SERVICE AGREEMENT

THIS SERVICE AGREEMENT (hereinafter referred to as the "AGREEMENT") is entered into this 1st day of July 2017, between the San Mateo Health Commission, hereinafter referred to as "HPSM", and the County of San Mateo Health System, Behavioral Health and Recovery Services, hereinafter referred to as "BHRS."

WHEREAS, HPSM has entered into and will maintain a contract with the Centers for Medicare and Medicaid Services (CMS), pursuant to which qualifying individuals who are dually eligible for Medicare and Medi-Cal and who have subscribed and enrolled under HPSM's CareAdvantage Cal MediConnect Plan will receive, through HPSM, health services hereinafter defined as "Medicare Services".

WHEREAS, HPSM has entered into and will maintain a contract with the California Department of Health Care Services (DHCS), pursuant to which individuals who subscribe and are enrolled under HPSM's CareAdvantage Cal MediConnect Plan will receive, through HPSM, Medi-Cal services provided as wraparound benefits to the Medicare Covered Services noted above, hereinafter defined as "Medi-Cal Wraparound Health Services".

WHEREAS, Medicare Services and Medi-Cal Wraparound Services together shall hereinafter be referred to as "Covered Services."

WHEREAS, BHRS has entered into and will maintain a contract with the California Department of Health Care Services (DHCS), pursuant to which individuals who are dually eligible for Medicare and Medi-Cal will receive, through BHRS, Medi-Cal-covered mental health and substance abuse recovery services provided as wraparound benefits to the Medicare Covered Services noted above, hereinafter defined as "Medi-Cal Wraparound Mental Health and Substance Abuse Recovery Services".

WHEREAS, BHRS has developed expertise in arranging for and managing delivery of mental health and substance abuse recovery services to Medi-Cal beneficiaries.

WHEREAS, HPSM seeks a delegated mental health and substance abuse recovery service benefit administrator to arrange for and manage the delivery of mental health and substance abuse recovery services to its CareAdvantage Cal MediConnect Plan members.

NOW THEREFORE, in consideration of the mutual promises and agreement herein contained, HPSM and BHRS hereby agree as follows:

ARTICLE 1
DEFINITIONS

1.1 Benefit Plans. The term "Benefit Plan" shall mean the scope of benefits indicated in the CareAdvantage Evidence of Coverage or CareAdvantage Cal MediConnect Plan Evidence of Coverage (Attachment A) as those are updated on an annual basis and which includes Claims processing parameters and other information specifying healthcare coverage for CareAdvantage or CareAdvantage Cal MediConnect Plan members, as those parameters currently exist or may be amended in the future. HPSM will provide BHRS with certain information relating to such Benefit Plans ("Benefit Plan Information") including, but not limited to the names of the CareAdvantage or

CareAdvantage Cal MediConnect Plan Members entitled to services and other parameters of the Benefit Plan as BHRS may reasonably request from time-to-time.

1.2 Case Management. The term “Case Management” shall mean the coordination and follow up by the Primary Care Physician of all services deemed necessary to provide the Member medically necessary and appropriate health care.

1.3 Commission. The term “Commission” shall mean the San Mateo Health Commission.

1.4 Contracted Hospital. The term "Contracted Hospital” shall mean a licensed hospital which has entered into an agreement with HPSM to provide Covered Services to Members.

1.5 Contracted Medical Group. The term "Contracted Medical Group” shall mean a medical group or independent practice association which has entered into an agreement with HPSM to provide Covered Services to Members.

1.6 Contracted Physician. The term "Contracted Physician” shall mean a physician who is duly licensed to practice medicine or osteopathy under California law and who has contracted with HPSM or is employed by or contracts with a Contracted Medical Group to provide Covered Services to Members.

1.7 Contracted Provider. The term "Contracted Provider” shall mean a Contracted Physician, Contracted Hospital, Contracted Medical Group or other licensed health facility or health professional which has entered into an agreement with HPSM to provide Covered Services to Members.

1.8 Copayment and Deductible. The term “Copayment and Deductible” shall mean cost sharing charges for Covered Services. CareAdvantage and CareAdvantage Cal MediConnect Plan members shall not be subject to any Copayments or Deductibles for any services provided under the terms of this contract.

1.9 Covered Services. The term "Covered Services" shall mean those health care services, equipment and supplies, inclusive of Medicare Services and Medi-Cal Wraparound Services, which a Member is entitled to receive under the CareAdvantage program or CareAdvantage Cal MediConnect Plan and which are set forth in the CareAdvantage Evidence of Coverage or CareAdvantage Cal MediConnect Plan Evidence of Coverage (Attachment A).

1.10 Delegated Entity. The term “Delegated Entity” shall mean a First Tier Entity with whom HPSM has contracted to perform specified delegated functions on HPSM’s behalf in accordance with state, local, and federal laws, rules, and guidelines, as well as in accordance with HPSM policies and procedures.

1.11 Downstream Entity. The term “Downstream Entity” shall mean any party that enters into an acceptable written arrangement with BHRS below the level of the arrangement between HPSM and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

1.12 Emergency. The term "Emergency" shall The term "Emergency" shall have the same meaning as "Psychiatric emergency medical condition", pursuant to California Health & Safety Code section 1317.1(k)(1). Thus the term "Emergency" shall mean a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either (A) an immediate danger to himself or herself or to others; or (B) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

1.13 Evidence of Coverage. The term "Evidence of Coverage" shall mean the document issued by HPSM to a Member that sets forth the HPSM's Covered Services.

1.14 First Tier Entity. The term "First Tier Entity" shall mean any party that enters into a written arrangement with HPSM to provide administrative services or health care services for a Medicare eligible individual.

1.15 Formulary. The term "Formulary" shall mean the list of prescription drugs and medications that are recommended by HPSM for routine use and which will be dispensed through Contracted Pharmacies.

1.16 Identification Cards. The term "Identification Cards" ("ID Cards") shall mean printed identification cards containing information about the benefits to which the Members are entitled.

1.17 Medi-Cal Wraparound Services. "Medi-Cal Wraparound Services" shall mean those Medi-Cal services that HPSM provides to eligible Medi-Cal beneficiaries who are enrolled in HPSM under HPSM's Medi-Cal contract with the California Department of Health Care Services and that are provided secondary to services, including Medicare Services, covered by other payers or programs that have primary payment responsibility.

1.18 Medically Appropriate. The term "Medically Appropriate" means services and medical supplies which are required for prevention, diagnosis, or treatment of sickness or injury, and which are:

1.18.1 Consistent with the symptoms of a medical condition or treatment of a medical condition;
1.18.2 Appropriate with regard to standards of good medical practice and generally recognized by the medical scientific community as effective;
1.18.3 Not solely for the convenience of the Member or provider of the service or medical supplies; and
1.18.4 The most cost effective of the alternative levels of service or medical supplies which can be safely provided to the Member in HPSM's judgment.

1.19 Medicare Services. The term "Medicare Services" means those health care services that are covered under the Original Medicare program in accordance with Medicare coverage guidelines and offered through HPSM CareAdvantage or HPSM's CareAdvantage Cal MediConnect Plan, as well as supplemental Medicare benefits offered through HSPM CareAdvantage or CareAdvantage Cal MediConnect in accordance with the Centers for Medicare and Medicaid Services approval of PLAN's annual Medicare Advantage-Prescription Drug Plan bid.

1.20 Members. The term “Members” shall mean those individuals who are enrolled in CareAdvantage or CareAdvantage Cal MediConnect who are entitled to receive Covered Services.

1.21 Non-Covered Services. The term “Non-Covered Services” means those services and supplies that HPSM is not required to provide to Members pursuant to the CareAdvantage Evidence of Coverage or the CareAdvantage Cal MediConnect Evidence of Coverage.

1.22 Non-Participating Provider. The term “Non-Participating Provider” means a provider of health care services or equipment that does not have a contract with HPSM to provide such services or equipment to Members.

1.23 Participating Providers. The term “Participating Providers” shall mean those individuals or organizations which contract directly with HPSM or BHRS to provide health care services or equipment for CareAdvantage or CareAdvantage Cal MediConnect Members.

1.24 Primary Care Provider (PCP). The term “Primary Care Provider” or “PCP” means a Participating Provider selected by a Member to render first contact medical care and certain Covered Services.

1.25 PCP Assignment. The term “PCP Assignment” refers to the process by which a Member is assigned by HPSM to a PCP for provision of certain Covered Services, or to the PCP assigned for a particular Member.

1.26 RBRVS. The term "RBRVS" (Resource-Based Relative Value Scale) means the current year's physician compensation schedules published by the United States Centers for Medicare and Medicaid Services (“CMS”), which are used by CMS to reimburse those physicians contracted in the Federal Medicare Program (“Medicare”).

1.27 Referral. The term "Referral” shall mean the process by which a Contracted Physician directs a Member to a Non-Contracted Provider.

1.28 Referral Provider. The term "Referral Provider” shall mean a Contracted Physician who is professionally qualified to practice his/her designated specialty and whose agreement with HPSM includes responsibility for providing Covered Services in his/her designated specialty.

ARTICLE 2
DUTIES TO BE PERFORMED BY HPSM

2.1 Member Eligibility. HPSM shall provide up-to-date information on the eligibility status of CareAdvantage and CareAdvantage Cal MediConnect members via its HPSM Web Claims system. Eligibility information provided shall be in accordance with HPSM’s best available information. However, if retroactive changes are made to individual members’ eligibility, final eligibility status information shall be honored by BHRS.

2.2 Benefit Plan Information. HPSM will deliver to BHRS detailed Benefit Plan Information. Such information shall contain all of the elements required by BHRS so that BHRS may verify, price, and pay the Claims submitted by Participating Providers, as well as prepare the various reports as described in Exhibit A. In addition, HPSM shall provide any Benefit Plan Information changes to BHRS within thirty (30) days of the date such changes shall become effective (the "change date").

2.3 Notification Requirements. HPSM will review all reports, statements, and invoices provided by BHRS and shall notify BHRS in writing of any errors or objections within ninety (90) days of receipt. Specifically, this shall also apply to all service requests, benefit change requests, and any operation change requests. Until HPSM notifies BHRS in writing of any errors or objections, BHRS will be entitled to rely on the information contained in the reports, statements, and invoices. If HPSM does not notify BHRS in writing of any errors or objections within the ninety (90) day period, the information contained therein will be deemed accurate, complete, and acceptable to HPSM, and thereafter BHRS shall have no liability related thereto. This does not apply with respect to any undercharges or underpayments of HPSM. BHRS shall document and retain supporting documentation for audit purposes. If HPSM notifies BHRS within the ninety (90) day period of any errors or objections, BHRS shall compensate HPSM for any verifiable errors or objections. Nothing in this article will absolve BHRS of any liability of errors, discrepancies, objections, or omissions identified under Section 5.3 of this contract.

ARTICLE 3
DUTIES TO BE PERFORMED BY BHRS

3.1 Provision of Services to HPSM. BHRS shall provide to HPSM the services listed in Exhibit A, attached hereto and incorporated herein as referenced. These services shall be provided at the agreed upon rates listed in Exhibit B, attached hereto and incorporated herein as referenced.

3.2 Compliance with Laws and Regulations. BHRS shall comply with all applicable Federal laws, regulations, reporting requirements, and CMS instructions, and with HPSM's policies and procedures and contractual obligations with the California Department of Health Care Services, including, but not limited to, 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, Federal criminal law, the False Claims Act (31 U.S.C. §3729 et.seq.) and the Anti-Kickback statute (section 1128B(b) of the Act), HIPAA, and the HIPAA administrative simplification rules at 45 CFR Part 160, 162, and 164. BHRS agrees to include the requirements of this section in its contracts with any Downstream Entity, and to require any Downstream Entity to comply accordingly. BHRS further agrees to cooperate with HPSM by providing any information necessary to assess compliance.

3.3 Capacity to Contract. BHRS acknowledges that HPSM is prohibited by CMS and the California Department of Health Care Services from contracting with any entity that itself, its employees, managers, or Downstream Entities are excluded from participating in the Medicare or Medi-Cal programs. BHRS warrants that it shall review the Office of the Inspector General, General Services Administration, and Medi-Cal exclusions,

debarment, licensure or sanctions lists at the time of entering into this Agreement and annually thereafter to ensure that neither itself, nor any employee, manager, Downstream Entity, or subcontractor responsible for administering or delivering benefits under any federal or state health care program is listed. If BHRS finds any employee, manager, or Downstream Entity is on an exclusion list, that person or entity will immediately be removed from any work related directly or indirectly to all federal or state health care programs.

ARTICLE 4
PAYMENT DUE BHRS AND TO HEALTH CARE PROVIDERS

4.1 Monthly Statement for Payment Administrative Services. As set forth in Exhibit B of this Agreement, HPSM shall remit payment to BHRS within thirty (30) calendar days of the close of each month payment of a monthly administration fee. HPSM will prepare a statement using current month's CareAdvantage Cal MediConnect member counts plus/minus adjustments for the previous month. If BHRS questions the amount of the monthly administrative services statement, BHRS shall notify HPSM of its questions regarding said amount. If HPSM receives such a notice, both BHRS and HPSM shall make a reasonable effort to resolve such questions within thirty (30) calendar days. Upon and in accordance with such resolution, HPSM will remit to BHRS any outstanding amount due, if applicable, to BHRS within thirty (30) calendar days of the resolution.

4.2 Payment to Health Care Providers. BHRS shall process and issue payments to health care providers based on approved claims for Covered Services provided to Members. As a delegated entity, BHRS shall follow all applicable CMS policies and guidelines regarding timely and appropriate processing of claims, member notification of claims denial, and appropriate payment levels to contracted and non-contracted providers. Claims shall be processed at least twice per month to ensure payment no later than thirty (30) working days after the date of receipt of a complete claim by BHRS. BHRS shall accept and adjudicate claims for health care services provided to HPSM members in accordance with the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28 of the Health and Safety Code. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective payment dispute resolution mechanism under which providers may submit payment disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving payment disputes, including the location and telephone number where information regarding disputes may be submitted.

4.3 Payment of Health Care Costs. BHRS shall electronically submit claims to HPSM for reimbursement of health care costs paid under this Agreement. HPSM shall issue payment according to Exhibit B for adjudicated claims to BHRS within thirty (30) calendar days from the date of submission.

4.4 No Member Liability. BHRS agrees that neither BHRS nor any of its Downstream Entities, in any circumstances, including, but not limited to nonpayment by HPSM shall bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any HPSM member for services performed under

this Agreement. This provision shall survive the termination of this Agreement for any reason and shall be construed to be for the benefit of HPSM members. Whenever HPSM receives notice of any such member billing it shall take appropriate action.

4.5 HPSM Authority to Assume Responsibility. HPSM has authority to assume responsibility for the processing and timely reimbursement of provider claims in the event that BHRS fails to timely and accurately reimburse its claims, including the payment of interest and penalties.

ARTICLE 5
RECORDS

5.1 Maintenance of Records. BHRS shall maintain, and require any of its Downstream Entities, contractors, or subcontractors, to maintain, documentation of all activity conducted under this Agreement, including Claims processed, for a minimum of ten (10) years. Such documentation, including books and records, shall be in a format and media deemed appropriate by BHRS and HPSM and sufficient to accommodate periodic auditing of the records to evaluate the quality, appropriateness and timeliness of services performed by BHRS under this Agreement. The records shall be accessible to HPSM upon thirty (30) days prior written notice for annual audits, or sooner if required by the circumstances or state or local oversight agencies.

5.2 Use of Information. BHRS and HPSM may use, reproduce, or adapt information obtained in connection with this Agreement, including Claims data information and eligibility information, in any manner they deem appropriate, except that each party and its agents, employees, and contractors shall maintain the confidentiality of this information to the extent required by applicable Law, including the provisions of the Health Insurance Portability and Accountability Act of 1996, Subtitle F – Administrative Simplification, (referred to in this Agreement as "HIPAA"), and may not use the information in any way prohibited by Law. Each party shall be solely responsible for its own use of the information, and shall indemnify and hold the other party harmless for, from and against any and all costs, losses, and damages incurred by such other party as a result of such use.

5.3 Right to Audit Claims and Business Records. BHRS agrees to permit access to, inspection, and audit by HPSM, the California Department of Managed Health Care, the California Department of Health Services, the United States Department of Health and Human Services, the Centers for Medicare and Medicaid Services, the Comptroller General of the United States, and or their designees, at all reasonable times of all facilities, books, records and documents maintained or utilized by BHRS in the performance of this Agreement.

HPSM and representatives of a regulatory or accreditation agency may each inspect and audit, at least once quarterly or as required, BHRS's business records that directly relate to billings made to HPSM for Claims. BHRS may inspect and audit, or cause to be inspected and audited, once annually, the books and records of HPSM directly relating to this Agreement, including the existence and number of Members. HPSM and BHRS shall fully cooperate with and assist and provide information to representatives of each

other, independent accountants hired by either party, and representatives of any regulatory or accreditation agency, to conduct any such inspection or audit. To the extent that HPSM and/or BHRS have control of the following, such audits shall be at the auditing party's sole expense and shall only be made during normal business hours, following thirty (30) days written notice, without undue interference to the audited party's business activity, and in accordance with reasonable audit practices. Where a regulatory or accreditation agency imposes demands that do not meet the above standards for conducting an audit, HPSM and BHRS will cooperate with the requirements of the auditing agency to the extent possible. An audit of BHRS's records may be conducted at BHRS's office where such records are located and shall be limited to transactions over the ten (10) year period preceding such audit unless the document retention period is extended according to applicable law. If a completed audit reveals a discrepancy in the results and the previous calculations of the audited party, then the auditing party shall deliver written notice setting forth in reasonable detail the basis of such discrepancy. The parties shall use reasonable efforts to resolve the discrepancy within thirty (30) days following delivery of the notice, and such resolution shall be final, binding, and conclusive upon the parties. Upon a final and conclusive determination of a discrepancy revealed by an audit procedure under this Agreement, the party that owes money shall pay such sums to the other party within thirty (30) days of the delivery of the conclusive audit findings.

ARTICLE 6
INDEMNIFICATION

6.1 Mutual Indemnification. HPSM and BHRS shall indemnify and hold harmless each other from and against all third party claims, demands, losses, damages and reasonable expenses arising from or in connection with the performance of the terms of this Agreement, except to the extent that such claims, demands, losses, damages and expenses result from the negligence of the other.

6.2 Concurrent Negligence. In the event of concurrent negligence of HPSM, its officers and/or employees, and BHRS, its officers and/or employees, then the liability for any and all claims for injuries or damage to persons and/or property which arise out of terms and conditions of this Agreement shall be apportioned according to the California theory of comparative negligence.

ARTICLE 7
NON-DISCRIMINATION

7.1 Non-Discrimination.

7.1.1 BHRS shall comply with § 504 of the Rehabilitation Act of 1973, which provides that no otherwise qualified handicapped individual shall, solely by reason of a

disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of this Agreement.

7.1.2 *General non-discrimination*. No person shall, on the grounds of race, color, ethnicity, religion, ancestry, gender, age (over 40), national origin, medical condition (cancer), physical or mental disability, sexual orientation, pregnancy, childbirth or related medical condition, marital status, claims experience, medical history, evidence of insurability, genetic information, source of payment, or political affiliation be denied any benefits or subject to discrimination under this Agreement. BHRS shall implement procedures to ensure that Members are not discriminated against in the delivery of health care services consistent with the benefits covered under CareAdvantage or CareAdvantage Cal MediConnect based on any of these factors.

7.1.3 *Equal employment opportunity.* BHRS shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this Agreement. BHRS's equal employment policies shall be made available to HPSM upon request.

7.1.4 *Violation of Non-discrimination provisions.* Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject BHRS to penalties, to be determined by the HPSM Executive Director, including but not limited to:

7.1.4.1 termination of this Agreement;
7.1.4.2 disqualification of BHRS from bidding on or being awarded a contract with HPSM for a period of up to 3 years;
7.1.4.3 liquidated damages of $2,500 per violation;
7.1.4.4 imposition of other appropriate contractual and civil remedies and sanctions, as determined by the Executive Director.

To effectuate the provisions of this section, the Executive Director or his/her designee shall have the authority to examine BHRS's employment records with respect to compliance with this paragraph and/or to set off all or any portion of the amount described in this paragraph against amounts due to BHRS under the Service Agreement or any other Service Agreement between BHRS and HPSM.

BHRS shall report to HPSM the filing by any person in any court of any complaint of discrimination or the filing by any person of any and all charges with the Equal Employment Opportunity Commission, the Fair Employment and Housing Commission or any other entity charged with the investigation of allegations within 30 days of such filing, provided that within such 30 days such entity has not notified BHRS that such charges are dismissed or otherwise unfounded. Such notification shall include the name of the complainant, a copy of such complaint, and a description of the circumstance. BHRS shall provide HPSM with a copy of their response to the Complaint when filed.

7.1.5 *Compliance with Equal Benefits Ordinance*. With respect to the provision of employee benefits, BHRS shall comply with the San Mateo County Ordinance

which prohibits contractors from discriminating in the provision of employee benefits between an employee with a domestic partner and an employee with a spouse.

7.1.6 Where applicable, BHRS shall comply fully with the non-discrimination requirements required by 41 CFR 60-741.5(a), which is incorporated herein as if fully set forth.

7.1.7 *Jury Service.* BHRS shall comply with the San Mateo County Ordinance with respect to provision of jury duty pay to employees and have and adhere to a written policy that provides that its employees shall receive from BHRS, on an annual basis, no less than five days of regular pay for actual jury service in San Mateo County. The policy may provide that employees deposit any fees received for such jury service with BHRS or that BHRS deduct from the employees' regular pay the fees received for jury service.

ARTICLE 8
CONFIDENTIALITY

8.1 Confidential Information. The term "Confidential Information" means information of a confidential or proprietary nature relating to the subject matter described in this Agreement which is taken from or disclosed by one party (the "Disclosing Party") to the other (the "Receiving Party"). Confidential Information includes, but is not limited to, matters of a technical nature such as trade secrets, methods, compositions, data and know-how, designs, systems, processes, computer programs, files and documentation, similar items or research projects, and any information derived there from; matters of a business nature, such as the terms of this Agreement (including any pricing terms and contract terms which must be subject to a protective order), marketing, sales, strategies, proposals, and lists of actual or potential Members, Participating Providers as well as any other information that is designated by either party as confidential.

8.2 Treatment of Confidential Information. Subject to the California Public Records Act and related state and federal legislation, the Receiving party agrees: (i) to hold the Disclosing Party's Confidential Information in strict confidence and to take reasonable precautions to protect such Confidential Information (including, without limitation, all precautions Receiving Party employs with respect to its own confidential materials); (ii) not to divulge any such Confidential Information or any information derived there from to any third party unless required in the performance of the Receiving Party's duties under this Agreement or pursuant to controlling law; (iii) not to make any use whatsoever at any time of such Confidential Information except for the purpose of this Agreement and will not use it for its own or any third party's benefit; and (iv) not to copy, analyze, transcribe, transmit, decompile, disassemble or reverse engineer any such Confidential Information, and not use such Confidential Information in any patent application. The confidentiality obligations of this Section 8.2 shall not apply to information which, as evidenced in writing:

8.2.1 is or becomes publicly known by Receiving Party through no breach of this Agreement;
8.2.2 is learned by the Receiving Party from a third party entitled to disclose it;

8.2.3 is rightfully obtained by the Receiving Party prior to this Agreement; or
8.2.4 is required by law to be disclosed.

The confidential obligations contained in the foregoing clauses (i), (ii), (iii) and (iv) shall be perpetual. Receiving Party may make disclosures required by law or court order provided Receiving Party uses diligent, reasonable efforts to afford the Disclosing Party the opportunity to limit disclosure and to obtain confidential treatment or a protective order.

8.3 No Transfer or Right or Title. Receiving Party acknowledges that it shall not acquire any rights or title to any Confidential Information merely by virtue of its use or access to such Confidential Information hereunder. Neither the execution of this Agreement nor the furnishing of any Confidential Information hereunder shall be construed as granting, either expressly or by implication, or otherwise, the Receiving Party any license under any invention or patent now or hereafter owned by or controlled by the Disclosing Party. Each party agrees that it may not be adequately compensated for damages arising from a breach or threatened breach of any of the covenants contained in this Article 8 by the other party, and each party shall be entitled to injunctive relief and specific performance in addition to all other remedies. None of the information that may be submitted or exchanged by the parties shall constitute any representation, warranty, assurance, guarantee, or inducement by a party to the other with respect to the infringement of patents, copyrights, trademarks, trade secrets, or any other rights of third persons.

ARTICLE 9
EXCLUSIVITY

9.1 Exclusivity. HPSM agrees that BHRS shall be the sole and exclusive agent providing administration services for behavioral health and recovery services provided to CareAdvantage or CareAdvantage Cal MediConnect members during the term of this Agreement.

ARTICLE 10
TERM AND TERMINATION

10.1 Term. This Agreement shall have an Effective Date of January 1, 2017 and shall be for a term of three (3) years, ending December 31, 2019. Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination.

10.2 Termination with Cause. This Agreement may be terminated at anytime by either party based on a material breach of any terms or conditions herein stated provided that thirty (30) days' advance written notice of such material breach shall be given to the other party and such party shall have the opportunity to cure such material breach during such thirty (30) day notice period.

10.3 Effect of Termination. If this Agreement is terminated pursuant to this Article 10: (i) all further obligations of the parties under this Agreement shall terminate (but not such party's obligation to make payments arising prior to the termination of this Agreement or

any obligation surviving the termination hereof); (ii) all Confidential Information provided by either party shall, except for Confidential Information required by law to be retained by a party, be immediately returned by a Receiving Party (as defined in Section 8.1), or such Receiving Party shall certify to the Disclosing Party that such materials have been destroyed; (iii) neither party shall be relieved of any obligation or liability arising from any prior breach of such party or any provision of this Agreement; and (iv) the parties shall, in all events, remain bound by and continue to be subject to the provisions set forth in Sections 5.1, 5.2, 5.3, 6.1, 6.2, 8.1, 8.2, 8.3, 11.1, 11.7, 11.9, 11.10, 11.12, 11.13, 11.17, 11.18, 11.19, 12.1, 12.2, and 12.4.

ARTICLE 11
GENERAL PROVISIONS

11.1 Use of BHRS Software. HPSM acknowledges that BHRS owns, or possesses license rights (including off-the-shelf vendor agreements) from certain third parties to the entire software system used by BHRS in processing Claims and preparing reports including computer programs, system and program documentation, and other documentation relating thereto (collectively, including certain license rights, the "BHRS Software System"), and that BHRS Software System is the exclusive and sole property of BHRS. HPSM disclaims any rights to BHRS Software System as described above (including access to any applicable source codes), any procedures or forms developed by BHRS, as well as development or modification of BHRS Software System as a result of any customization performed by any party.

11.2 Insurance. Each party shall obtain (to the extent not already possessed) and maintain, with respect to the activities in which such party engages pursuant to this Agreement, professional liability (errors and omissions) insurance in amounts reasonable and customary for the nature and scope of business engaged in by such party and comprehensive liability insurance. Upon request, either party shall promptly deliver to the other party evidence of such insurance. Each party agrees to notify the other party immediately upon such party's receipt of any notice canceling, suspending or reducing the coverage limits of its professional liability insurance or comprehensive liability insurance.

11.3 Successors and Assigns. Neither this Agreement nor any of the rights, interests or obligations hereunder shall be assigned by either party hereto (whether by operation of law or otherwise) without the prior written consent of the other party hereto. Subject to the preceding sentence, this Agreement shall be binding upon, inure to the benefit of and be enforceable by the parties and their respective successors and permitted assigns. Notwithstanding anything to the contrary contained in this Agreement (including this Section11.3), no consent shall be required and this Agreement will apply to, be binding in all respects upon, and inure to the benefit of any successors of HPSM to this Agreement resulting from a Change of Control. A "Change of Control" shall occur if as a result of one or a series of related transactions: (i) all or substantially all the assets of SMMC are disposed of to any entity not wholly owned and controlled by HPSM, outside the ordinary course of business; (ii) SMMC effects a merger with one or more other entities in which HPSM is not the surviving entity; or (iii) HPSM engages in a transaction that results in any entity holding securities possessing a majority of the voting power that does not hold such voting power as of the time of this Agreement.

HPSM shall provide BHRS with thirty (30) days' advance written notice in the event of any transaction(s) resulting in a Change of Control, as well as an Officer's Certificate from the successor entity, agreeing to be bound by the terms and conditions of this Agreement.

11.4 Waiver. Any term or condition of this Agreement may be waived at any time by the party that is entitled to the benefit thereof, but no such waiver shall be effective unless set forth in a written instrument duly executed by or on behalf of the party waiving such term or condition. No waiver by any party of any term or condition of this Agreement, in any one or more instances, shall be deemed to be or construed as a waiver of the same or other term or condition of this Agreement on any future occasion.

11.5 Severability. In the event that any provision of this Agreement shall be determined to be invalid, unlawful, void or unenforceable to any extent, the remainder of this Agreement, and the application of such provision other than those as to which it is determined to be invalid, unlawful, void or unenforceable, shall not be impaired or otherwise affected and shall continue to be valid and enforceable to the fullest extent permitted by law.

11.6 Further Assurances. Each party hereto shall execute and cause to be delivered to each other party hereto such instruments and other documents, and shall take such other actions, as such other party may reasonably request (at or after the date hereof) for the purpose of carrying out or evidencing any of the transactions contemplated by this Agreement.

11.7 Choice of Law. This Agreement shall be construed, interpreted, and governed according to the laws of the State of California without regard to its conflict of laws and rules.

11.8 Force Majeure. The performance obligations of BHRS and/or HPSM respectively hereunder shall be suspended to the extent that all or part of this Agreement cannot be performed due to causes which are outside the control of BHRS and/or HPSM, and could not be avoided by the exercise of due care, including but not limited to acts of God, acts of a public enemy, acts of a sovereign nation or any state or political subdivision or any department or regulatory agency thereof or entity created thereby, acts of any person engaged in a subversive or terrorist activity or sabotage, fires, floods, earthquakes, explosions, strikes, slow-downs, lockouts or labor stoppage, freight embargoes, or by any enforceable law, regulation or order. The foregoing shall not be considered to be a waiver of any continuing obligations under this Agreement, and as soon as conditions cease, the party affected thereby shall fulfill its obligations as set forth under this Agreement. In order to benefit from the provisions of this Section 11.8, the party claiming force majeure must notify the other reasonably promptly in writing of the force majeure condition. If any event of force majeure, in the reasonable judgment of the parties, is of a severity or duration such that it materially reduces the value of this Agreement, then this Agreement may be terminated without liability or further obligation of either party (except for any obligation expressly intended to survive the termination of this Agreement and except for all amounts that have become or will become due and payable hereunder).

11.9 Entire Agreement; No Third Party Beneficiaries. This Agreement, including the Exhibits: (i) constitutes the entire agreement among the parties with respect to the subject matter hereof and supersedes all prior agreements and understandings, both written and oral,

among the parties with respect to the subject matter hereof; and (ii) is intended solely for the benefit of each party hereto and their respective successors or permitted assigns, and it is not the intention of the parties to confer third party beneficiary rights, and this Agreement does not confer any such rights, upon any other third party.

11.10 Use of Name. Neither party shall use the other party's name, trade or service mark, logo, or the name of any affiliated company in any advertising or promotional material, presently existing or hereafter established, except in the manner and to the extent permitted by prior written consent of the other party.

11.11 Notice. Any notice required or permitted by this Agreement, unless otherwise specifically provided for in this Agreement, shall be in writing and shall be deemed given: (i) one (1) day following delivery to a nationally reputable overnight courier; (ii) one (1) day following receipt by facsimile during the receiving party's business hours with written confirmation thereof; or (iii) three (3) days after the date it is deposited in the United States mail, postage prepaid, registered or certified mail, or hand delivered addressed as follows:

To: BHRS
Louise Rodgers, Chief
San Mateo County Health System
225 37th Avenue
San Mateo, CA 94403

To: HPSM
Maya Altman, Chief Executive Officer
Health BHRS of San Mateo
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

Any party may at any time change its address for notification purposes by mailing a notice stating the change and setting forth the new address.

11.12 Counterparts; Facsimile. This Agreement may be executed in one or more counterparts, all of which shall be considered one and the same agreement and shall become effective when one or more counterparts have been signed by each of the parties and delivered to the other parties, it being understood that all parties need not sign the same counterpart. This Agreement may be executed and delivered by facsimile and upon such delivery the facsimile signature will be deemed to have the same effect as if the original signature had been delivered to the other party. The original signature copy shall be delivered to the other party by express overnight delivery. The failure to deliver the original signature copy and/or the nonreceipt of the original signature copy shall have no effect upon the binding and enforceable nature of this Agreement.

11.13 Independent Contractors. HPSM and BHRS are independent entities and nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee or principal and agent or franchiser and franchisee or any relationship, fiduciary or otherwise, other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement. Nothing in this Agreement is intended to be construed, or be deemed to create, any rights or remedies in any third party, including but not limited to a Member. Nothing in this Agreement shall

be construed or deemed to confer upon BHRS any responsibility for or control over the terms or validity of the Covered Services. BHRS shall have no final discretionary authority over or responsibility for HPSM's administration. Further, because BHRS is not an insurer or HPSM sponsor, BHRS shall have no responsibility for: (i) any funding of HPSM or CareAdvantage Cal MediConnect benefits; or (ii) any insurance coverage relating to HPSM or any BHRS contract of HPSM or Members, except as described in Exhibit A.

11.14 Consent to Amend. This Agreement or any part or section of it may be amended at any time during the term of this Agreement only by mutual written consent of duly authorized representatives of BHRS and HPSM.

11.15 Headings. The headings of Articles, Sections and Exhibits contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

11.16 Compliance with Laws and Regulations. This Agreement will be in compliance with all pertinent federal and state statutes and regulations. If this Agreement, or any part hereof, is found not to be in compliance with any pertinent federal or state statute or regulation, then the parties shall renegotiate the Agreement for the sole purpose of correcting the non-compliance.

11.16.1 Plan is subject to the requirements of Chapter 2.2 of Division 2, and of Chapter 1 of Title 28 of, the California Code of Regulations, and any provision required to be in Plan's subcontracts by either regulatory provision shall bind the Plan whether or not provided in this contract.

11.16.2 Upon termination of a provider contract, BHRS shall be liable for covered services rendered by such provider to an HPSM Member who retains eligibility under the care of such provider at the time of such termination until the services being rendered to the HPSM Member by such provider are completed, unless BHRS makes reasonable and medically appropriate provision for the assumption of such services by a contracting provider.

11.17 Construction.

11.17.1 For purposes of this Agreement, whenever the context requires: the singular number shall include the plural, and vice versa; the masculine gender shall include the feminine and neuter genders; the feminine gender shall include the masculine and neuter genders; and the neuter gender shall include the masculine and feminine genders.

11.17.2 The parties hereto agree that any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not be applied in the construction or interpretation of this Agreement.

11.17.3 As used in this Agreement, the words "include" and "including," and variations thereof, shall not be deemed to be terms of limitation, but rather shall be deemed to be followed by the words "without limitation."

11.17.4 Except as otherwise indicated, all references in this Agreement to "Articles," "Sections" and "Exhibits" are intended to refer to Articles of this Agreement, Sections of this Agreement and Exhibits to this Agreement.

11.18 Remedies Cumulative; Specific Performance. The rights and remedies of the parties hereto shall be cumulative (and not alternative). The parties to this Agreement agree that to the extent permitted by applicable law, in the event of any breach or threatened breach by any party to this Agreement of any covenant, obligation or other provision set forth in this Agreement for the benefit of any other party to this Agreement, such other party shall be entitled (in addition to any other remedy that may be available to it) to: (i) a decree or order of specific performance to enforce the observance and performance of such covenant, obligation or other provision; and (ii) an injunction restraining such breach or threatened breach. Neither party shall be required to provide any bond or other security in connection with any such decree, order or injunction or in connection with any related action or legal proceeding.

11.19 HIPAA Compliance. For the purposes of this Agreement, BHRS is deemed to be a "Business Associate" of HPSM as such term is defined in the Privacy Standard of the Federal Register, published on December 28, 2000 (Business Associate Requirements, Exhibit C, attached hereto and incorporated herein as referenced). The parties will endeavor to comply with all applicable regulations published pursuant to HIPAA, as of the effective enforcement date of each standard. In addition, without limiting any other provision of this Agreement:

11.19.1 all services provided by BHRS under this Agreement will be provided in such a manner as to enable HPSM to remain at all times in compliance with all HIPAA regulations applicable to HPSM, to the extent that HPSM's compliance depends upon the manner in which such services are performed by BHRS;

11.19.2 all software, application programs and other products licensed or supplied by BHRS under this Agreement will contain such characteristics and functionality (including as applicable, but not limited to, the ability to accept and securely transmit data using the standard HIPAA transaction sets) as necessary to ensure that HPSM's use of such software, application programs and other products and associate documentation from BHRS, when utilized by HPSM in the manner as directed by BHRS, will fully comply with the HIPAA regulations applicable to HPSM. In the event any amendment to this Agreement is necessary for HPSM to comply with the HIPAA regulations as they relate to this Agreement or its subject matter, including, but not limited to, requirements pertaining to Business Associate agreements, HPSM and BHRS will negotiate in good faith and amend this Agreement accordingly, with such amendment to be effective prior to the date compliance is required under each standard of the HIPAA regulations; and

11.19.3 all software, application programs, eligibility lists or other member-specific information and other products licensed or supplied by HPSM under this Agreement will contain such characteristics and functionality (including as applicable, but not limited to, the ability to accept and securely transmit data using the standard HIPAA transaction sets) as necessary to ensure that BHRS's use of such software, application programs and other products and associate documentation from HPSM, when utilized by BHRS in the manner as directed by HPSM, will fully comply with the HIPAA regulations applicable to BHRS. In the event any amendment to this Agreement is necessary for BHRS to comply with the HIPAA regulations as they relate to this Agreement

or its subject matter, including, but not limited to, requirements pertaining to Business Associate agreements, BHRS and HPSM will negotiate in good faith and amend this Agreement accordingly, with such amendment to be effective prior to the date compliance is required under each standard of the HIPAA regulations.

11.20 Cultural Competence. BHRS shall ensure that all services, both clinical and non-clinical, are accessible to all CareAdvantage and CareAdvantage Cal MediConnect members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills and those with diverse cultural backgrounds.

ARTICLE 12
COMPLIANCE WITH LAWS AND REGULATIONS

12.1 BHRS understands that HPSM oversees and is accountable to the Centers for Medicare and Medicaid Services (CMS) for any functions or responsibilities that are described in the laws or regulations applicable to Medicare Plans, and that HPSM may be held accountable by CMS if BHRS and/or its Downstream Entity violates the provisions of such law or regulations or HPSM's policies in the performance of this Agreement. In furtherance of the foregoing, BHRS shall comply with and ensure any of its Downstream Entities or related entities providing services under this Agreement also comply with applicable Medicare laws, regulations, reporting requirements, and CMS instructions, and will cooperate, assist, and provide information, as requested.

12.2 BHRS shall comply with the reporting requirements in 42 CFR §422.516 and the requirements in 42 CFR §422.310 for submitting data to CMS for the purposes of reporting costs, utilization, quality, enrollee health status, and fiscal soundness to CMS, as well as of enabling CMS to characterize the context and purpose of each item and service provided to a Medicare enrollee for accurate application of CMS's risk adjustment payment model. BHRS also agrees to furnish medical records and/or ensure that Participating Providers furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

12.3 BHRS understands and agrees that HPSM is responsible for the monitoring and oversight of all duties of BHRS under this Agreement, and that HPSM has the authority and responsibility to: (i) implement, maintain and enforce HPSM's policies governing BHRS's duties under this Agreement; (ii) conduct audits, inspections and/or investigations in order to oversee BHRS's performance of duties described in this Agreement; (iii) require BHRS to take corrective action if HPSM or an applicable federal or state regulator determines that corrective action is needed with regard to any duty under this Agreement; and/or (iv) revoke the delegation of any duty, if BHRS fails to meet HPSM standards in the performance of that duty. BHRS shall cooperate with HPSM in its oversight efforts and shall take corrective action as HPSM determines necessary to comply with the laws, accreditation agency standards, HPSM policies governing the duties of BHRS or the oversight of those duties.

12.4 If BHRS gives Confidential Information including Protected Health Information, as defined in 45 CFR §164.501, received from HPSM, or created or received by BHRS on behalf of HPSM, to any of its Downstream Entities, including agents or subcontractors,

BHRS shall require the Downstream Entity to agree to the same restrictions and conditions that apply to BHRS under this Agreement. BHRS shall be fully liable to HPSM for any acts, failures or omissions of the Downstream Entity in providing the services as if they were BHRS's own acts, failures or omissions, to the extent permitted by law. BHRS further expressly warrants that its agents will be specifically advised of, and will comply in all respects with the terms of this Agreement.

12.5 BHRS shall comply with CMS instructions regarding responsibilities of delegated entities as outlined in Attachment B.

The provisions of this Agreement shall bind and inure to the benefit of the parties hereto and their heirs, legal representatives, successors and assignees. This Agreement constitutes the entire understanding between the parties hereto.

SAN MATEO HEALTH COMMISSION d.b.a. HEALTH PLAN OF SAN MATEO	COUNTY OF SAN MATEO
BY	BY
MAYA ALTMAN **CHIEF EXECUTIVE OFFICER**	**PRESIDENT, BOARD OF SUPERVISORS**
DATE	DATE

EXHIBITS

1. Delegated Functions: Claims Processing and Data Management; Credentialing and Provider Relations; Utilization and Medical Management

2. Reporting

3. Payment

EXHIBIT 1

Delegated Functions
Roles and Responsibilities

The purpose of the following grid is to specify the activities delegated by HPSM to BHRS with respect to: (i) utilization management, (ii) credentialing and re-credentialing, and (iii) claims payment. All delegated activities are to be performed in accordance with currently applicable National Committee for Quality Assurance accreditation standards and State and Federal regulatory requirements, as modified from time to time. BHRS agrees to be accountable for all responsibilities delegated by HPSM and will not further delegate (sub-delegate) any such responsibilities without prior written authorization by HPSM. In the event deficiencies are identified through HPSM's oversight, BHRS will provide a specific corrective action plan to be approved by HPSM. If BHRS does not comply with the corrective action plan within the specified time frame, HPSM may revoke the delegation to BHRS, in whole or part.

Utilization Management

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
NCQA UM 1 - Utilization Management Structure: BHRS's UM program has clearly defined structures and processes, and assigns responsibility to appropriate individuals. **Element A - Written Program Description**: BHRS's UM program description includes the following: 1. A written description of the program structure 2. Involvement of a designated senior physician in UM program implementation 3. The program scope and process used to determine benefit coverage and medical necessity 4. Information sources used to determine benefit coverage and medical necessity **Element B - Physician Involvement:** A senior physician is actively involved in implementing BHRS's UM program. **Element D - Annual Evaluation**: The organization annually evaluates and	BHRS will implement a UM Program. The UM Program will describe BHRS's procedure to meet requirements listed in Elements A through C. BHRS will submit a copy of its UM Work Plan. BHRS will use the Industry Collaboration Effort (ICE) template, or proprietary template as approved by HEALTH PLAN.	HEALTH PLAN will review BHRS's UM Program, and provide feedback to BHRS as part of the HEALTH PLAN annual oversight audit. HEALTH PLAN will review BHRS's UM Work Plan, and provide feedback to BHRS as needed.

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
updates the UM program, as necessary.		
NCQA UM 2 - Clinical Criteria for UM Decisions: BHRS uses written criteria based on sound clinical evidence to make utilization decisions, and specifies procedures for appropriately applying the criteria. **Element A - UM Criteria:** BHRS: 1. Has written UM decision-making criteria that are objective and based on medical evidence 2. Has written policies for applying the criteria based on individual needs 3. Has written policies for applying the criteria based on an assessment of the local delivery system 4. Involves appropriate practitioners in developing, adopting and reviewing criteria 5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate. **Element B - Availability of Criteria:** BHRS: 1. States in writing how practitioners can obtain UM criteria 2. Makes the criteria available to its practitioners upon request **Element C - Consistency in Applying Criteria:** At least annually, the BHRS: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable	BHRS will describe in the UM program the types of Clinical Criteria used in the UM process as described in Element A. BHRS will implement policies and procedures describing how to apply Clinical Criteria.	HEALTH PLAN will review BHRS's UM Program and policies and procedures, and provide feedback to BHRS as part of the HEALTH PLAN annual oversight audit.

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
NCQA UM 3 - Communication Services: BHRS provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. **Element A - Access to Staff:** BHRS provides the following communication services for members and practitioners: 1. Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues 2. Staff can receive inbound communication regarding UM issues after normal business hours 3. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues 4. TDD/TTY services for members who need them 5. Language assistance for members to discuss UM issues	BHRS will describe in the UM program the type of access available to members and practitioners as required in Element A.	HEALTH PLAN will review BHRS's UM Program, and provide feedback to BHRS as part of the HEALTH PLAN annual oversight audit.
NCQA UM 4 - Appropriate Professionals: Qualified licensed health professionals assess the clinical information used to support UM decisions. **Element A - Licensed Health Professionals**: BHRS has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision making **Element B - Use of Practitioners for UM Decisions**: BHRS has a written job description with qualifications for	BHRS will describe in the UM program the type of professionals that assess the clinical information used to support UM decisions as required in Elements A through F.	HEALTH PLAN will review BHRS's UM Program, and provide feedback to BHRS as part of the HEALTH PLAN annual oversight audit.

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training or professional experience in medical or clinical practice 2. A current license to practice without restriction **Element F - Affirmative Statement About Incentives**: BHRS distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following: 1. UM decision making is based only on appropriateness of care and service and existence of coverage 2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage 3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization		
NCQA UM 5 - Timeliness of Utilization Management Decisions: BHRS makes UM decisions in a timely manner to accommodate the clinical urgency of the situation. **Element C - Timeliness of Behavioral Healthcare UM Decision Making**: BHRS adheres to the following time frames for timeliness of behavioral healthcare UM decision making: 1. For non-urgent pre-service decisions, the BHRS makes decisions within 14 calendar days of receipt of the request, as required by the DHCS 2. For urgent pre-service decisions, the BHRS makes	BHRS will specify in the UM program, or policies and procedures, timeliness requirements for the UM decision specified in Elements C, D, and F. BHRS notifications to HEALTH PLAN Members shall be in English, Spanish, Chinese and Tagalog, and shall be provided within the same timeframes as those required for making the authorization decisions.	HEALTH PLAN will review BHRS's UM Program, or policies and procedures, and provide feedback to BHRS as part of the HEALTH PLAN annual oversight audit.

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
decisions within 72 hours of receipt of the request. 3. For urgent concurrent review, the BHRS makes decisions within 24 hours of receipt of the request. 4. For post-service decisions, the BHRS makes decisions within 30 calendar days of receipt of the request. **Element D - Notification of Behavioral Healthcare Decisions**: BHRS adheres to the following time frames for notification of non-behavioral healthcare UM decisions: 1. For non-urgent pre-service decisions, the organization gives electronic or written notification of the decision to practitioners and members within 15 calendar days of the request. 2. For urgent pre-service decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request. 3. For urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within 24 hours of the request. 4. For post-service decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. **Element F - Policies and Procedures**: BHRS has written policies and procedures in place for the following time frames for timeliness of healthcare UM decision		

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
making: 1. For non-urgent pre-service decisions, the organization makes decisions within 15 calendar days of receipt of the request. 2. For urgent pre-service decisions, the organization makes decisions within 72 hours of receipt of the request. 3. For urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request. 4. For post-service decisions, the organization makes decisions within 30 calendar days of receipt of the request.		
NCQA UM 6 - Clinical Information: When making a determination of coverage based on medical necessity, BHRS obtains relevant clinical information and consults with the treating practitioner. **Element B - Relevant Information for Behavioral Decisions**: There is documentation that BHRS gathers relevant clinical information consistently to support behavioral healthcare UM decision making.	BHRS will specify in the UM program requirements for the UM decision specified in Element B.	HEALTH PLAN will review BHRS's UM Program, and provide feedback to BHRS as part of the HEALTH PLAN annual oversight audit.
NCQA UM 7 - Denial Notices: BHRS clearly documents and communicates the reasons for each denial. **Element D - Discussing a Denial with a Reviewer:** BHRS gives practitioners the opportunity to discuss behavioral healthcare UM denial decisions with a physician or other appropriate reviewer. **Element E - Reason for Behavioral Denial:** BHRS's written notification of non-behavioral healthcare denials, which it provides to members and	BHRS will document and communicate the reasons for each UM denial as specified in Elements D and F. BHRS will provide UM Denial Logs on a semi-annual basis.	HEALTH PLAN will review sample communication sent to members and practitioners, and provide feedback to BHRS as part of the HEALTH PLAN annual oversight audit. HEALTH PLAN will review BHRS's UM Denial Logs and provide feedback as part of its mid-year

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
their treating practitioners, contains the following information: 1. The specific reasons for the denial, in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request **Element F - Behavioral Healthcare Notice of Appeal Rights/Process**: BHRS's written behavioral healthcare denial notification to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal. 2. An explanation of the appeal process, including the right to member representation and appeal time frames 3. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.		review and the annual oversight audit.

Credentialing

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
NCQA CR 1 - Credentialing	BHRS will submit a copy of its	HEALTH PLAN will

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
Policies: BHRS has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. **Element A - Practitioner Credentialing Guidelines:** BHRS's credentialing policies and procedures specify: 1. The types of practitioners to credential and recredential. 2. The verification sources used. 3. The criteria for credentialing and recredentialing. 4. The process for making credentialing and recredentialing decisions. 5. The process for managing credentialing files that meet the BHRS's established criteria. 6. The process for delegating credentialing or recredentialing. 7. The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner. 8. The process for notifying practitioners if information obtained during BHRS's credentialing process varies substantially from the information they provided to BHRS. 9. The process for ensuring that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee's decision. 10. The medical director or other designated physician's direct responsibility and participation in the credentialing program. 11. The process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise	most recent Credentialing Program, or equivalent document(s). Credentialing Program will describe requirements listed in Element A and Element B.	review BHRS's Credentialing Program and provide feedback as part of the HEALTH PLAN annual oversight audit.

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
provided by law. 12. The process for ensuring listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty. **Element B - Practitioner Rights:** BHRS notifies practitioners about their right to: 1. Review information submitted to support their credentialing application. 2. Correct erroneous information. 3. Receive the status of their credentialing or recredentialing application, upon request.		
NCQA CR 2 - Credentialing Committee: BHRS designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions. **Element A - Credentialing Committee:** BHRS's Credentialing Committee: 1. Uses participating practitioners to provide advice and expertise for credentialing decisions. 2. Reviews credentials for practitioners who do not meet established thresholds. 3. Ensures that files that do not meet established criteria are reviewed and approved by a medical director or designated physician.	BHRS will establish a Credentialing Committee and implement policy and procedure to meet requirements listed in Element A.	HEALTH PLAN will review BHRS's Credentialing Committee policy and procedure and QI Committee minutes, and provide feedback as part of the HEALTH PLAN annual oversight audit.
NCQA CR 3 - Credentialing Verification: BHRS verifies credentialing information through primary sources, unless otherwise indicated.	BHRS will include procedure to meet requirements listed in CR 3, Element A, Element B, and Element C, in its Credentialing Program, or equivalent document(s).	HEALTH PLAN will review BHRS's credentialing files for new and reappointed practitioners, and provide feedback as

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
Element A - Verification of Credentials: BHRS verifies that the following are within the prescribed time limits: 1. A current and valid license to practice. 2. A valid DEA or CDS certificate, if applicable. 3. Education and training as specified in the explanation. 4. Board certification status, if applicable. 5. Work history. 6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner. **Element B - Sanction Information**: BHRS verifies the following sanction information for credentialing: 1. State sanctions, restrictions on licensure or limitations on scope of practice. 2. Medicare and Medicaid sanctions. **Element C - Credentialing Application:** applications for credentialing include the following: 1. Reasons for inability to perform the essential functions of the position. 2. Lack of present illegal drug use. 3. History of loss of license and felony convictions. 4. History of loss or limitation of privileges or disciplinary actions. 5. Current malpractice insurance coverage. 6. Current and signed attestation confirming the correctness and completeness of the application.		part of the HEALTH PLAN annual oversight audit. HPSM retains the right to approve, suspend and terminate individual practitioners and providers.
NCQA CR 4 - Recredentialing Cycle Length: BHRS formally recredentials its practitioners at least every 36 months.	BHRS will include procedure to meet requirements listed in CR 4, Element A, in its Credentialing Program, or	HEALTH PLAN will review BHRS's Credentialing Program and provide feedback

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
Element A - Recredentialing Cycle Length: the length of the recredentialing cycle is within the required 36-month time frame.	equivalent document(s).	as part of the HEALTH PLAN annual oversight audit.
NCQA CR 6 - Ongoing Monitoring: BHRS develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.	BHRS will include procedure to meet requirements listed in CR 6, in its Credentialing Program, or equivalent document(s).	HEALTH PLAN will review BHRS's Credentialing Program and provide feedback as part of the HEALTH PLAN annual oversight audit.
NCQA CR 7 - Notification to Authorities and Practitioner Appeal Rights: When the BHRS takes action against a practitioner for quality reasons; BHRS reports the action to the appropriate authorities and offers the practitioner a formal appeal process. **Element A: Actions Against Practitioners:** BHRS policies and procedures describe: 1. The range of actions available to the organization. 2. Reporting to authorities. 3. A well-defined appeal process. 4. Making the appeal process known to practitioners. **Element B: Reporting to Appropriate Authorities:** BHRS reports practitioner suspension or termination to the appropriate authorities, when appropriate. **Element C: Practitioner Appeal Process:** BHRS informs affected practitioners of its appeal process and includes the following information in process and notification: 1. Providing written notification	BHRS will include procedure to meet requirements listed in CR 7, Elements A, B, and C in its Credentialing Program, or equivalent document(s). Within five (5) business days. BHRS will notify HEALTH PLAN that an action has been taken against a practitioner.	HEALTH PLAN will review BHRS's Credentialing Program and provide feedback as part of the HEALTH PLAN annual oversight audit. HEALTH PLAN will review notification and inform BHRS if further action is needed.

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
indicating that a professional review action has been brought against the practitioner, reasons for the action and a summary of the appeal rights and process. 2. Allowing the practitioner to request a hearing and the specific time period for submitting the request. 3. Allowing at least 30 calendar days after the notification for the practitioner to request a hearing. 4. Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. 5. Appointing a hearing officer or a panel of individuals to review the appeal. 6. Providing written notification of the appeal decision that contains the specific reasons for the decision.		
NCQA CR 8 - Assessment of Organizational Providers: BHRS has written policies and procedures for the initial and ongoing assessment of providers with which it contracts. **Element A: Review and Approval of Provider:** BHRS's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every three years thereafter, it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the provider is not accredited.	BHRS will include procedure to meet requirements listed in CR 8, Elements A in its Credentialing Program, or equivalent document(s).	HEALTH PLAN will review BHRS's Credentialing Program and provide feedback as part of the HEALTH PLAN annual oversight audit.
The Joint Commission	Upon obtaining renewal of	HEALTH PLAN will

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
Accreditation: BHRS will maintain certification of accreditation status from The Joint Commission (TJC) and licenses for evaluating subcontracted organizational providers (hospital, home health, SNF) in order to be exempt from the required DHCS and DMHC credentialing file review audit	TJC accreditation, BHRS will submit evidence of its accreditation results.	maintain copy of BHRS's Joint Commission accreditation results in BHRS's annual oversight audit file.
NCQA - Credentialing Reports: 1. List of Initial and Recredentialed practitioners 2. List of Initial Assessment and Re-assessment of organizational providers.	BHRS will submit Credentialing Reports listed in items 1 and 2 on a quarterly basis.	HEALTH PLAN will review BHRS's Provider Network Summary Reports and provide feedback to BHRS as needed.

Network

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
1. BHRS ensures an adequate network to guarantee access and availability during reasonable hours of operation. 2. BHRS provides for reasonable after-hour services via the provider network or through self-performance as necessary. 3. BHRS shall ensure emergency health care services are available and accessible within the service area twenty-four hours a day, seven days a week.		1. HEALTH PLAN ensures BHRS shall provide covered health care services in a timely manner appropriate for the nature of a Member's condition consistent with good professional practice and offer Members appointments that meet the timeframes of the Department of Managed Health Care regulation (Title 28, Section 130.67.2.2).

Office Site Visits

Delegated Activities	BHRS Responsibilities	HEALTH PLAN Responsibilities
NCQA CR 5 - Practitioner Office Site Quality: BHRS has a process to ensure that the offices of all practitioners meet its office-site standards. **Element A - Performance Standards and Thresholds:** BHRS sets site performance standards and thresholds for: 1. Physical accessibility. 2. Physical appearance. 3. Adequacy of waiting and examining room space. 4. Adequacy of treatment record keeping. **Element B - Site Visits and Ongoing Monitoring**: BHRS implements appropriate interventions by: 1. Continually monitoring member complaints for all practitioner sites. 2. Conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met. 3. Instituting actions to improve offices that do not meet thresholds. 4. Evaluating the effectiveness of the actions at least every six months, until deficient offices meet the thresholds. 5. Documenting follow-up visits for offices that had subsequent deficiencies.	BHRS will implement Office Site performance standards to meet requirements listed in Element A and Element B in its Credentialing Program, or equivalent document(s). BHRS will perform Office Site visits as requested by HEALTH PLAN, and provide HEALTH PLAN with summary of findings, and a corrective action plan when deficiencies are found.	As a result of a member complaint, HEALTH PLAN will request BHRS to conduct an evaluation of a practitioner's Office Site.

Claims and Encounters

Delegated Activities	PROVIDER Responsibilities	HEALTH PLAN Responsibilities
Encounter Data: BHRS submits	BHRS will submit complete,	HEALTH PLAN will

electronic encounter data files regarding the delivery of services. 1. Data must, at a minimum, meet the reporting requirements outlined by HIPAA. 2. File names and format of files received by HEALTH PLAN must be consistent. Any change in file name or changes in the format of the file will cause the submitted file to be rejected.	timely, and accurate Encounter Data Submissions must be forwarded via the HEALTH PLAN secure FTP site.	review the data for completeness, timeliness, and accuracy. If deficiencies are found HEALTH PLAN will notify BHRS in writing, request correction and resubmission of the relevant data.
Claims Processing: 1. BHRS processes claims for payment from Participating Providers, and Non-Participating Providers as needed, for authorized Covered Behavioral Health and Recovery Services on behalf of HEALTH PLAN.	1. Claims shall be processed at least twice per month, to ensure payment no later than thirty (30) working days after the date of receipt of a complete claim by BHRS. BHRS shall accept and adjudicate claims for health care services provided to HPSM members in accordance with the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28 of the California Code of Regulations. BHRS promptly pays providers for all complete clean claims within thirty (30) working days.	1. HEALTH PLAN will review BHRS's Quarterly Claims Payment Performance Report for compliance with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28 of the California Code of Regulations. HEALTH PLAN will provide feedback to BHRS as needed.
2. BHRS maintains a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4	2. BHRS maintains a tabulated record of each provider dispute received, categorized by date of receipt, and including the identification of the provider, type of dispute, disposition, and working days to resolution, as to each provider dispute received.	2. HPSM maintains authority to assume responsibility for the processing and timely reimbursement of provider claims in the event that BHRS fails to timely and accurately reimburse its claims, including

of title 28 of the California Code of Regulations, unless HPSM assumes this function.		the payment of interest and penalties.
3. BHRS offers providers an unconditional right of appeal to HPSM's dispute resolution process for provider claim disputes involving an issue of medical necessity or utilization review.	3. BHRS issues written decisions to provider claim disputes, pursuant to the provisions of section 1300.71.38(a)(4) of title 28 of the California Code of Regulations.	3. HEALTH PLAN maintains a provider for provider claim disputes involving an issue of medical necessity or utilization review, providing a de novo review and resolution for a period of 60 working days from BHRS's Date of Determination, pursuant to the provisions of section 1300.71.38(a)(4) of title 28 of the California Code of Regulations.

EXHIBIT 2
REPORTING

HPSM is responsible for the monitoring and oversight of BHRS's performance under this Agreement. BHRS will provide the following reports to support HPSM's monitoring and oversight, and facilitate Plan's compliance with State regulatory agencies or private accreditation requirements. Additional reports or information, which may not be set forth in this Agreement, may be required of HPSM by State or federal regulatory agencies or private accreditation organizations from time to time. BHRS shall provide such reports and information to HPSM in a mutually agreeable time and manner that enables HPSM to meet its obligations.

1. Required Reports:

Category	**Report Name**	**Frequency**	**Due Date to HPSM**	**HPSM Contact for Report Submission**
Call Center	Monthly Call Center Statistics	Monthly	5th day of each month	Director of Provider Network
Claims	Claims Settlement Practices Report	Quarterly	Jan 30 April 30 Jul 31 Oct 31	Claims Director
Provider Network	Provider Network Roster	Monthly	5th day of each month	Director of Provider Network
Provider Network	Appointment Access Report	Annually	Mar 30	Director of Provider Network
Utilization Management	UM Summary Report	Quarterly	Jan 30 April 30 Jul 31 Oct 31	Chief Medical Officer

EXHIBIT 3
PAYMENT

1. Provider Payment Rates

Effective July 1, 2017, for services under this agreement, HPSM shall reimburse BHRS at 100% of the Medicare allowable rates in effect on the date-of-service.

2. Administrative Rate

Effective January 1, 2017, HPSM shall pay to BHRS a monthly administrative rate for performance of the scope of services in this Agreement, of $1.50 per member per month. The count of HPSM's CareAdvantage CalMediConnect members shall be based upon HPSM's CareAdvantage CalMediConnect monthly membership count and shall be applied throughout the Term of this Agreement. Payment of the administrative rate shall be contingent upon the measurement and performance of Performance Measures in paragraph 3, below.

3. Performance Measures

Payment of five percent (5%) of the Administrative Rate in paragraph 2 shall be based upon the following Performance Measures. For each calendar quarter, beginning July through September 2017, achievement of these performance measures shall be assessed retrospectively no later than forty-five days following the end of the calendar quarter. For each Performance Measure below, 1% of the monthly Administrative Rate shall be paid or forfeited based upon achievement of the Target. HPSM will withhold payment of amounts due under this paragraph when BHRS has any pending corrective action plan due to HPSM for non-compliance with state or federal regulatory requirements, until such time when the corrective actions are resolved

.Measure	Definition	Target
Access	Number of days between initial BHRS referral and initial appointment	95% within 10 days
Phone abandonment rate	Percentage of calls abandoned after 10 seconds	Less than 5%
Diagnosis Coding	Percentage of submitted claims which include diagnosis codes of "other" or "unspecified" or "not otherwise specified".	Less than 2%
HEDIS Follow-Up Visit	Percentage of members discharged from an inpatient hospital stay who had an outpatient visit within 7 days of discharge	76%
Reporting	Timely reporting to meet due dates of Appendix 1-C	100% timely