice from Provider, make reasonable efforts to assist Provider in obtaining such payment. However, any continuing dispute with respect to such payment shall be settled solely between Provider and such Other Payor.

11.3 **Applicability of Agreement; Identity of Other Payors.** The provisions of this Agreement shall apply to services rendered to Members enrolled in health benefit programs of Other Payors. Blue Shield will periodically give Provider notice of the identity of Other Payors.

XII. GENERAL PROVISIONS

12.1 **Entire Agreement.** The attached Exhibits, together with all documents incorporated by reference in the Exhibits, and the Provider Manual, as from time to time amended in accordance with this Agreement, form an integral part of this Agreement and are incorporated by reference into this Agreement. This Agreement constitutes the entire understanding and agreement of the parties regarding its subject matter, and supersedes

any prior oral or written agreements, representations, understandings or discussions among the parties with respect to such subject matter. Notwithstanding the foregoing, this Agreement shall neither supersede nor replace any capitated HMO (including, without limitation, Medicare Advantage) Provider agreement that may exist between Provider and Blue Shield, which agreement shall solely apply with respect to the provision of services to any HMO Members for whom Provider has financial responsibility for Covered Services under such capitated agreement.

12.2 **Amendments.** Except as provided in Section 2.10, Section 5.8(c) and this Section 12.2, this Agreement may be amended only by mutual, written consent of Blue Shield and Provider's duly authorized representatives. Notwithstanding the foregoing, if Blue Shield's legal counsel determines in good faith that this Agreement must be modified to be in compliance with applicable federal or state law or to meet the requirements of accreditation organizations that accredit Blue Shield and its providers, Blue Shield may amend this Agreement by delivering to Provider a written amendment to this Agreement incorporating the legally required modifications (the "Legally Required Amendment"), along with an explanation of why such Legally Required Amendment is necessary. If Provider does not object to the Legally Required Amendment, in writing, within sixty (60) days following receipt thereof, such Legally Required Amendment shall be deemed accepted by Provider and an amendment to this Agreement. If Provider timely objects to the Legally Required Amendment, then Provider and Blue Shield shall confer in good faith regarding Provider's objection(s). If Provider and Blue Shield are unable to resolve Provider's objection(s) to the parties' mutual satisfaction within thirty (30) days of Provider's notice, then, within sixty (60) days of Provider's notice, Provider may elect to terminate this Agreement upon ninety (90) days' prior written notice to Blue Shield. Unless Provider so terminates this Agreement, such Legally Required Amendment shall be deemed accepted by Provider and an amendment to this Agreement.

12.3 **Assignment.** Neither party shall assign, transfer, or subcontract any of its rights, interests, duties, or obligations under this Agreement, whether by sale, assignment, negotiation, pledge or otherwise, without the prior written consent of the other party. Without limiting the foregoing, the following events shall constitute an assignment of this Agreement for purposes of this Section 12.3: (a) the sale, transfer or other disposition of all or substantially all of the issued and outstanding voting securities or interests of Provider or Provider's direct or indirect corporate parent; (b) the merger, consolidation or other reorganization of Provider if, immediately following such transaction, either Provider or its member(s) shareholders or other equity holders (as existing immediately preceding such transaction) do not own a majority of all classes of the issued and outstanding membership interests or voting securities of the surviving, consolidated or reorganized entity; and (c) the issuance of any class of voting securities or interests by Provider (or its successor) if, immediately following such transaction, Provider's shareholders or other equity holders existing immediately preceding such issuance do not own a majority of all classes of the issued and outstanding voting securities or interests of Provider. Subject to the foregoing, this Agreement shall be binding on and shall inure to the benefit of the parties and their respective heirs, successors, assigns and representatives.

12.4 **Third Party Beneficiaries.** This Agreement shall not confer or be construed to confer any rights or benefits to any person or entity other than the parties, and no action to enforce the terms of this Agreement may be brought against either party by any person or entity who is not a party hereto.

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

12.6 **Independent Contractors.** In the performance of each party's work, duties, and obligations pursuant to this Agreement, each of the parties shall at all times be acting and performing as an independent contractor, and nothing in this Agreement shall be construed or deemed to create a relationship of employer and employee, principal and agent, partner, or joint venturer.

12.7 **Indemnification.** Each party agrees to indemnify the other party for, and to defend and hold harmless the other party from, any claims, causes of action, or costs, including reasonable attorneys' fees, arising out of the indemnifying party's alleged or actual negligence or otherwise improper performance of its obligations hereunder. In addition, Provider shall indemnify Blue Shield for any sanctions imposed by CMS upon Blue Shield arising out of or related to Provider's employment of or contract with an individual or entity excluded or suspended from participation in Medicare.

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

12.9 **Force Majeure.** Neither party is liable for nonperformance or defective or late performance of any of its obligations under this Agreement to the extent and for such periods of time as such nonperformance, defective performance or late performance is due to reasons outside such party's control, including acts of God, war (declared or undeclared), action of any governmental authority, riots, revolutions, fire, floods, explosions, sabotage, nuclear incidents, lightning, weather, earthquakes, storms, sinkholes, epidemics, or strikes (or similar nonperformance or defective performance or late performance of employees, suppliers or subcontractors).

12.10 **Confidentiality.** Except as otherwise set forth in this Section 12.10, as necessary to Provider's and Blue Shield's performance hereunder, or as required by and consistent with the requirements of an applicable law or regulation, the terms and conditions set forth in this Agreement, including, but not limited to, payment rates, shall be considered confidential and may not be disclosed without the written consent of the non-disclosing party. Notwithstanding the foregoing:

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

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

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

(d) No Gag Clauses; Compliance with Transparency Requirements. Nothing in this Agreement may be construed to restrict Blue Shield from disclosing information required by applicable state or federal law or regulation including, without limitation, the federal Hospital Price Transparency Rule, the federal Transparency in Coverage Rule, the federal Consolidated Appropriations Act of 2021, and, where applicable, the implementing regulations thereof, including without limitation 45 C.F.R. Section 180.00 et seq.; 26 C.F.R Section 54.9815-2715A2; 26 C.F.R Section 54.9815-2715A3; 29 C.F.R. Section 2590.715-2715A2; 29 C.F.R. Section 2590.715-2715A3; 45 C.F.R. Section 147.211; and 45 C.F.R. Section 147.212, as they may be amended from time to time. Without limiting the foregoing, nothing in this Agreement or otherwise shall directly or indirectly restrict Blue Shield, or

group health plans Blue Shield insures or administers with respect to their applicable Members, from:

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

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

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

12.11 Non-Solicitation. During the term of this Agreement, and for one (1) year thereafter, Provider shall not solicit, induce, or encourage any Member to disenroll from Blue Shield or select another health care service plan for health care services. Notwithstanding the foregoing, Provider shall be entitled to freely communicate with Members regarding any aspect of their health status or treatment.

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

12.13 Governing Law. This Agreement shall be governed by and construed according to the laws of the State of California, including, without limitation the Knox-Keene Act and the regulations promulgated thereunder. Any provision required to be in this Agreement by the Knox-Keene Act and/or the regulations promulgated thereunder shall bind Blue Shield and Provider, whether or not provided in this Agreement.

12.14 **Preemption by Federal Law.** To the extent any of the requirements of the Knox-Keene Act and the regulations promulgated thereunder are preempted by federal law applicable to the Medicare program, no such requirements shall apply with respect to Blue Shield's Medicare Advantage Program.

12.15 **Compliance With Law.** Each party shall comply with all applicable state and federal laws. Without limiting the foregoing:

(a) Provider shall comply with all applicable Medicare laws, regulations, and CMS instructions including, without limitation, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and shall require its contractors and subcontractors to do the same. In addition, all such Covered Services shall be performed in a manner consistent and otherwise in compliance with Blue Shield's agreement with CMS. Provider shall include the requirements of this Section and all other provisions required by federal and state laws, including, without limitation, the BBA and related regulations, in all contracts or subcontracts with other providers or entities.

(b) To the extent Employee Retirement Income Security Act ("ERISA") statutes and regulations apply to the claims payment and Member complaint functions performed by Provider, Provider shall comply with all such requirements.

(c) Provider shall comply with all applicable provisions of the Patient Protection and Affordable Care Act and regulations promulgated thereunder, and shall require its contractors and subcontractors to do the same. In addition, all such Covered Services shall be performed in a manner consistent and otherwise in compliance with Blue Shield's agreement with Covered California, and require its contractors and subcontractors to do the same.

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

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

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

12.19 **Claims Reimagined Program.** Blue Shield has developed an alternative, simplified mechanism for claims generation, submission, processing and payment (Claims Reimagined Program or "CR Program"). The CR Program imports necessary information from Provider's electronic medical record after Provider signs off on the clinical encounter, and automatically creates the claim based on this information, submits the claim to the Blue Shield adjudication system, and posts the result of the claim back to the Provider's revenue cycle management system (RCM). The CR Program requires integration with Provider's electronic medical record and revenue cycle management system. The parties agree to meet and confer in good faith regarding mutually agreeable terms and conditions for Provider's adoption of CR Program. The parties agree to the following process: Blue Shield shall notify Provider in writing following Blue Shield's determination that it has completed initial development of the CR Program technology and operational parameters. The parties shall schedule a demonstration meeting to occur within ninety (90) days of the date of Blue Shield's written notice. The demonstration meeting shall include staff and leadership from both parties who have operational, claims administration, and information technology decision-making authority. Within thirty (30) days following the completion of the demonstration meeting, the parties shall meet and confer in good faith to discuss the components of the CR Program demonstration and the feasibility of implementing CR Program at a mutually agreeable alternative date.

12.20 **Health Information Data and Record Sharing with Blue Shield.** Provider shall comply with State requirements regarding electronic health record data exchange, including without limitation those outlined in the California Health and Human Services Data Exchange Framework, and the compliance milestones established for Calendar Year 2022-2024 and other program policy and procedure requirements, and additional state and federal regulations as applicable. The Parties agree such program requirements and State law, implementing regulations and regulatory guidance shall govern their sharing of electronic health record data beginning January 31, 2024. The Parties acknowledge Blue Shield is able to receive electronic health record data through the following platforms: (i) EPIC Payer platform, (ii) Manifest MedEx platform, and (iii) State Qualifying Health Data Exchange platform. Provider agrees to participate in and utilize one of the aforementioned options in providing electronic health record data to Blue Shield at a mutually agreeable date.

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

BLUE SHIELD OF CALIFORNIA		**BHC FREMONT HOSPITAL, INC., DBA FREMONT HOSPITAL**	
Signature:	Signed by: Tracy Barnes 905D5619DD9D477...	**Signature:**	DocuSigned by: B7E376FE6A584A1...
Print Name:	Tracy Barnes	**Print Name:**	Patricia Williams
Title:	Vice President Network Management	**Title:**	CEO
Date:	4/14/2025	**Date:**	4/14/2025

EXHIBIT A
Behavioral Health Services Acute Psychiatric Hospital Agreement

PROVIDER INFORMATION

Fremont Hospital

Effective Date: June 1, 2025

1. Address for Notice:

BLUE SHIELD
Blue Shield of California
6300 Canoga Avenue, 7th Floor
Woodland Hills, CA 91367
Attn.: Senior Vice President, Provider Partnerships & Network Management
Fax No.: 818-228-5101
Email: ContractNotifications@blueshieldca.com

PROVIDER
Fremont Hospital
39001 Sundale Dr.
Fremont, California 94538-2005
Attn.: Director of Marketing and Business Development
Fax No.: 510-574-4801

2. Provider Facility Locations: (Include all facility locations & fictitious business names [DBAs] covered by this Agreement under the Hospital license.)

PROVIDER NAME(S)	**PHYSICAL ADDRESS**	**NATIONAL PROVIDER ID (NPI)**	**TAX ID (TIN)**
FREMONT HOSPITAL	39001 SUNDALE DR. FREMONT, CALIFORNIA 94538	1245346741	621658532

EXHIBIT B
Behavioral Health Services Acute Psychiatric Hospital Agreement

APPLICABLE BENEFIT PROGRAMS

Fremont Hospital

Effective Date: June 1, 2025

This Agreement is applicable to the following Benefit Programs:

1.	Commercial Benefit Programs	[X] Yes	[ ] No
2.	Blue Shield Medicare Advantage	[X] Yes	[ ] No
3.	Other (Describe): _____		

EXHIBIT C
Behavioral Health Services Acute Psychiatric Hospital Agreement

COMPENSATION AMOUNTS/PAYMENT SCHEDULE

Fremont Hospital

Effective Date: June 1, 2025

I. INPATIENT SERVICES

A. Psychiatric and Substance Abuse Per Diem Rates

(1) Psychiatric Services Per Diem Rates

INPATIENT PSYCHIATRIC SERVICES & IDENTIFYING CODES	EFFECTIVE 06/01/2025	EFFECTIVE 06/01/2026	EFFECTIVE 06/01/2027
Acute Revenue Code 0114, 0124, 0134, 0144, 0154	$1,757	$1,827	$1,882

(2) Substance Abuse Services Per Diem Rates

INPATIENT SUBSTANCE ABUSE SERVICES & IDENTIFYING CODES	EFFECTIVE 06/01/2025	EFFECTIVE 06/01/2026	EFFECTIVE 06/01/2027
Detoxification Revenue Code 0116, 0126, 0136, 0146, 0156	$1,757	$1,827	$1,882

II. OUTPATIENT SERVICES

A. Outpatient Psychiatric and Substance Abuse Treatment Programs

(1) Psychiatric and Substance Abuse Treatment Program Rates

OUTPATIENT PSYCHIATRIC SERVICES & IDENTIFYING CODES	PER VISIT RATE 06/01/2025	PER VISIT RATE 06/01/2026	PER VISIT RATE 06/01/2027
Partial Hospitalization Revenue Codes 0912, 0913	$751	$781	$804
Intensive Outpatient Revenue Code 0905, 0907	$495	$515	$530

B. INTENTIONALLY LEFT BLANK

C. INTENTIONALLY LEFT BLANK

III. GENERAL NOTES

A. Disallowed Charges

Prior to calculating the reimbursement amount, Blue Shield reviews Provider billed charge invoices to determine which charges are "allowed." The parties hereto agree, as part of the review process, Blue Shield may disallow the following types of charges:

- Patient comfort/convenience items
- Daily or bundled supply charges (these charges are included in the daily charge associated with the room in which services are delivered)
- Incremental nursing charges
- Personnel charges
- Ventilator/respiratory equipment charges, as well as personnel charges (e.g., respiratory therapists, for related respiratory support) in the NICU Level 4 setting
- Equipment charges
- Blood draw, venipuncture, and collection charges
- Stat charges, after hour charges, "emergency use of" charges
- Portable fees/transportation charges
- Monitoring fees/charges
- Services/supplies considered as included in a global procedure charge(s) (*e.g.*, charges for medication include all necessary diluents)
- Set-up charges
- Duplicate charges (charges for this service or supply exceed a daily or 24-hour increment charge for date of service)
- "Miscellaneous" charges/supplies not specifically identified or described
- Stand-by charges

B. **Facility Fees For Professional Office Visit Services** Blue Shield shall not reimburse or pay Provider for clinic facility charges billed under revenue codes 510-529. Reimbursement for facility fees associated with office services is included in the physician professional fee and is not paid separately to Provider.

C. **Coding Requirements** As a precondition to payment, all Provider Services must be billed and coded in accordance with Blue Shield requirements as detailed in this Agreement and the Provider Manual. Blue Shield's requirements are based on nationally recognized and industry standard coding structures, including, but not limited to, the National Uniform Billing Committee, the AMA Current Procedural Terminology, the Healthcare Common

Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), and the appropriate International Classification of Diseases (ICD) code set as indicated by the Centers for Medicare and Medicaid Services ("CMS").

D. **Coding Updates** If an identifying code (e.g., Revenue Code, ICD-10 Procedure Code, etc.) for a Provider Service set forth in this Exhibit C is modified or updated by the organization responsible for maintaining such coding structure, Blue Shield may make corresponding modifications or updates to this Exhibit C.

E. **ICD-10 Service Category Code File** The ICD-10 Service Category Code File reflects the ICD-10 procedure codes and ICD-10 diagnosis codes associated with each Service Category.

F. **Telehealth Services** For Members enrolled in a Commercial Benefit Program, Provider shall be reimbursed for the diagnosis, consultation, or treatment of a Member delivered through telehealth services on the same basis and to the same extent that Provider would be reimbursed through in-person diagnosis, consultation or treatment.

EXHIBIT C-1
Behavioral Health Services Acute Psychiatric Hospital Agreement

COMPENSATION AMOUNTS/PAYMENT SCHEDULE
(MEDICARE ADVANTAGE BENEFIT PROGRAMS)

Fremont Hospital

Effective Date: June 1, 2025

I. INPATIENT SERVICES

For Inpatient Services provided to a Member enrolled in a Blue Shield Medicare Advantage Benefit Program, Blue Shield shall pay Hospital the following reimbursement:

A. Psychiatric and Substance Abuse Rates

(1) Psychiatric Services

INPATIENT PSYCHIATRIC SERVICES & IDENTIFYING CODES	PERCENTAGE OF MEDICARE
Acute Revenue Code 0114, 0124, 0134, 0144, 0154	106% percent of the reimbursement established by the Medicare program

(2) Substance Abuse Services

INPATIENT SUBSTANCE ABUSE SERVICES & IDENTIFYING CODES	PERCENTAGE OF MEDICARE
Detoxification Revenue Code 0116, 0126, 0136, 0146, 0156	106% percent of the reimbursement established by the Medicare program

II. OUTPATIENT SERVICES

For Outpatient Services provided to a Member enrolled in a Blue Shield Medicare Advantage Benefit Program, Blue Shield shall pay Hospital the following reimbursement:

II. OUTPATIENT SERVICES

A. Outpatient Psychiatric and Substance Abuse Treatment Programs

(1) Psychiatric and Substance Abuse Treatment Program Rates

OUTPATIENT PSYCHIATRIC SERVICES & IDENTIFYING CODES	PER VISIT RATE 06/01/2025	PER VISIT RATE 06/01/2026	PER VISIT RATE 06/01/2027
Partial Hospitalization Revenue Codes 0912, 0913	$751	$781	$804
Intensive Outpatient Revenue Code 0905, 0907	$495	$515	$530