NOTE 11 – LONG-TERM DEBT

A summary of long-term debt and capital lease obligations as of December 31 is as follows:

	2023	2022
City of Temple Terrace, Florida Revenue Refunding Bond, (Chapters Health System Project), Series 2017, with Regions Bank as bondholder, commencing April 2017, maturing April 2031, secured by certain assets of CHS, principal maturing in varying amounts, interest payable monthly at 0.67% of one-month simple SOFR plus 1.12% (4.79% at December 31, 2023) (Series 2017 Bond).	$ 9,620,300	$ 10,749,600
Conventional taxable loan, with Regions Bank as bondholder, commencing April 2017, maturing December 2035, secured by certain assets of CHS, principal maturing in varying amounts, interest payable monthly at 0.67% of one-month simple SOFR plus 1.75% (7.22% at December 31, 2023) due through 2035 (Taxable Loan)	13,256,000	13,679,000
Conventional term loan, with Regions Bank, commencing May 2023, secured by certain assets of CHS, principal maturing in varying amounts, interest payable at 1.75% plus one-month simple SOFR (5.41% at December 31, 2023) due through May 2027	7,100,089	-
	30,036,389	24,428,600
Less current portion of long-term debt	(2,200,646)	(1,552,300)
Less unamortized debt issuance costs	(463,566)	(333,492)
	$ 27,372,177	$ 22,542,808

The agreement underlying the bond issues and the 2017 Taxable Loan as described above were modified in May 2023 to change the Obligated Group. The Obligated Group now includes Chapters Health Palliative Care, LLC, Chapters Health Pharmacy, LLC, Chapters Health Staffing, LLC, Chapters Health Home Connect, Inc., Hospice of Okeechobee, and Cornerstone Health Services, LLC. The addition was to add Cornerstone.

The agreements underlying the bond issues and the 2017 Taxable Loan described above contain covenants that provided for, among other things, the maintenance of certain ratios, conditions for issuance of additional indebtedness and the transferability of funds. At December 31, 2023, CHS was out of compliance with certain financial covenants. CHS obtained a waiver from the financial institution subsequent to year end. The Series 2017 Bond and 2017 Taxable Loan are secured under a Master Trust Indenture and Supplemental Indentures and are collateralized by pledged revenues, all rights, titles, interests and estates in and to all real property and the revenue fund as outlined in the agreements.

(Continued)

NOTE 11 – LONG-TERM DEBT (Continued)

Debt Issuance Costs: Debt issuance costs are netted against the related obligation and amortized over the term of the related obligation. In conjunction with the issuance of the Series 2017 Bond, 2017 Taxable Loan, 2023 Term Loan, and 2023 Revolver, CHS recorded debt issuance costs of approximately $165,000.

Unamortized debt issuance costs as of December 31, 2023 and 2022, was approximately $463,000 and $333,000, respectively, and is included in the non-current portion of long-term debt in the accompanying consolidated balances sheets. Amortization expense was approximately $60,000 for the years ended December 31, 2023 and 2022 and is included in interest in the accompanying consolidated statements of operations.

Debt Maturities: Maturities of long-term debt and capital lease obligations are as follows:

	Series 2017 & 2023 Bonds & Loans
2024	$ 2,200,646
2025	2,284,337
2026	2,367,458
2027	6,986,097
2028	1,795,400
Thereafter	14,402,451
	$ 30,036,389

Interest Rate Swap Agreements: CHS utilizes interest rate swap agreements to modify CHS's exposure to interest rate risk by converting a portion of its variable rate borrowings to a fixed-rate basis, thus reducing the impact of interest-rate changes on future interest expense. These agreements involve the receipt of variable-rate payments amounts in exchange for fixed-rate interest payments over the life of the agreements without an exchange of the underlying principle amount. In conjunction with the Series 2017 Bond and 2017 Taxable Loan, in March 2017, CHS entered into two interest rate swap agreements with Regions Bank to convert a portion of its variable-rate borrowings to a fixed-rate basis. These swap agreements matured on April 1, 2024.

CHS pays a fixed rate of 1.45% and receives a variable-rate payment based on 67% of SOFR for one swap and pays a fixed rate of 2.182% and receives a variable-rate payment based on SOFR for the other swap. At December 31, 2023 and 2022, the notional amount of these swap agreements totaled approximately $22,876,000 and $24,429,000, respectively.

NOTE 12 – EMPLOYEE BENEFIT PLANS

CHS sponsors noncontributory supplemental executive retirement plans (SERP) for a select group of management or highly compensated employees. The plans call for benefits to be paid in a lump sum amount on the 45th day following separation from service as long as the participant has attained the vesting dates for employer-contributed amounts. Employee-contributed amounts may be distributed based on a list of options provided in the plans.

(Continued)

NOTE 12 – EMPLOYEE BENEFIT PLANS (Continued)

Distributions equal to 100% of the amount credited to the participant's account will be made to the participant or beneficiary if the event of total and permanent disability, death, termination due to change in the control of the employer or termination without cause prior to the vesting date. Total assets held to fund the liability and total accrued liabilities to the plans were approximately $2,117,000 and $1,851,000 at December 31, 2023 and 2022, respectively and are included in other assets and other long-term liabilities in the accompanying consolidated balance sheets.

CHS, in its sole discretion, may at any time make additional deposits of cash or other property in trust with the plans' trustee to augment the principle to be held, administered, and disposed of by the Plans' trustee as provided in the trust agreement. Expenses related to these plans were approximately $1,021,000 and $697,000 for the years ended December 31, 2023 and 2022, respectively

CHS has established a retirement plan under Section 403(b) of the Internal Revenue Code whereby eligible employees may elect to defer a portion of their salary. The plan allows employees to make deposits to self-directed savings accounts through payroll deductions. CHS has the option to make discretionary nonelective contributions for eligible participating employees, as well as matching contributions based upon the amount of eligible compensation contributed by the employee up to certain specified limitations. Employees vest in the employer discretionary nonelective contributions and matching contribution over a six-year period. Participants' forfeitures are used to offset CHS's future plan contributions. Employer contributions to the plan were approximately $2,247,000 and $1,829,000 for the years ended December 31, 2023 and 2022, respectively.

Cornerstone has established a retirement plan under Section 403(b) of the Internal Revenue Code whereby eligible employees may elect to defer a portion of their salary. The plan allows employees to make deposits to self-directed savings accounts through payroll deductions. CHS has the option to make discretionary nonelective contributions for eligible participating employees, as well as matching contributions based upon the amount of eligible compensation contributed by the employee up to certain specified limitations. Employees must normally work in excess of twenty hours a week to participate in the plan and over 1,000 hours a year to vest in the employer's contribution. Employer contributions to the plan were approximately $234,000 for the period of April 1, 2022 through December 31, 2022 and are included in salaries and benefits on the consolidated statements of operations. Cornerstone migrated to the CHS plan on October 1, 2022.

Hope has established 3 retirement plans under Section 403(b) of the Internal Revenue Code whereby eligible employees may elect to defer a portion of their salary. Two of the plans only allow for employee contributions. Hope does not contribute to either of those two plans. The third plan is a retirement plan under Section 403(b) of the Internal Revenue Code in which eligible employees who are at least 21 years of age and have one year of service. This retirement plan is solely funded by Hope, at the discretion of the board of directors and is determined annually. Employer contributions to the plan were approximately $798,000 for the period of March 1, 2023 through December 31, 2023, and are included in salaries and benefits on the consolidated statements of operations.

Capital Caring has established a retirement plan under Section 403(b) of the Internal Revenue Code whereby eligible employees may elect to defer a portion of their salary. Capital Caring matches employee contributions dollar for dollar up to 1% of each eligible employee's salary. Employer contributions to the plan were approximately $158,000 for the period of May 1, 2023 through December 31, 2023, and are included in salaries and benefits on the consolidated statements of operations

(Continued)

NOTE 13 – RELATED PARTY TRANSACTIONS

Cornerstone Foundation was established to exclusively foster, promote, support, develop, and encourage the functions of Cornerstone. U.S. GAAP requires Cornerstone to recognize as an asset its interest in the net assets of Cornerstone Foundation, and to reflect in its changes in net assets the changes in the net assets of Cornerstone Foundation. Total net assets held by the Foundation as of December 31, 2023 and 2022 amounted to $7,925,900 and $6,993,985, respectively, and are classified as interest in net assts of Cornerstone Foundation on the consolidated balance sheets and with donor restrictions by Cornerstone because Cornerstone does not control the timing or amount of the contributions made by Cornerstone Foundation. The change in beneficial interest in the net assets of Cornerstone Foundation is recorded within the consolidated statements of operations within the changes in net assets with donor restrictions.

During the period ended December 31, 2023 and 2022, Cornerstone Foundation made grants to Cornerstone totaling approximately $1,500,000 and $5,619,000, respectively to provide funding for certain programs of Cornerstone. Cornerstone Foundation owed Cornerstone $536,633 and $1,492,303 at December 31, 2023 and 2022, respectively, for operating expenses paid on Cornerstone Foundation's behalf and unpaid grants to Cornerstone. Such amounts are recorded as due from related party in the consolidated balance sheets at December 31, 2023 and 2022.

NOTE 14 – COMMITMENTS AND CONTINGENCIES

Litigation: During the normal course of business, CHS may be subject to various threatened or asserted claims related to professional liability, employment or other matters. CHS maintains commercial insurance on a claims-made basis for medical malpractice, as well as other commercial insurance to cover general liabilities. Management is not aware of any threatened claims that are not covered by its risk management programs or that, in the event of an adverse outcome, would have a significant impact on the financial position of CHS.

Workers' Compensation: CHS maintains workers' compensation insurance through a captive insurance company. Accruals for workers' compensation claims have been estimated by management based upon loss runs and claims data provided by the insurance company. Estimated accruals for workers' compensation claims totaled approximately $1,299,000 and $632,000 at December 31, 2023 and 2022, respectively, and are included in accrued employee compensation and related benefits in the accompanying consolidated balance sheets.

NOTE 15 – SELF-FUNDED INSURANCE

Employee Health Insurance: CHS is self-insured for employee health care to provide medical and other health care benefits to eligible employees and covered dependents. Reinsurance, covering costs above $200,000, for years enced December 31, 2023 and 2022, per individual is maintained through a commercial excess coverage policy. Estimated accruals for claims incurred but not yet reported totaled approximately $2,092,000 and $1,420,000 at December 31, 2023 and 2022, respectively, and are included in accrued employee compensation and related benefits in the accompanying consolidated balance sheets. The estimate of the liability for unasserted claims arising from incurred but not reported claims is based on an analysis of historical claims data. CHS incurred approximately $20,819,000 and $10,512,000 in expense related to self-insured employee health benefits in the accompanying consolidated statements of operations during the years ended December 31, 2023 and 2022, respectively.

(Continued)

NOTE 15 – SELF-FUNDED INSURANCE (Continued)

Cornerstone was self-insured for a portion of employee health benefits and migrated to CHS' plan in October 2022. Estimated accruals for claims incurred but not yet reported totaled approximately $589,000 at December 31, 2022 and are included in accrued employee compensation and related benefits in the accompanying consolidated balance sheets. The estimate of the liability for unasserted claims arising from incurred but not reported claims is based on an analysis of historical claims data. Cornerstone incurred approximately $3,370,000 in expense related to self insured employee health benefits in the accompanying consolidated statements of operations during the period of April 1 through December 31, 2022.

Capital Caring is self-insured for employee health care to provide medical and other health care benefits to eligible employees and covered dependents. Estimated accruals for claims incurred but not yet reported totaled approximately $722,000 at December 31, 2023 and are included in accrued employee compensation and related benefits in the accompanying consolidated balance sheets. The estimate of the liability for unasserted claims arising from incurred but not reported claims is based on an analysis of historical claims data. Capital Caring incurred approximately $3,179,000 in expense related to self-insured employee health benefits in the accompanying consolidated statements of operations during the period of May 1, 2023 through December 31, 2023.

NOTE 16 – LIABILITY FOR UNPAID CLAIMS

Medical claims expense and the liability for unpaid claims include estimates of CHS' obligations for medical care services that have been rendered by third parties on behalf of insured consumers for which the CHS is contractually obligated to pay (through the CHS' capitation arrangements), but for which claims have either not yet been received, processed, or paid. CHS develops estimates for medical care services incurred but not reported ("IBNR"), which includes estimates for claims that have not been received or fully processed, utilizing actuarial models. CHS recorded a liability for accrued third-party medical expense claims of approximately $2,463,000 and $1,613,000 at December 31, 2023 and 2022, respectively.

CHS purchases provider excess insurance to protect against significant, catastrophic claims expenses incurred on behalf of its patients. The total amount of provider excess insurance premiums was $4,065,215 and $440,509 for the years ended December 31, 2023 and 2022, respectively. The provider excess insurance premiums less reimbursements are reported in medical claims expense in the consolidated statements of operations. Recoveries due are included in capitated accounts receivable in the consolidated balance sheets. CHS' provider excess insurance deductible for the plan was $17.52 and $17.70 per member per month for the years ended December 31, 2023 and 2022, respectively.

(Continued)

NOTE 17 – NET ASSETS WITH DONOR RESTRICTIONS

Net assets with donor restrictions are available for the following purposes at December 31:

	2023	2022
Beneficial interest in the net assets of Cornerstone Foundation	$ 7,925,900	$ 6,993,965
For the operations of LifePath Hospice	4,178,730	3,125,461
For the operations of Good Shepherd Hospice	2,254,725	2,157,307
For the operations of Hernando-Pasco Hospice	1,805,032	732,700
For the operations of Capital Caring Hospice	3,492,559	-
For the operations of Hope Healthcare	223,581	-
Endowment – LifePath Hospice	844,605	844,605
Endowment – Good Shepherd Hospice	166,994	166,994
Endowment – Capital Caring	2,481,515	-
For the operations of Chapters Health Foundation	(56,405)	407,769
	$ 23,317,246	$ 14,428,801

NOTE 18 – FAIR VALUE MEASUREMENTS OF FINANCIAL INSTRUMENTS

U.S. GAAP defines fair value as the price that would be received for an asset or paid to transfer a liability (an exit price) in the CHS's principle or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. The fair value hierarchy requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. There are three levels of inputs that may be used to measure fair value as follows:

Level 1: Quoted prices for identical assets or liabilities in active markets that the entity has the ability to access as of the measurement date. The fair values of cash and cash equivalents, money market funds, mutual funds, equity securities, and real estate funds are determined by obtaining quoted prices on nationally recognized securities exchanges.

Level 2: Significant other observable inputs other than Level 1 prices such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data. The fair values of CHS's government debt securities and corporate bonds are determined by matrix pricing, a market method, which is a mathematical technique widely used in the industry to value debt securities without relying exclusively on quoted prices for the specific securities but rather by relying on the securities' relationship to other benchmark quoted securities. CHS's derivatives, which are comprised of two interest rate swap agreements, are also reported at fair value using Level 2 inputs. CHS obtained the fair value from a financial institution which utilizes internal models with observable market data inputs to estimate the value of this instrument (market approach valuation technique).

(Continued)

NOTE 18 – FAIR VALUE MEASUREMENTS OF FINANCIAL INSTRUMENTS (Continued)

Level 3: Significant unobservable inputs that reflect a reporting entity's own assumptions about the assumptions that market participants would use in pricing an asset or liability. The interest in net assets of Cornerstone Foundation is based on the underlying assets of Cornerstone Foundation, which are not redeemable upon request by Cornerstone or CHS. The interest in net assets of Cornerstone Foundation is largely composed of underlying investments that have observable inputs and market activity allowing for pricing based on the market prices of the items in the investments (market approach valuation technique).

In many cases, a valuation technique used to measure fair value includes inputs from multiple levels of the fair value hierarchy. The lowest level of significant input determines the placement of the entire fair value measurement in the hierarchy.

The following tables present the financial instruments carried at fair value on a recurring basis as of December 31, 2023 and 2022, by valuation hierarchy, all of which were based on the market approach which uses prices and other relevant information generated by market transactions involving identical or comparable assets.

Assets and liabilities measured on a recurring basis are as follows:

	Fair Value Measurement at December 31, 2023			
	Level 1	Level 2	Level 3	Total
Assets				
Assets limited as to use:				
Cash and cash equivalents	$ 6,629,801	$ -	$ -	$ 6,629,801
Money market funds	1,953,555	-	-	1,953,555
Mutual funds	1,864,123	-	-	1,864,123
Total assets limited as to use	10,447,479	-	-	10,447,479
Investments				
Cash and cash equivalents	859,729	-	-	859,729
Money market funds	3,252,303	-	-	3,252,303
U.S. government agencies	-	1,527,559	-	1,527,559
Corporate bonds	-	991,281	-	991,281
Equity mutual funds	74,242,791	-	-	74,242,791
Bond mutual funds	9,802,093	-	-	9,802,093
Commodities mutual funds	1,422,439	-	-	1,422,439
Real estate fund	16,175,034	-	-	16,175,034
Equity securities	1,010,474	-	-	1,010,474
Total investments	106,764,863	2,518,840	-	109,283,703
Interest rate swap agreements	-	282,822	-	282,822
Interest in net assets of Cornerstone Foundation	-	-	7,925,900	7,925,900
Total assets	$ 117,212,352	$ 2,801,662	$ 7,925,900	$ 127,939,914

(Continued)

NOTE 18 – FAIR VALUE MEASUREMENTS OF FINANCIAL INSTRUMENTS (Continued)

	Fair Value Measurement at December 31, 2022			
	Level 1	Level 2	Level 3	Total
Assets				
Assets limited as to use:				
Cash and cash equivalents	$ 3,452,644	$ -	$ -	$ 3,452,644
Money market funds	60,097	-	-	60,097
Mutual funds	1,728,286	-	-	1,728,286
Total assets limited as to use	5,241,027	-	-	5,241,027
Investments				
Cash and cash equivalents	1,780,247	-	-	1,780,247
Money market funds	7,420,132	-	-	7,420,132
U.S. government agencies	-	673,813	-	673,813
Corporate bonds	-	258,390	-	258,390
Equity mutual funds	71,095,887	-	-	71,095,887
Bond mutual funds	8,818,080	-	-	8,818,080
Commodities mutual funds	1,509,974	-	-	1,509,974
Real estate fund	943,147	-	-	943,147
Equity securities	8,956,981	-	-	8,956,981
Total investments	100,524,447	932,203	-	101,456,651
Interest rate swap agreements	-	678,387	-	678,387
Interest in net assets of Cornerstone Foundation	$ -	$ -	$ 6,993,965	$ 6,993,965
Total assets	$ 105,765,475	$ 1,610,590	$ -	$ 107,376,065

A reconciliation of beginning and ending balances for Organization's fair value measurements using Level 3 inputs is as follows:

	Interest in Net Assets of Cornerstone Founds
Assets at January 1, 2023	$ 6,993,965
Change in interest in net assets of Cornerstone Foundation	931,935
Assets at December 31, 2023	$ 7,925,900

(Continued)

NOTE 19 – FUNCTIONAL EXPENSES

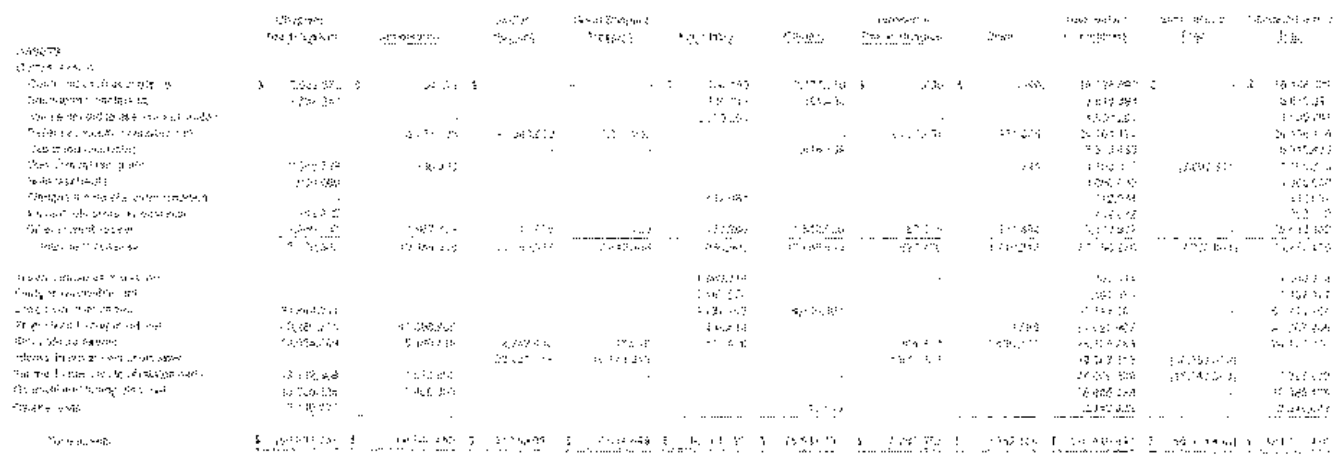
The consolidated financial statements report certain categories of expenses that are attributable to more than one program or supporting function. Therefore, these expenses require allocation on a reasonable basis that is consistently applied. The expenses that are allocated include depreciation, interest, and occupancy, which are allocated on a square-footage basis, as well as salaries and benefits, which are allocated on the basis of estimates of time and effort.

Year ended December 31, 2023	Program Services	Management and General	Fundraising	Total Expenses 2023
Salaries and benefits	$ 299,526,441	$ 6,663,622	$ 5,798,112	$ 311,988,175
Purchased services	44,733,195	1,194,317	932,357	46,859,869
Durable medical equipment, supplies and drugs	35,448,678	956,932	702,032	37,107,842
Medical claims expense	32,867,719	362,227	633,051	33,862,997
Insurance and other	57,729,684	1,389,155	1,093,302	60,212,040
Depreciation and amortization	11,115,640	220,485	217,823	11,551,948
Interest	2,164,514	54,673	39,971	2,269,158
Affiliation expenses	-	1,188,528	-	1,188,528
	$ 483,573,972	$ 12,039,937	$ 9,416,649	$ 505,030,558

Year ended December 31, 2022	Program Services	Management and General	Fundraising	Expenses 2022
Salaries and benefits	$ 135,224,058	$ 26,684,925	$ 2,837,125	$ 164,746,108
Purchased services	21,612,064	463,010	267,358	22,342,452
Durable medical equipment, supplies and drugs	15,885,746	-	-	15,885,746
Medical claims expense	24,912,802	-	-	24,912,802
Insurance and other	35,855,789	3,048,320	2,204,621	40,908,730
Depreciation and amortization	-	9,183,759	-	9,183,759
Interest	-	1,063,989	-	1,063,989
Affiliation expenses	-	375,000	-	375,000
	$ 233,290,479	$ 40,818,903	$ 5,309,104	$ 279,418,486

SUPPLEMENTARY INFORMATION

CHAPTERS HEALTH SYSTEM, INC. AND AFFILIATES
OBLIGATED GROUP BALANCE SHEET
December 31, 2023



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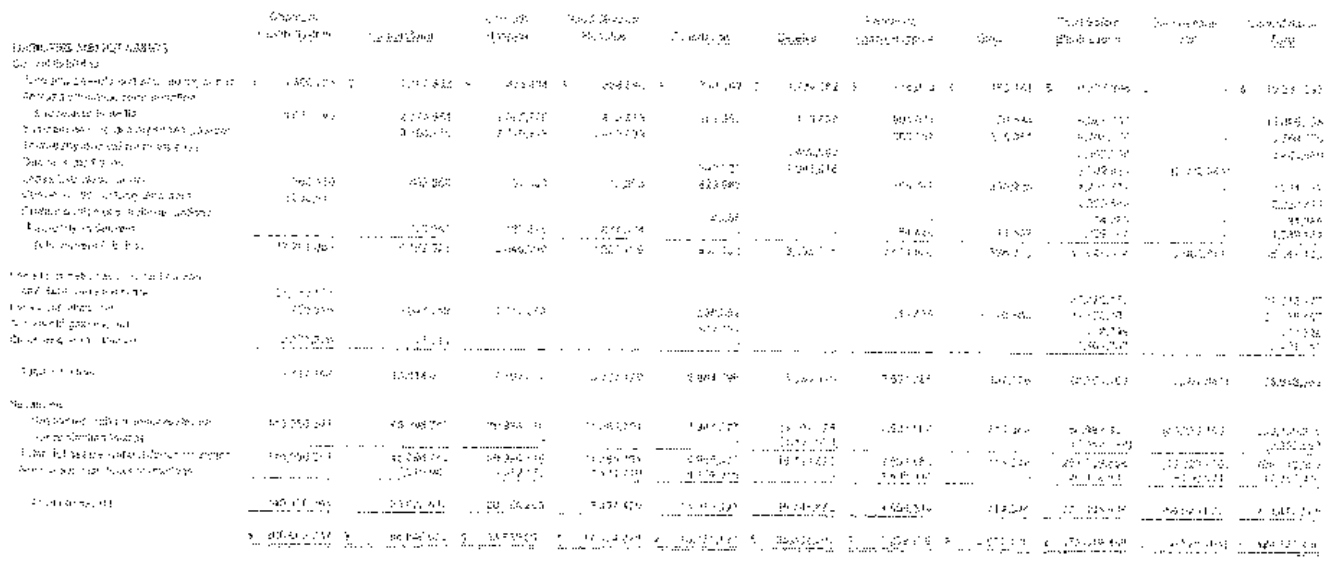
CHAPTERS HEALTH SYSTEM, INC. AND AFFILIATES
OBLIGATED GROUP BALANCE SHEET
December 31, 2023



See accompanying independent auditor's report.

CHAPTERS HEALTH SYSTEM, INC. AND AFFILIATES
CONSOLIDATING BALANCE SHEET
December 31, 2023

	Obligated Group	Home Healthcare	Capital Caring Hospice	Other	Total Before Eliminations	Eliminations Total	Consolidated Total
ASSETS							
Current assets							
Cash and cash equivalents	$ 16,198,692	$ 10,469,924	$ 6,375,674	$ 299,811	$ 33,810,101	$	$ 33,810,101
Short-term investments	3,610,391	7,962,148		-	11,572,539	-	11,572,539
Assets limited as to use, current portion	4,839,261	-	-	-	4,839,261		4,839,261
Patient accounts receivable, net	24,504,174	8,791,271	10,568,911	239,990	43,823,346	-	43,823,346
Capitation receivable	6,516,409	-	-	-	6,516,409		6,516,409
Due from related party	1,100,779	-	169,980	-	1,270,759	(594,783)	675,980
Note receivable	3,000,000			-	3,000,000	(3,000,000)	
Pledges receivable, current portion	412,084	-	11,370	-	423,454		423,454
Interest rate swap agreements	282,822	-		-	282,822	-	282,822
Other current assets	15,412,202	3,136,091	950,871	47,873	19,547,437	-	19,547,437
Total current assets	75,477,435	30,343,434	19,398,719	678,574	124,894,162	(3,594,783)	121,299,379
Assets limited as to use, net	1,963,314		3,944,914		5,908,228	-	5,908,228
Pledges receivable, net	1,407,974		2,259,114	-	3,667,088		3,667,088
Long-term investments	97,711,194			-	97,711,194		97,711,194
Property and equipment, net	91,097,905	34,905,261	16,929,124		142,932,290	-	142,932,290
Right of use assets	24,124,288	3,825,101	22,673,432	-	50,622,821		50,622,821
Interest in net assets of related party	7,925,900	-		-	7,925,900	-	7,925,900
Goodwill and intangibles, net	18,265,428	5,375,000	7,200,000		30,840,428	-	30,840,428
Other assets	2,340,022	-	19,841		2,359,863	-	2,359,863
Total assets	$ 320,121,430	$ 84,476,796	$ 73,117,144	$ 678,574	$ 486,391,944	$ (3,594,783)	$ 482,797,161

(Continued)

CHAPTERS HEALTH SYSTEM, INC. AND AFFILIATES
CONSOLIDATING BALANCE SHEET
December 31, 2023

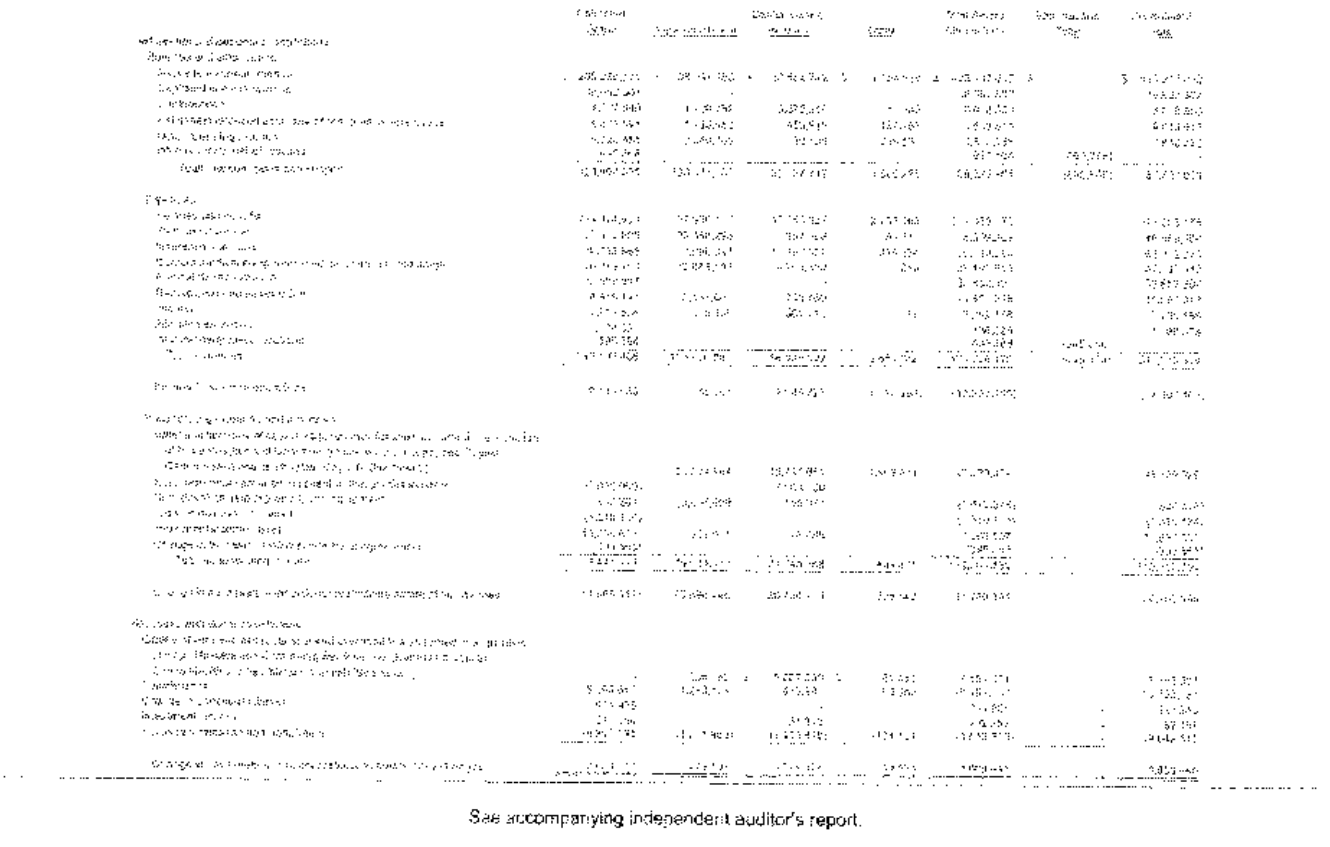
LIABILITIES AND NET ASSETS	Obligated Group	Hope Healthcare	Capital Caring Hospice	Other	Total Before Eliminations	Eliminating Entries	Consolidated Total
Current liabilities							
Accounts payable and accrued expenses	$ 14,237,396	$ 5,297,553	$ 5,069,539	$ 84,680	$ 21,633,476	$ -	$ 21,630,978
Accrued employee compensation and related benefits	15,096,736	4,434,488	5,506,679	94,290	25,132,193	-	25,132,193
Estimated patient care expenses payable	8,794,179	1,135,711	2,734,753		12,664,638	-	12,664,638
Third-party medical claim expense	2,462,980	-			2,462,980		2,462,980
Due to related party		295,227	-	299,556	594,783	(594,783)	-
Lease liabilities, current	4,291,777	1,066,635	2,190,297		7,548,904	-	7,548,804
Current portion of long-term debt	2,200,848		3,000,000	-	5,200,848	(3,000,000)	2,200,848
Current portion of annuity obligations	34,265		75,190	-	109,455		109,455
Third-party settlements	1,939,144	(795,725)	384,521		1,527,940		1,527,940
Total current liabilities	45,047,133	11,444,389	18,960,956	478,524	75,871,003	(3,594,783)	72,276,220
Long-term debt, net of current portion and debt issuance costs	27,372,177	-	-		27,372,177	-	27,372,177
Lease liabilities, net	21,178,407	2,802,434	20,727,506	-	44,708,347		44,708,347
Annuity obligations, net	149,795	217,757	-	-	367,552		367,552
Other long-term liabilities	2,901,050	90,396	20,473	-	3,011,719	-	3,011,719
Total liabilities	96,648,562	14,554,787	40,708,955	416,524	152,333,748	(3,594,783)	148,738,915
Net assets							
Net assets without donor restriction	209,705,651	79,554,446	26,434,116	196,385	316,095,598	-	316,095,598
Noncontrolling interest	(3,352,698)	-	-	-	(3,352,698)	-	(3,352,698)
Total net assets without donor restriction	206,412,552	79,568,448	26,434,115	194,285	312,743,900		312,743,900
Net assets with donor restrictions	17,059,916	253,591	5,974,074	59,665	23,317,246	-	23,317,246
Total net assets	223,472,868	79,822,039	32,408,189	258,950	335,961,148	-	335,961,148
	$ 320,121,430	$ 94,376,796	$ 73,117,144	$ 675,474	$ 488,311,044	$ (3,594,783)	$ 484,797,151

See accompanying notes to consolidated financial statements

CHAPTERS HEALTH SYSTEM, INC. AND AFFILIATES
OBLIGATED GROUP STATEMENT OF OPERATIONS
Year ended December 31, 2023

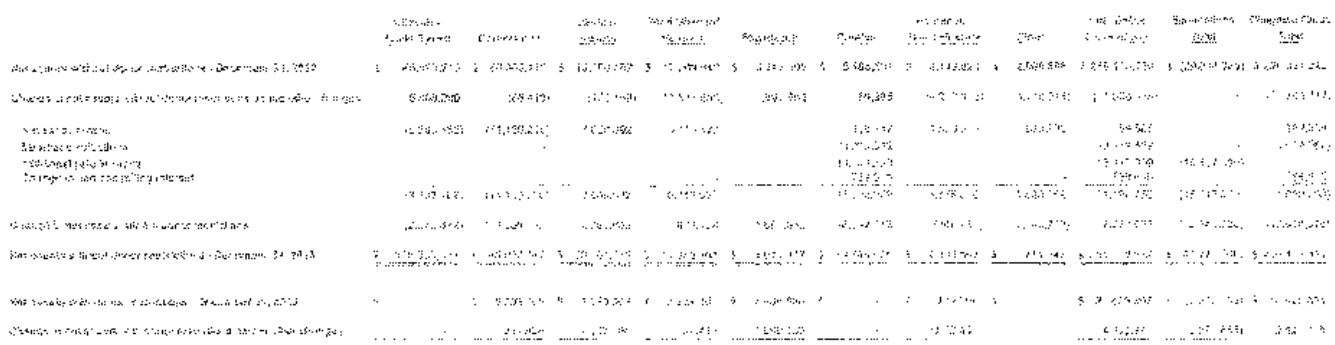
See accompanying notes to consolidated financial statements

CHAPTERS HEALTH SYSTEM, INC. AND AFFILIATES
CONSOLIDATING STATEMENT OF OPERATIONS
Year ended December 31, 2023



See accompanying independent auditor's report.

CHAPTERS HEALTH SYSTEM, INC. AND AFFILIATES
OBLIGATED GROUP STATEMENT OF CHANGES IN NET ASSETS
Year ended December 31, 2023



See accompanying independent auditor's report.

CHAPTERS HEALTH SYSTEM, INC. AND AFFILIATES
CONSOLIDATING STATEMENT OF CHANGES IN NET ASSETS
Year ended December 31, 2023

	Obligated Group	[illegible] Healthcare	Capital Giving Reserve	Other	Total Before Eliminations	Eliminations	Consolidated Total
Net assets without donor restrictions - December 31, 2022	$ 279,051,324	$	$ -	$ 262,425	$ [illegible]	$ -	$ [illegible]
Change in net assets without donor restrictions before other changes	(11,588,311)	79,988,248	29,434,115	295,848	94,780,064	-	94,780,064
Net asset transfer	359,858	-	-	(359,469)		-	
Member distributions	(3,076,582)	-	-	-	(3,079,582)		(3,079,582)
Change in non-controlling interest	769,315		-	-	769,315	-	769,315
	(1,950,030)	-		(359,469)	(2,309,957)	-	(2,309,947)
Change in net assets without donor restrictions	(13,538,370)	79,988,248	29,434,115	(54,349)	92,458,147	-	92,458,147
Net assets without donor restrictions - December 31, 2023	$ 265,412,954	$ 79,988,248	$ 29,434,115	$ 196,345	$ [illegible]	$	$ [illegible]
Net assets with donor restrictions - December 31, 2022	$ 14,028,801	$	$ -	$	$ 14,028,801	$ -	$ [illegible]
Change in net assets with donor restrictions before other changes	2,631,115	273,551	5,371,074	59,695	8,085,445	-	8,085,445
Net assets without donor restrictions - December 31, 2023	$ 17,059,916	$ [illegible]	$ 5,371,074	$ 59,695	$ [illegible]	$ -	$ [illegible]

NOTE 1 – CONSOLDATING DETAIL

The accompanying consolidating balance sheet and consolidating statement of operations reflect the financial position and operations and changes in net assets of Chapters Health System, Inc. (CHS) and its major operating entities. The amounts included in CNU are comprised of CNU, Assurity Direct Contracting Entity, Inc., and eliminations between the two companies.

The amounts included in other within the Obligated Group includes: Chapters Health Palliative Care, LLC, Chapters Health Pharmacy, LLC, Chapters Health Staffing, LLC, Chapters Health Home Connect, Inc., Hospice of Okeechobee, and Cornerstone Health Services, LLC.

The amounts included in Capital Caring includes: Capital Caring Health and Capital Hospice.

The amounts included in other that are not in the Obligated Group are comprised of Allcare Medical of Florida, Care Partners, LLC, Achieve Home Care, LLC, Capital Caring Health, Capital Palliative Care Consultants, Capital Caring Stay at Home Services, Inc., and Capital Caring Advanced Illness Services, Inc.

FLORIDA DEPARTMENT OF STATE
Division of Corporations

January 11, 2022

CORPORATION SERVICE COMPANY

Re: Document Number 763935

The Articles of Amendment to the Articles of Incorporation of CHAPTERS HEALTH SYSTEM, INC., a Florida corporation, were filed on January 10, 2022.

Should you have any questions regarding this matter, please telephone (850) 245-6050, the Amendment Filing Section.

Irene Albritton
Regulatory Specialist III
Division of Corporations

Letter Number: 622A00000783

Account number: I20000000195

Amount charged: 35.00

SECOND ARTICLES OF AMENDMENT

to

THIRD RESTATED ARTICLES OF INCORPORATION

of

CHAPTERS HEALTH SYSTEM, INC.

Pursuant to the provisions of Sections 617.1001, 617.1002 and 617.1006 of the Florida Statutes, Chapters Health System, Inc., a Florida not for profit corporation, hereby adopts the following amendments to its Third Restated Articles of Incorporation (the "**Articles of Incorporation**" or "**Articles**"), to be effective upon filing:

1. **Name of Corporation**. The name of the corporation is Chapters Health System, Inc. (the "**Corporation**").

2. **Text of Amendments.**

FIRST: Article I of the Articles of Incorporation is hereby deleted in its entirety and replaced with the following:

ARTICLE I

Name and Address

The name of the Corporation is Chapters IIealth System, Inc. (the "**Corporation**"). The principal office address of the Corporation is 12470 Telecom Drive, Suite 301, Temple Terrace, Florida 33637.

SECOND: Article III of the Articles of Incorporation is hereby deleted in its entirety and replaced with the following:

ARTICLE III

Purposes

The Corporation is a not for profit corporation that is (i) organized exclusively for charitable, religious, educational, and scientific purposes, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Internal Revenue Code, as amended, or the corresponding section of any future federal tax code

(the "**Code**"), (ii) established, organized and operated in accordance with Section 501(c)(3) of the Code; (iii) incorporated under the Florida Not For Profit Corporation Act; and, (iv) organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the tax-exempt purposes and missions of LifePath Hospice, Inc., Good Shepherd Hospice, Inc., Hernando-Pasco Hospice, Inc., Hospice of Okeechobee, Incorporated and Chapters Health Home Connect, Inc., each an organization described in Section 501(c)(3) and classified as a public charity under Section 509(a)(2) of the Code (collectively, the "**Supported Organizations**"), for so long as the Supported Organizations qualify as organizations described in Section 501(c)(3) of the Code and classified as pubic charities under Section 509(a)(2) of the Code. In connection with its relationship with the Supported Organizations, no less than a majority of the directors of the Corporation must also be persons who are directors of the Supported Organizations. The Corporation is also authorized to perform any lawful act or activity for which corporations not-for-profit may be formed under the Florida Not For Profit Corporation Act, including, without limitation:

1. To own, lease, establish, support, manage or furnish, directly or indirectly, any asset, facility, single-member limited liability company (the single-member of which shall be the Corporation) or service for the support and care of persons with or affected by advanced illness.

2. To promote the philosophy that the quality of life is important and that life should be lived to its fullest extent by those persons with or affected by advanced illness.

3. To promote understanding of the needs of persons with or affected by advanced illness.

4. To obtain public involvement and support by disseminating the aims, purposes and activities of the Supported Organizations, this Corporation and its single member limited liability companies to the general public.

5. To solicit, raise and receive funds and endowments for the purpose of carrying out the purposes of the Corporation.

6. To operate without regard to race, creed, age, sex, religion or national origin.

7. To do all other tasks, including the conducting of all activities, necessary, suitable, convenient, useful or expedient in connection with, or incidental to, the accomplishment of any of the purposes set forth herein to the full extent permitted by the laws of the sovereign State of Florida.

Restrictions. Notwithstanding any other provisions of these Articles to the contrary, the Corporation shall not have or exercise any power which would cause it not to qualify as a tax-exempt organization under Sections 501(c)(3) or 509(a)(3) of the Code; nor shall the Corporation engage directly or indirectly in any activity which would cause the loss of such qualification.

Notwithstanding any other provision of these Articles to the contrary, the Corporation shall not pay dividends and no part of the net earnings, current or accumulated, or property of the Corporation, shall inure to the benefit of, or be distributed to, the Corporation's members, directors, officers or other private persons, except that the Corporation may pay compensation in a reasonable amount to its members, directors, or officers for services rendered, may confer benefits upon its members in conformity with the Corporation's purposes so long as such members are qualifying exempt organizations under Section 501(c)(3) of the Code at the time of conferring such benefits, and upon dissolution, final liquidation or partial liquidation, may make distributions to its qualifying members to the extent permitted by these Articles of Incorporation and applicable law.

Notwithstanding any other provision of these Articles to the contrary, no substantial part of the activities of the Corporation shall be carrying on of propaganda, or otherwise attempting to influence legislation.

Notwithstanding any other provision of these Articles to the contrary, the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office.

Notwithstanding any other provision of these Articles to the contrary, the Corporation shall not be controlled directly or indirectly by one or more disqualified persons (as defined in Section 4946 of the Code) other than foundation managers and other than one or more organizations described in Sections 509(a)(1) or 509(a)(2) of the Code.

THIRD: Article IV of the Articles of Incorporation is hereby deleted in its entirety and replaced with the following:

ARTICLE IV

Registered Agent and Office Address

The Registered Agent for this Corporation is Andrew K. Molosky. The Registered Office address for this Corporation is 12470 Telecom Drive, Suite 301 Temple Terrace, Florida 33637.

FOURTH: Article V of the Articles of Incorporation is hereby deleted in its entirety and replaced with the following:

ARTICLE V

Management

The affairs of the Corporation shall be managed by its Board of Directors. The number of directors, election and terms of office shall be determined by the By-Laws of the corporation. An elected Director may be removed from the Board of Directors for cause at any time by a majority vote of all Directors then entitled to vote. An elected Director may be removed from the Board without cause at any time by a vote of two-thirds of the Directors then entitled to vote.

3. **Date and Manner of Adoption**. There are no members or members entitled to vote on these Articles of Amendment. These Articles of Amendment were approved by the Corporation's Board of Directors at a regularly scheduled meeting held on December 7, 2021 at which a quorum of directors was present, to be effective upon filing. The number of votes cast in favor of approval of these Articles of Amendment was sufficient for approval.

IN WITNESS WHEREOF, the President of the Corporation has executed these Second Articles of Amendment to Third Restated Articles of Incorporation on this 7th day of December, 2021, to be effective upon filing.

CHAPTERS HEALTH SYSTEM, INC.

By [redacted]
Andrew K. Molosky, President/CEO

State of Florida

Department of State

I certify the attached is a true and correct copy of the Restated Articles of Incorporation, filed on December 17, 2012, for CHAPTERS HEALTH SYSTEM, INC., a Florida corporation, as shown by the records of this office.

The document number of this corporation is 763935.

Given under my hand and the
Great Seal of the State of Florida
at Tallahassee, the Capital, this the
Seventeenth day of December, 2012

[redacted]

Ken Detzner
Secretary of State

CR2EO22 (1-11)

THIRD RESTATED

ARTICLES OF INCORPORATION

of

CHAPTERS HEALTH SYSTEM, INC.

(A Corporation Not for Profit)

These Third Restated Articles of Incorporation restate the original provisions of the Second Restated Articles of Incorporation of Chapters Health System, Inc., f/k/a HPC Healthcare, Inc., f/k/a LifePath Hospice and Palliative Care, Inc., f/k/a LifePath, Inc., f/k/a Hospice of Hillsborough, Incorporated, filed on May 1, 2008, as amended on January 24, 2011, May 25, 2011 and June 1, 2011, and as amended by the Articles of Restatement dated November 27, 2012, to be effective as of December 17, 2012.

ARTICLE I

Name and Address

The name of the Corporation is Chapters Health System, Inc. (the **Corporation**"). The principal office address of the Corporation is 12470 Telecom Drive, Suite 300 West, Temple Terrace, Florida 33637.

ARTICLE II

Term of Existence

This not for profit corporation shall have perpetual existence.

ARTICLE III

Purposes

The Corporation is a not for profit corporation that is (i) organized exclusively for charitable, religious, educational, and scientific purposes, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Internal Revenue Code, as amended, or the

corresponding section of any future federal tax code (the "**Code**"), (ii) established, organized and operated in accordance with Section 501(c)(3) of the Code; (iii) incorporated under the Florida Not For Profit Corporation Act; and, (iv) organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the tax-exempt purposes and missions of LifePath Hospice, Inc., Good Shepherd Hospice, Inc., and Chapters Health Senior Independence, Inc., each an organization described in Section 301(c)(3) and classified as a public charity under Section 509(a)(2) of the Code (collectively, the "**Supported Organizations**"), for so long as the Supported Organizations qualify as organizations described in Section 501(c)(3) of the Code and classified as pubic charities under Section 509(a)(2) of the Code. In connection with its relationship with the Supported Organizations, no less than a majority of the directors of the Corporation must also be persons who are directors of the Supported Organizations. The Corporation is also authorized to perform any lawful act or activity for which corporations not-for-profit may be formed under the Florida Not For Profit Corporation Act, including, without limitation:

1. To own, lease, establish, support, manage or furnish, directly or indirectly, any asset, facility, single-member limited liability company (the single-member of which shall be the Corporation) or service for the support and care of persons with or affected by advanced illness.

2. To promote the philosophy that the quality of life is important and that life should be lived to its fullest extent by those persons with or affected by advanced illness.

3. To promote understanding of the needs of persons with or affected by advanced illness.

4. To obtain public involvement and support by disseminating the aims, purposes and activities of the Supported Organizations, this Corporation and its single member limited liability companies to the general public.

5. To solicit, raise and receive funds and endowments for the purpose of carrying out the purposes of the Corporation.

6. To operate without regard to race, creed, age, sex, religion or national origin.

7. To do all other tasks, including the conducting of all activities, necessary, suitable, convenient, useful or expedient in connection with, or incidental to, the accomplishment of any of the purposes set forth herein to the full extent permitted by the laws of the sovereign State of Florida.

Restrictions. Notwithstanding any other provisions of these Articles to the contrary, the Corporation shall not have or exercise any power which would cause it not to qualify as a tax-exempt organization under Sections 501(c)(3) or 509(a)(3) of the Code; nor shall the Corporation engage directly or indirectly in any activity which would cause the loss of such qualification.

Notwithstanding any other provision of these Articles to the contrary, the Corporation shall not pay dividends and no part of the net earnings, current or accumulated, or property of the Corporation, shall inure to the benefit of, or be distributed to, the Corporation's members, directors, officers or other private persons, except that the Corporation may pay compensation in a reasonable amount to its members, directors, or officers for services rendered, may confer benefits upon its members in conformity with the Corporation's purposes so long as such members are qualifying exempt organizations under Section 501(c)(3) of the Code at the time of conferring such benefits, and upon dissolution, final liquidation or partial liquidation, may make distributions to its qualifying members to the extent permitted by these Articles of Incorporation and applicable law.

Notwithstanding any other provision of these Articles to the contrary, no substantial part of the activities of the Corporation shall be carrying on of propaganda, or otherwise attempting to influence legislation.

Notwithstanding any other provision of these Articles to the contrary, the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office.

Notwithstanding any other provision of these Articles to the contrary, the Corporation shall not be controlled directly or indirectly by one or more disqualified persons (as defined in Section 4946 of the Code) other than foundation managers and other than one or more organizations described in Sections 509(a)(1) or 509(a)(2) of the Code.

ARTICLE IV

Registered Agent and Office Address

The Registered Agent for this corporation is Kathy L. Fernandez. The Registered Office address for this corporation is 12470 Telecom Drive, Suite 300 West, Temple Terrace, Florida 33637.

ARTICLE V

Management

The affairs of the Corporation shall be managed by its Board of Directors. Number of members, election and terms of office shall be determined by the By-Laws of the corporation. Any member of the Board of Directors may be removed by at least a two-thirds majority vote of the Board of Directors present at a regularly called meeting containing a quorum of 50% plus one person.

ARTICLE VI

By-Laws

The By-Laws of this Not for Profit Corporation shall be adopted by the Board of Directors and said By-Laws may be thereafter altered, amended, added to or rescinded by at least a majority vote of the directors then in office.

ARTICLE VII

Amendments

The Corporation reserves the right to amend these Third Restated Articles of Incorporation at any regular or special meeting of the Board of Directors by at least a majority vote of the directors then in office.

ARTICLE VIII

Distributions on Liquidation or Dissolution

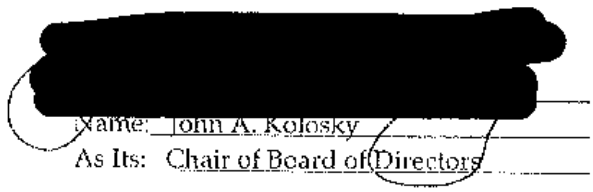
Upon dissolution of the Corporation, or liquidation of its assets, whether voluntary or involuntarily or by operation of law, except as, and to the extent otherwise provided or required by law, the net assets remaining after payment of all debts and obligations of the Corporation and of all costs and expenses of such liquidation or dissolution, shall be distributed to an organization which shall have qualified for a Federal Income Tax Exemption under the terms of section 501(c)(3) of the Code, as amended, or to the State of Florida, Educational Trust Fund, subject always to the provisions of these Articles, a specific condition of which is that none of the net assets of this Corporation shall be distributed to or used for the benefit of any officer or director of the Corporation or any other private individual; provided, however, that nothing contained in these Articles shall be construed to prevent a distribution from the net assets of the Corporation to a distributee otherwise properly made in accordance with the provisions of these Articles and applicable law.

ARTICLE IX

Indemnification

The Corporation shall indemnify any officer, director or employee, or any former officer, director or former employee, to the fullest extent permitted by law.

WHEREFORE, the undersigned Chair of the Board of Directors of Chapters Health System, Inc., has executed these Third Restated Articles of Incorporation this 27th day of November, 2012, to be effective as of December 17, 2012.



Name: John A. Kolosky
As Its: Chair of Board of Directors

FIRST ARTICLES OF AMENDMENT

to

THIRD RESTATED ARTICLES OF INCORPORATION

of

CHAPTERS HEALTH SYSTEM, INC.

(Document No. 763935)

Pursuant to the provisions of Sections 617.1001, 617.1002 and 617.1006 of the Florida Statutes, Chapters Health System, Inc., a Florida not for profit corporation, hereby adopts the following amendments to its Third Restated Articles of Incorporation (the "**Articles of Incorporation**" or "**Articles**"), to be effective as of February 1, 2015:

1. **Name of Corporation**. The name of the corporation is Chapters Health System, Inc. (the "**Corporation**").

2. **Text of Amendments**.

FIRST: Article III of the Articles of Incorporation is hereby deleted in its entirety and replaced with the following:

ARTICLE III

Purposes

The Corporation is a not for profit corporation that is (i) organized exclusively for charitable, religious, educational, and scientific purposes, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Internal Revenue Code, as amended, or the corresponding section of any future federal tax code (the "**Code**"), (ii) established, organized and operated in accordance with Section 501(c)(3) of the Code; (iii) incorporated under the Florida Not For Profit Corporation Act; and, (iv) organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the tax-exempt purposes and missions of LifePath Hospice, Inc., Good Shepherd Hospice, Inc., Hernando-Pasco Hospice, Inc., and Chapters Health Home Connect, Inc., each an organization described in Section 501(c)(3) and classified as a public charity under Section 509(a)(2) of the Code (collectively, the "**Supported Organizations**"), for so long as the Supported Organizations qualify as organizations described in Section 501(c)(3) of the Code and classified as pubic charities under Section 509(a)(2) of the Code. In connection with its relationship with the Supported Organizations, no less than a majority of the

directors of the Corporation must also be persons who are directors of the Supported Organizations. The Corporation is also authorized to perform any lawful act or activity for which corporations not-for-profit may be formed under the Florida Not For Profit Corporation Act, including, without limitation:

1. To own, lease, establish, support, manage or furnish, directly or indirectly, any asset, facility, single-member limited liability company (the single-member of which shall be the Corporation) or service for the support and care of persons with or affected by advanced illness.

2. To promote the philosophy that the quality of life is important and that life should be lived to its fullest extent by those persons with or affected by advanced illness.

3. To promote understanding of the needs of persons with or affected by advanced illness.

4. To obtain public involvement and support by disseminating the aims, purposes and activities of the Supported Organizations, this Corporation and its single member limited liability companies to the general public.

5. To solicit, raise and receive funds and endowments for the purpose of carrying out the purposes of the Corporation.

6. To operate without regard to race, creed, age, sex, religion or national origin.

7. To do all other tasks, including the conducting of all activities, necessary, suitable, convenient, useful or expedient in connection with, or incidental to, the accomplishment of any of the purposes set forth herein to the full extent permitted by the laws of the sovereign State of Florida.

Restrictions. Notwithstanding any other provisions of these Articles to the contrary, the Corporation shall not have or exercise any power which would cause it not to qualify as a tax-exempt organization under Sections 501(c)(3) or 509(a)(3) of the Code; nor shall the Corporation engage directly or indirectly in any activity which would cause the loss of such qualification.

Notwithstanding any other provision of these Articles to the contrary, the Corporation shall not pay dividends and no part of the net earnings, current or accumulated, or property of the Corporation, shall inure to the

benefit of, or be distributed to, the Corporation's members, directors, officers or other private persons, except that the Corporation may pay compensation in a reasonable amount to its members, directors, or officers for services rendered, may confer benefits upon its members in conformity with the Corporation's purposes so long as such members are qualifying exempt organizations under Section 501(c)(3) of the Code at the time of conferring such benefits, and upon dissolution, final liquidation or partial liquidation, may make distributions to its qualifying members to the extent permitted by these Articles of Incorporation and applicable law.

Notwithstanding any other provision of these Articles to the contrary, no substantial part of the activities of the Corporation shall be carrying on of propaganda, or otherwise attempting to influence legislation.

Notwithstanding any other provision of these Articles to the contrary, the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office.

Notwithstanding any other provision of these Articles to the contrary, the Corporation shall not be controlled directly or indirectly by one or more disqualified persons (as defined in Section 4946 of the Code) other than foundation managers and other than one or more organizations described in Sections 509(a)(1) or 509(a)(2) of the Code.

SECOND: Article V of the Articles of Incorporation is hereby deleted in its entirety and replaced with the following:

ARTICLE V

Management

The affairs of the Corporation shall be managed by its Board of Directors. The number of directors, election and terms of office shall be determined by the By-Laws of the corporation. Any member of the Board of Directors may be removed by at least a two-thirds majority vote of the Board of Directors present at a regularly called meeting containing a quorum of 50% plus one person.

3. **Date and Manner of Adoption**. There are no members or members entitled to vote on these Articles of Amendment. These Articles of Amendment were approved by the Corporation's Board of Directors at a regularly scheduled meeting held on

December 2, 2014, at which a quorum of directors was present, to be effective upon filing. The number of votes cast in favor of approval of these Articles of Amendment was sufficient for approval.

IN WITNESS WHEREOF, the President of the Corporation has executed these First Articles of Amendment to Third Restated Articles of Incorporation on this 2nd day of December, 2014, to be effective as of February 1, 2015.

CHAPTERS HEALTH SYSTEM, INC.

[redacted]

Kathy L. Fernandez, President

Twelfth Amended Bylaws

of

Chapters Health System, Inc.

ARTICLE I: Name

The name of the corporation shall be Chapters Health System, Inc. (the "Corporation"), a not-for-profit, non-political, non-sectarian Florida corporation.

ARTICLE II: Purpose

The purposes of this Corporation are those stated in Article III of its Articles of Incorporation.

ARTICLE III: Place of Business

The principal office of the Corporation shall be located at 12470 Telecom Drive, Suite 300 West, Temple Terrace, Florida, or at such other location in Hillsborough County, Florida, approved by the Board of Directors.

ARTICLE IV: Fiscal Year

The fiscal year of the Corporation shall be from January 1 to December 31, both inclusive, of each year.

ARTICLE V: Board of Directors

SECTION 1. Membership

The Board of Directors of the Corporation (the "Board" or the "Board of Directors") shall consist of the President and Chief Executive Officer ("President/CEO") of the Corporation and not less than fourteen (14) or more than twenty (20) other duly elected members (each individually, a "Director," collectively, the "Directors").

SECTION 2. Qualifications

Each Director shall be eighteen (18) years of age or older, of good moral character and reputation and shall possess by reason of education, experience and background the technical skills and judgment to be a director of the Corporation.

SECTION 3. Election

A. Any Director or other person may submit a name to the Nominating Committee for consideration as an elected director. Election of persons to replace elected Directors whose terms have expired shall occur at the annual meeting. Election of persons to fill vacated or newly created seats on the Board may occur at any meeting of the Board. The Nominating Committee shall submit its slate of nominees for election as directors at the applicable meeting of the Board. Directors may also make nominations from the floor. Those persons who are approved by a majority vote of the Directors present at such meeting at which a quorum is present shall be deemed elected.

B. Effective April 1, 2022, through March 31, 2027, the Board shall include eight (8) individuals elected by the Board in its discretion from among individuals presented to the Nominating Committee for consideration by Cornerstone Hospice & Palliative Care, Inc., a Florida not-for-profit corporation ("Cornerstone"). During the five (5) year period following April 1, 2022, the Cornerstone board of directors (the "Cornerstone Board") will present to the Nominating Committee individuals to succeed such Directors (or for renewal of their existing terms), and the Board will only elect successors (or renewals) of such eight (8) Directors from individuals designated by the Cornerstone Board. In the event the Board fails to elect an individual designated by the Cornerstone Board, then any vacancy in such eight (8) Board seats shall be filled by a representative designated by the Cornerstone Board and such representative(s) shall have full rights and authority as any other member of the Board. From April 1, 2022 through March 31, 2027, in the event of an increase in the maximum number of Board seats as set forth in Article V, Section 1 of these Bylaws, the Cornerstone Board shall have the sole authority to designate individuals to additional seats (in addition to the eight (8) Board seats referenced above) if necessary to assure that the ratio of individuals designated by the Cornerstone Board to serve on the Chapters Board shall not be less than one-third (1/3) of the total members of the Chapters Board. For purposes of designating individuals to serve on the Chapters Board as referenced in this Article V, Section 3.B., all references to "Cornerstone Board" shall be interpreted as excluding all officers and employees of the Corporation serving thereon.

SECTION 4. Term of Office

A. Directors elected by the Board of Directors at the annual meeting shall hold office until a successor has been elected or until death, resignation, removal or declaration of vacancy. Each term of an elected Director who is not an employee of the Corporation shall consist of three (3) years or any portion thereof.

B. An elected Director who is not an employee of the Corporation may serve no longer than three (3) consecutive terms, or, if his or her initial term was less than one (1) year as required by Article V, Section 4.C below, no longer than four (4) consecutive terms, and may be re-elected to the Board after a one (1) year hiatus following the completion of his or her service as a Director. If an elected Director reaches the maximum term limit described above while he or she is serving as the Immediate Past Board Chairperson on the Executive Committee, his or her term shall be extended until he or she is replaced by a new Immediate Past Board

Chairperson on the Executive Committee.

C. The initial term of a Director elected at a regular meeting to fill a vacancy created by reason of the departure of a Director or an increase in the number of directors shall expire at the next annual meeting at which Directors are elected.

SECTION 5. Attendance

If an elected Director is absent unreasonably from two (2) consecutive Board meetings, a letter may be sent asking that his or her intent be clarified. If an elected Director is absent unreasonably from three (3) consecutive Board meetings, the Director may be removed for cause from the Board of Directors and his or her seat on the Board declared vacant by a majority vote of all Directors then entitled to vote. The Director who is removed and whose seat is declared vacant will be notified of such declaration.

SECTION 6. Resignation

An elected Director may resign at any time by giving written notice of such resignation to the Chairperson of the Board of Directors. Such resignation will be effective on the date specified in the resigning Director's notice of resignation, but if no effective date is set forth in such notice, then the effective date of such resignation shall be the date of such notice of resignation. If a resignation is made effective at a later date, then the vacancy created by such resignation may be filled before the vacancy occurs, provided, however, the new Director may not take office until the vacancy occurs.

SECTION 7. Removal

An elected Director may be removed from the Board of Directors for cause at any time by a majority vote of all Directors then entitled to vote. An elected Director may be removed from the Board without cause at any time by a vote of two-thirds (2/3) of the Directors then entitled to vote. Any Director who is removed from the Board is not eligible to stand for election again until the next annual meeting at which directors are elected. Any Director removed from the Board of Directors shall turn over to the Board within 72 hours any and all records of the Corporation in his or her possession.

SECTION 8. Vacancies

Any seat on the Board that becomes vacant through resignation, removal or death of an elected Director, or through an increase in the number of directors, shall be filled without undue delay. At the next regular meeting of the Board after a vacancy occurs where a quorum is present, following a nomination by the Nominating Committee, a new Director shall be elected to fill the vacant seat by a majority vote of the Directors present, with vacancies in the eight (8) Board seats filled by individuals designated by the Cornerstone Board to be filled in the manner described in Article V, Section 3.B. of these Bylaws.

SECTION 9. Quorum

A. A quorum of the Directors shall be 8 if the total number of Directors on the Board is then 15, 16 or 17.

B. A quorum of the Directors shall be 9 if the total number of Directors on the Board

is then 18 or 19.

C. A quorum of the Directors shall be 10 if the total number of Directors on the Board is then 20 or 21.

D. A quorum of the Directors shall be a simple majority if the total number of Directors on the Board is then less than 15 due to any vacancy or vacancies not yet filled as prescribed in these Bylaws. However, under no circumstances shall a quorum of Directors be fewer than five (5).

E. If no quorum is present at a meeting of the Board and if written notification of the meeting and agenda has been given to all Directors, the Executive Committee may act on all matters on the agenda, except as limited by Article VII, Section 1, of these Bylaws.

SECTION 10. Meetings

A. Regular meetings of the Board of Directors shall be held not less than quarterly in each calendar year, or as often as deemed necessary by at least one-third of the Directors present at a meeting at which a quorum is present, at a date, time, and place that they determine. Meeting notices shall be given to all Directors at least ten (10) days in advance, either orally (by telephone or in person) or by written notice delivered via hand delivery, overnight commercial courier, United States mail or facsimile, or by correct delivery of the notice to an electronic mail ("e-mail") address at which the Director has consented to receive notice.

B. Special meetings of the Board of Directors may be called by the Chairperson of the Board or by any three Directors. All requests for special meetings must be given to the Secretary or Assistant Secretary in writing signed by the requesting Director(s). The Secretary or Assistant Secretary shall notify all Directors of the date, time and place of such special meetings, specifying the purpose, at least two (2) days in advance, either orally (by telephone or in person) or by written notice delivered via hand delivery, overnight commercial courier, United States mail or facsimile, or by correct delivery of the notice to an e-mail address at which the Director has consented to receive notice.

C. The annual meeting of the Corporation shall be convened by the Board of Directors on or before May 31st of each year.

D. Directors may participate in a meeting of the Board of Directors or a committee thereof by means of a conference telephone or similar electronic communication device whereby all persons can hear each other at the same time. Such participation shall constitute presence in person at the meeting.

E. Any action required to be taken or that may be taken at a meeting of the Board of Directors or a committee thereof, may be taken without a meeting if a consent in writing, setting forth the action so taken or to be taken, signed by all of the Directors or all of the members of the committee, as the case may be, is filed in the minutes of the proceedings of the Board of Directors or of the committee, as the case may be. Such consent shall have the same effect as a unanimous vote.

SECTION 11. Waiver of Notice of Meeting

Notice of a meeting of the Board of Directors need not be given to any Director who signs a waiver of notice either before or after the meeting.

SECTION 12. Powers and Duties

The powers and duties of the Board of Directors shall be as follows:

A. To assume ultimate responsibility and full legal authority for the Corporation;

B. To ensure that proper policies are in place for governance of the Corporation's total operation;

C. To develop and implement an effective organizational planning process addressing the needs of external and internal customers of the Corporation;

D. To define the Corporation's long range strategic and operational plans, budget and resource allocation;

E. To ensure the organizational mission, core purpose and core values of the Corporation are sustained over time;

F. To ensure that ethical and legal standards are practiced and monitored by exercising reasonable oversight with respect to the adoption and implementation of an effective corporate compliance plan and reporting system;

G. To hold meetings of the Board and its committees as specified;

H. To elect and remove Directors of the Corporation;

I. To appoint and remove the principle executive officer of the Corporation;

J. To ensure that proper financial controls are in place for disbursement of the funds of the Corporation;

K. To ensure that an annual financial statement audit is conducted in accordance with generally accepted auditing standards by an independent certified public accountant selected by the Audit and Compliance Committee;

L. To appoint and elect officers of the Corporation as set forth in these Bylaws;

M. To take all actions that the Corporation or Board or Directors are required or authorized to take in accordance with the articles of incorporation, articles of organization, bylaws or operating agreements of all not-for-profit corporations or limited liability companies of which the Corporation is the sole member; and

N. To devise and carry into execution such other policies and programs as the Board deems necessary or proper to promote the objectives of the Corporation.

SECTION 13. Conflict of Interest

A. No contract or other business or personal transaction or relationship between the Corporation and one or more of its Directors or any other corporation, firm, association, entity in which one or more of its Directors are directors, officers, or employees or are financially interested, or a person with which one or more of its directors are related, shall be void or voidable because of such interest or kinship, because such Director or Directors are present at the meeting of the Board of Directors or a committee thereof which authorizes, approves, or ratifies such contract, transaction or relationship, or because his or her or their vote(s) are counted for such purpose, if:

1. The fact of such interest or kinship is disclosed by the interested or related Director(s) as soon as practicable and in no case later than five (5) days following knowledge of its existence, or the fact of such interest or kinship is otherwise known to the Board of Directors or committee which authorizes, approves or ratifies the contract, transaction or relationship by a vote or consent sufficient for the purpose without counting the vote(s) or consent(s) of such interested or related Director(s); or

2. The contract, transaction or relationship is fair and reasonable as to the Corporation at the time it is authorized by the Board, a committee, or the Directors entitled to vote on such contract, transaction or relationship.

B. Common or interested Directors may be counted in determining the presence of a quorum at a meeting of the Board of Directors or a committee thereof which authorizes, approves or ratifies such contract, transaction or relationship.

SECTION 14. Compliance

A. The Board of Directors shall abide by the authority and objectives set forth in all applicable federal and state laws and rules, governmental third party program requirements, accreditation standards, and these Bylaws as adopted and amended.

B. The Board of Directors shall act with the highest integrity to advance the best interests of the Corporation and to help the Corporation achieve its mission and operate in a manner consistent with its charitable purposes.

C. Any Director who contributes to or participates in activities that are not in compliance with or that contribute to the Corporation's non-compliance with any applicable federal or state law or rule, governmental third party program requirement, accreditation standard, or these Bylaws as adopted and amended, or who fails to act with the highest integrity to advance the best interests of the Corporation and to help the Corporation achieve its mission and operate in a manner consistent with its charitable purpose, shall be subject to removal from the Board for cause.

SECTION 15. Compensation

Directors who are not employees of the Corporation shall receive no compensation for their services as members of the Board of Directors or any committee thereof; provided, however, Directors may, pursuant to Article V, Section 13 of these Bylaws, receive compensation that is fair and reasonable for services rendered to the Corporation in a separate capacity. The Board

of Directors may authorize the reimbursement of expenses incurred by any Director for the benefit of the Corporation.

ARTICLE VI: Officers

SECTION 1. Categories

The officers of the Corporation shall be the Chairperson, Vice Chairperson, Secretary and Treasurer of the Board, the President/CEO, and one or more other senior executive officers who have the word "chief" in their titles ("C-Suite Officers"). There may also be one or more Assistant Secretaries.

SECTION 2. Election/Appointment and Term of Office

A. At the annual meeting of the Board of Directors, the Directors shall elect, by a majority of those present, one Director to serve as Chairperson, one Director to serve as Vice Chairperson, one Director to serve as Treasurer and one Director to serve as Secretary of the Board. Notwithstanding any other provision of these Bylaws to the contrary, the Chairperson, Vice Chairperson, Treasurer and Secretary of the Board must be elected at a meeting of the Board of Directors at which a quorum is present. The Chairperson, Vice Chairperson, Treasurer and Secretary of the Board shall serve for a term of two (2) years.

B. The President/CEO of the Corporation shall be appointed by the Board of Directors and serve until resignation, removal or death.

C. The C-Suite Officers shall be appointed by the President/CEO and shall serve until resignation, removal or death.

D. The Executive Assistant to the President/CEO shall serve in the capacity as an Assistant Secretary until his or her resignation, removal or death. In the temporary absence of the Executive Assistant to the President/CEO, an Executive Assistant or Administrative Assistant appointed by the President/CEO shall serve as an Assistant Secretary.

SECTION 3. Vacancies

Any officer position that becomes vacant through resignation, removal or death shall be filled without undue delay. Should the position of Chairperson, Vice Chairperson, Treasurer or Secretary become vacant, at the next regular meeting of the Board after the vacancy occurs where a quorum is present, the Directors shall elect a director to fill the vacant office by a majority vote of those present.

SECTION 4. Powers and Duties

The powers and duties of the respective officers of the Corporation shall be as follows:

A. **Chairperson of the Board**

1. The Chairperson of the Board shall preside over all Board meetings and perform all duties incident to the office of Chairperson and such duties as

from time to time may be assigned to him or her by the Board of Directors.

2. The Chairperson of the Board shall chair the Executive Committee of the Board of Directors

B. **Vice Chairperson of the Board**

In the temporary absence of the Chairperson of the Board, the Vice Chairperson of the Board shall act as the Chairperson and perform all duties assigned to that position.

C. **Secretary and Assistant Secretaries**

1. The Secretary shall keep the minutes of the meetings of the Board of Directors, insure that all notices are duly given in accordance with the provisions of these Bylaws, be custodian of the Corporation's records, and, in general, perform all duties incident to the office of Secretary and such duties as from time to time may be assigned to him or her by the Board of Directors or the Chairperson of the Board.

2. Each Assistant Secretary shall assist the Secretary in keeping the minutes of the meetings of the Board of Directors, insuring that all notices are duly given in accordance with the provisions of these Bylaws, and being custodian of the Corporation's records, and, in general, shall perform all duties incident to the office of Assistant Secretary and such duties as from time to time may be assigned to him or her by the Board of Directors, the Chairperson of the Board, the President/CEO or the Secretary.

D. **Treasurer**

1. The Treasurer shall be responsible for the financial affairs of the Corporation and shall generally perform all duties and possess such powers incident to the office of treasurer of a Florida corporation; including such other duties and powers as may from time to time be assigned or delegated to that office by the Board of Directors, or by the Chairperson. The day-to-day implementation of financial policy decisions of the Board of Directors shall be the responsibility of the President/CEO.

2. The Treasurer shall chair the Finance Committee of the Board of Directors. The Treasurer shall submit to the Finance Committee an unaudited fiscal report monthly.

3. The Treasurer shall provide all financial reports and statements to the Board of Directors and Executive Committee as they may require or request.

E. **President/CEO**

1. The President/CEO shall be the principal executive officer of the Corporation and shall, in general, supervise and control all of the business and affairs of the Corporation. He or she may sign on behalf of the

Corporation all contracts, deeds, mortgages, bonds and other financial or transactional instruments, as well as any other instruments which the Board has authorized to be executed, except where execution thereof is expressly delegated by the Board of Directors or by these Bylaws, or by statute, to some other officer or agency of the Corporation.

2. The President/CEO shall perform all duties incident to his or her office, and other duties as may be prescribed by the Board of Directors from time to time. The President/CEO or his or her designee shall represent the Corporation in matters of policy and negotiation with other agencies, and shall be responsible for administering the work of the Corporation in conformity with these Bylaws, the Corporation's Policies and Procedures, and other policies established by the Board of Directors.

F. **C-Suite Officers**

The C-Suite Officers shall have such powers and duties that may be assigned to them from time to time by the President/CEO or the Board of Directors.

SECTION 5. Chain of Command – Absence of President/CEO

In the temporary absence of the President/CEO, the Corporation's Chain of Command Policy and Procedure will dictate the individual responsible to perform the duties of the President/CEO. Except for the powers inuring to the President/CEO as a member of the Board of Directors, this individual shall have all the powers of and be subject to all the restrictions upon the President/CEO.

ARTICLE VII: Committees

SECTION 1. Executive Committee

A. The Executive Committee shall carry out the work of the Board of Directors between meetings and at meetings in accordance with Article V, Section 9.E, of these Bylaws and make recommendations to the Board of Directors for its action. The Executive Committee shall have all the authority of the Board of Directors except that the Executive Committee is not authorized to: (1) recommend actions or proposals required to be approved by Board members; (2) fill vacancies on the Board or any committee thereof; or (3) adopt, amend, supplement, restate, repeal, or rescind these Bylaws.

B. The members of the Executive Committee shall be as follows:

1. Chairperson, Vice Chairperson, Treasurer and Secretary of the Board;

2. Immediate past Chairperson of the Board;

3. President/CEO of the Corporation;

4. Effective April 1, 2022, and continuing until March 31, 2027, four (4) of the eight (8) individuals elected to the Board in its discretion from

among individuals presented to the Nominating Committee for consideration by the Cornerstone Board; and

5. No less than two (2) additional elected Directors and/or elected directors of affiliate boards as appointed by the Board Chairperson.

C. The Chairperson of the Board shall chair the Executive Committee.

D. The appointed Directors shall serve on the Executive Committee for a term of two (2) years. A Director appointed to the Executive Committee may be re-appointed by the Board Chairperson without any hiatus following the applicable two (2) year term.

E. The Executive Committee shall meet monthly, or as necessary or appropriate.

SECTION 2. Other Standing Committees

A. Other standing committees and their purposes shall be as follows:

1. **Finance Committee**

The Finance Committee oversees, reviews and approves budgets and Corporation funding, recommends fiscal policies affecting operations, and monitors all fiscal operations. Its members shall be the Treasurer of the Board, President/CEO of the Corporation, all members of the Executive Committee and any other members appointed at the discretion of the Chairperson of the Finance Committee. Appointed Committee members shall serve a term of two (2) years. The Committee shall be chaired by the Treasurer and shall meet as necessary and appropriate, but at least six (6) times per year.

2. **Investment Committee**

The Investment Committee assists the Board and the Corporation in ensuring that the Corporation's financial resources are preserved and increased through prudent investment strategies. Its members shall be appointed by the Chairperson of the Investment Committee and shall include the President/CEO of the Corporation. The Committee may include, from time to time, qualified individuals who are not Directors. Appointed Committee members shall serve a term of two (2) years. The Chairperson of the Investment Committee shall be appointed by the Chairperson of the Board. The Investment Committee shall meet as necessary and appropriate.

3. **Development Committee**

The Development Committee oversees and assists the Board and the Corporation in development and fund raising. Its members shall be appointed by the Chairperson of the Development Committee and may include, from time to time, qualified individuals who are not Directors. Appointed Committee members shall serve a term of two (2) years. The Chairperson of the Development Committee shall be appointed by the

Chairperson of the Board. The Development Committee shall meet as necessary and appropriate.

4. **Bioethics Committee**

The Bioethics Committee reviews ethical issues and provides recommendations and guidance to the standards and policies governing the delivery of health care services by the Corporation and its affiliates. The Bioethics Committee shall be composed of multi-disciplinary community leaders experienced and qualified to participate in discussions related to current ethical topics, some of whom may be Directors of the Corporation. The Bioethics Committee serves as an educational resource for Staff Ethics Committee(s) of the Corporation and/or its affiliates and reviews cases involving ethical dilemmas presented to Staff Ethics Committee(s) for additional insight and recommendations. The Bioethics Committee also serves as an advisory and review committee for research activities of the Corporation and, in that capacity, provides review of appropriate organizational studies, evaluates potential risk, privacy and other research-related related issues.

The Bioethics Committee members shall be appointed by the Chairperson of the Bioethics Committee and may include, from time to time, qualified individuals who are not Directors. Appointed Committee members shall serve a term of two (2) years. The Chairperson of the Bioethics Committee shall be appointed by the Chairperson of the Board. The Bioethics Committee shall meet as necessary and appropriate.

5. **Nominating Committee**

The Nominating Committee develops, in accordance with these Bylaws, the slate of candidates to serve as elected Directors, and recommends nominees to fill vacancies. The Nominating Committee also develops and submits to the Board a slate of candidates to serve in the offices of Chairperson, Vice Chairperson, Secretary and Treasurer of the Board, and recommends nominees to fill vacancies in those offices.

The members of the Nominating Committee shall be appointed by the Chairperson of the Nominating Committee from among the sitting Board of Directors and shall include the Immediate Past Chairperson of the Board, the President/CEO of the Corporation and a minimum of three (3) additional Directors. Appointed Committee members shall serve a term of two (2) years. The Nominating Committee shall be chaired by the Immediate Past Chairperson of the Board and shall meet as necessary and appropriate.

6. **Compensation Committee**

The Compensation Committee establishes a compensation philosophy for the Corporation and evaluates the performance and development of the Corporation's President/CEO on an annual basis in achieving corporate goals and objectives and to assure that the President/CEO of the Corporation is compensated effectively in a manner consistent with the strategy of the Corporation, competitive practice, and all tax, accounting,

legal and regulatory requirements. With the assistance of the President/CEO and external compensation specialist(s), as needed, the Compensation Committee also oversees and approves the administration of all compensation, equity and executive staff/disqualified persons benefit plans and programs and approves or disapproves all requests for additions and/or deletions of corporate officer positions. The Compensation Committee shall have the resources and authority necessary to discharge its duties and responsibilities, including but not limited to, the sole authority to select, retain and terminate such compensation consultants, outside legal counsel and other advisors as the Committee may deem necessary.

Voting members of the Compensation Committee shall be composed of all members of the Executive Committee and shall be independent and free of conflicts of interest. The Corporation's President/CEO and most senior Human Resources staff member shall be ex officio, non-voting members of the Committee. Voting members of the Committee members shall serve a term of two (2) years. The Compensation Committee shall be chaired by the Chairperson of the Board and shall meet at least annually, or as necessary and appropriate.

7. **Audit and Compliance Committee**

The Audit and Compliance Committee oversees the establishment and implementation of accounting policies and processes that ensure the integrity of the Corporation's financial statements and the effectiveness of the Corporation's internal control over financial reporting. The Audit and Compliance Committee oversees the selection and performance of the Corporation's internal audit function and independent public accountants. The Audit and Compliance Committee oversees the effectiveness of the Corporation's compliance and risk processes with respect to high risk areas and assists the Board of Directors in promoting an organizational culture that encourages a commitment to compliance with the law. In addition to ensuring that the Corporation implements and maintains a corporate information and reporting system designed to prevent and detect violations of the law, the Audit and Compliance Committee exercises reasonable oversight with respect to the effectiveness of such system and educates the Board about its content and operation. The Audit and Compliance Committee ensures that legally appropriate document retention policies and procedures are in place and that "non-retaliation" protections are in place for employees who disclose potential legal violations under the reporting system. The Corporation's Chief Compliance Officer shall have direct access and report to the Audit and Compliance Committee. The Chief Compliance Officer shall have direct, overall responsibility for the Corporation's compliance system and be given adequate resources and authority to carry out such responsibility. The Audit and Compliance Committee shall report to the Board of Directors regularly including an annual report regarding the Corporation's independent audit results and compliance activities.

The Audit and Compliance Committee members shall be appointed by the Chairperson of the Audit and Compliance Committee from among the sitting Board of Directors and shall include a minimum of three (3)

independent elected Directors. Non-voting members shall include the Corporation's President/CEO, Chief Operating Officer, Chief Medical Officer, Chief Financial Officer, Chief Compliance Officer, Chief Information Officer and most senior Human Resources staff member. Appointed Committee members shall serve a term of two (2) years. The Chairperson of the Audit and Compliance Committee shall be appointed by the Chairperson of the Board. The Audit and Compliance Committee shall meet quarterly, or as necessary and appropriate.

8. **Bylaws Committee**

The Bylaws Committee reviews the bylaws of the Corporation and its affiliate corporations annually, or more frequently if necessary and appropriate, and submits recommendations for amendments, if any, to the Board of Directors. Its members shall include the Chairperson and Immediate Past Chairperson of the Board, the vice chairperson of the board of directors of each of the Corporation's affiliate corporations, and the Corporation's President/CEO. The Bylaws Committee shall be chaired by the Immediate Past Chairperson of the Board and shall meet as necessary and appropriate. When a member of the Bylaws Committee is acting in his or her capacity as a vice chairperson of one of the Corporation's affiliate corporations at a Bylaws Committee meeting, he or she shall only be entitled to vote at such meeting concerning recommended amendments to the bylaws of the corporation for which he or she serves as vice chairperson.

B. Unless otherwise indicated, standing committees shall meet as necessary or appropriate.

SECTION 3. Ad Hoc Committees

Ad Hoc committees may be appointed at the discretion of the Chairperson of the Board and meet as necessary or appropriate.

SECTION 4. Committee Chairpersons

Unless otherwise stated in Article VII, Section 2 of these Bylaws, the Chairperson of the Board shall appoint committee chairpersons and may serve as a chairperson and/or voting member of one or more committees.

SECTION 5. Quorum

Unless otherwise designated by the Board of Directors, a majority of the whole committee shall constitute a quorum.

SECTION 6. Rules

Each committee may adopt rules for its own government not inconsistent with these Bylaws or with the rules adopted by the Board of Directors.

SECTION 7. Removal

The Chairperson of the Board may remove any committee member at will.

ARTICLE VIII: Fiscal Policies

SECTION 1. Contracts

The Board of Directors may authorize any officer or agent, in addition to the officers so authorized by these Bylaws or the Corporation's Contracting Policy and Procedure and/or Guidelines, to enter into any contract or execute and deliver any instrument in the name of or to the Corporation.

SECTION 2. Checks, Drafts, Etc.

All checks, drafts, or orders for the payment of money, notes or other evidence of indebtedness issued in the name of the Corporation shall be signed by such officer(s) or agent(s) as determined by resolution of the Board of Directors.

SECTION 3. Deposits

All corporate funds shall be deposited to the credit of the Corporation in such bonds, trusts, or other depositories as the Board of Directors may select.

ARTICLE IX: Books and Records

SECTION 1. Minute Book

The Corporation shall keep at its principle office, or such other place as the Board of Directors may order, a book of the minutes of all meetings of directors, with the times and places of holding, whether regular or special, how authorized, the notice given, the names of those present, and the proceedings thereof.

SECTION 2. Corporate Records

The Corporation shall keep and maintain at its principle office, or such other place as the Board of Directors may order, adequate and correct accounts of its properties and business transactions, including accounts of its assets, liabilities, receipts, disbursements, gains and losses.

SECTION 3. Confidentiality of Patient/Family Information

The records of any committee or board of the Corporation which contain information relating specifically to any patient served by the Corporation or any of its affiliates shall be considered confidential. Any disclosure of such information shall be in accordance with statutes and rules of the State of Florida and the United States, in effect at the time, pertaining to disclosure of confidential patient information.

ARTICLE X: Waiver of Notice

When notice is required under the provisions of the Florida Not for Profit Corporation Act, the Corporation's Articles of Incorporation or these Bylaws, a written waiver signed by the person or persons entitled to such notice, whether before or after the time stated herein, shall be deemed equivalent to the giving of such notice.

ARTICLE XI: Amendments

The Board of Directors may amend, supplement, restate, repeal, or rescind these Bylaws or any of them or any combination of them by a majority vote of those Directors present at any meeting of the Board at which a quorum is present, provided that written notice of the meeting and of the proposed change is mailed or otherwise delivered or communicated to all sitting Directors at least ten (10) days prior to the meeting date. Notwithstanding the prior sentence, from April 1, 2022 through March 31, 2027, before any amendment, restatement, repeal or rescission of any of the following Bylaws provisions becomes effective, to the extent it impacts on the rights of those Directors designated by Cornerstone then serving on the Board, at least one such Director designated by Cornerstone must be among the Directors approving such amendment, restatement, repeal or rescission: Article V, Section 3.B.; Article V, Section 8; and Article VII, Section 1. B.4.

ARTICLE XII: Indemnification

To the fullest extent permitted by applicable law, the Directors, Officers and committee members of the Corporation shall be indemnified and held harmless by the Corporation for any and all claims made against them personally while acting within the scope of their duties for the Corporation.

Approved by the Corporation's Board of Directors on December 2, 2021 to be effective as of April 1, 2022.

CHAPTERS HEALTH SYSTEM, INC.

By: [redacted]
Andrew K. Molosky
President & CEO

Title 11, California Code of Regulations, § 999.5(d)(10)

PUBLIC COMMUNICATIONS

11 Cal. Code Reg. Section 999.5(d)(10)

The written notice of any proposed agreement or transaction set forth in section 999.5(a)(1) shall include a description of the applicant's efforts to inform local governmental entities, professional staff and employees of the health facility or facility that provides similar health care and the general public of the proposed transaction. This description shall include any comments or reaction to this effort.

An internal announcement was issued to employees of Chapters on October 29, 2024. An internal announcement was issued to employees of Hospice East Bay on October 31, 2024. A public press release was issued by Chapters on October 30, 2024. Copies of the Chapters internal announcement and public press release are attached and the Hospice East Bay internal announcement is part of this application as the response to (d)(1)(c). A video related to the proposed affiliation titled Chapters Health West Affiliation Announcement was also published on YouTube and can be accessed at the following link. https://www.youtube.com/watch?v=cUqdBtT4TO4

In addition, once the affiliation transaction was announced "town hall" meetings were held with employees of Hospice East Bay.

CHAPTERS
HEALTH SYSTEM

TO: Chapters Health System All Staff

FROM: Andrew Molosky, President/CEO, Chapters Health System
Bill Musick, Interim CEO, Hospice East Bay
Cathy Conway, CEO, Hospice of Santa Cruz County
Karen Rubel, President/CEO, Nathan Adelson Hospice
Iria T. Nishimura, Willamette Vital Health

SUBJECT: Creation and Launch of Chapters Health West

DATE: October 29, 2024

We have exciting news to share with you. Chapters Health System, in partnership with Hospice East Bay, Hospice of Santa Cruz County, Nathan Adelson Hospice and Willamette Vital Health, have joined together to create and launch Chapters Health West. A press release announcing the launch of Chapters Health West is scheduled for distribution to the media on Wednesday, October 30, 2024.

Chapters Health and all the Chapters Health West affiliates share missions that historically demonstrate the preservation as well as enhancement of the not-for-profit hospice model of comprehensive, community-based care. In 2024, a new era in chronic disease management begins for Chapters Health, and the other Chapters Health West affiliates as together we are destined to change the healthcare landscape. Combining resources, we continue to support ongoing innovation and critical care expansion with increased opportunities for team members.

We recognize questions may arise regarding the creation of Chapters Health West but wanted to emphasize the commitment to not only preserving but promoting and advancing our combined legacy of exceptional care for the communities we collectively serve.

As always, thank you for your commitment and for all you do for patients, families and communities!

CHAPTERS
HEALTH® SYSTEM

FOR IMMEDIATE RELEASE

Chapters Health System Launches New Chapters Health West Division

Pioneering a New Era of Not-for-Profit Hospice Care in Western States

Temple Terrace, FL (October 30, 2024): Chapters Health System, in collaboration with four highly respected not-for-profit organizations — Hospice East Bay (Pleasant Hill, CA), Hospice of Santa Cruz County (Santa Cruz, CA), Nathan Adelson Hospice (Las Vegas, NV) and Willamette Vital Health (Salem, OR) — is proud to announce the creation and official launch of **Chapters Health West**. This landmark partnership signifies the beginning of a new era in not-for-profit hospice care across the Western United States, blending innovation with a commitment to compassionate, community-based care.

"We are building a future where we can do more, innovate more and serve more," said Andrew Molosky, MBA, CHPCA, president and chief executive officer for Chapters Health. "By aligning our strengths, we will continue to deliver exceptional care while expanding our capacity to meet the growing needs of those navigating serious illness and grief in our communities."

The launch of Chapters Health West comes at a critical time when the healthcare landscape is rapidly changing, with a growth prevalence of for-profit entities in hospice care. The new partnership underscores the mission of all involved affiliates to preserve and enhance the not-for-profit hospice model, prioritizing patient care over profit.

"Chapters Health West will leverage the combined strengths of its partner organizations to enhance services, foster innovation and ensure the legacy of compassionate care remains intact," continued Molosky. "While joining forces under the broader Chapters Health System, each hospice will maintain its local leadership, culture and deep-rooted community relationships. This ensures that care remains personal, meaningful and aligned with the values of each unique community."

The Chapters Health West partnership unites the pioneering spirit of the Western United States with the long-standing values of not-for-profit care. Patients, families and caregivers can expect expanded services, advanced resources and continued support at every stage of serious illness and grief.

"As we officially welcome Hospice East Bay, Hospice of Santa Cruz County, Nathan Adelson Hospice and Willamette Vital Health into the Chapters Health family, we are excited to work in lock step with our shared mission to constantly elevate home and community-based, end-of-life care while at the same time preserve their long-standing tradition in the community," added Molosky.

--more--

CHAPTERS
HEALTH® SYSTEM

About Chapters Health System
As a forward-thinking leader and distinguished healthcare organization, Chapters Health System is committed to pioneering care across the spectrum of chronic illness and beyond. Established in 1983 as a community-centered, not-for-profit entity, Chapters Health has continually expanded its reach and offerings to meet evolving healthcare needs. Dedication to innovation and excellence is evident through its diverse portfolio of companies, including 10 hospices, comprehensive behavioral health services, PACE Centers and an integrated pharmacy company. As part of its ongoing mission to enhance the patient and family experience, Chapters Health continues to evolve and innovate, ensuring that individuals facing advanced illness receive compassionate, comprehensive care tailored to their unique needs. To learn more, visit www.chaptershealth.org, like us on Facebook or follow us on X and LinkedIn.

About Hospice East Bay
Hospice East Bay is a nonprofit hospice agency dedicated to providing compassionate care, supportive services, and grief counseling to individuals and families facing life-limiting illnesses. Founded in 1977, our mission is to enhance the quality of life for patients and support the journey of their loved ones.

About Hospice of Santa Cruz County
Since 1978, Hospice of Santa Cruz County has committed to ensuring dignified living and dying for the people of Santa Cruz and Northern Monterey County. As the leading nonprofit provider of hospice care for individuals of all ages, the organization has consistently demonstrated exemplary end-of-life care. Its broad spectrum of services includes community grief support for adults, Camp Erin for bereaved children, palliative care services, KidWISE for concurrent care for children, pet companion, and music therapy programs, hospice care for veterans, and bilingual end-of-life education and outreach. Accredited by ACHC, Hospice of Santa Cruz County boasts the highest quality scores in the region.

About Nathan Adelson Hospice
Hospice Nathan Adelson Hospice, the trusted partner in hospice care and palliative medicine, is the largest and longest-established hospice in southern Nevada. Founded in 1978, Nathan Adelson Hospice provides comprehensive end-of-life care to more than 400 patients and families every day. Recognized as a national model for superior care, the vision of Nathan Adelson Hospice is that no one should end the journey of life alone, afraid or in pain. For more information, visit www.nah.org.

About Willamette Vital Health
Willamette Vital Health has been the area's non-profit, mission-driven provider of hospice and supportive care services in the mid-Willamette Valley for over 45 years. In addition to expert care and support for patients facing life-limiting illnesses and their families, Willamette Vital Health offers the Tokarski Home and a range of community Grief Care services.

###

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Title 11, California Code of Regulations, § 999.5(d)(11)

ADDITIONAL ATTACHMENTS

11 Cal. Code Reg. Section 999.5(d)(11)(A)

Any board minutes or other documents relating or referring to consideration by the board of directors of the applicant and any related entity, or any committee thereof of the agreement or transaction or of any other possible transaction involving any of the health facilities or facilities that provide similar health care that are the subject of agreement or transaction.

Please see (d)(11)(D) for all documents related to the consideration of this transaction. HEB has considered numerous alternative transactions, but that none of them were in direct competition with this transaction.

11 Cal. Code Reg. Section 999.5(d)(11)(B)

Copies of all documents relating or referring to the reasons why any potential transferee was excluded from further consideration as a potential transferee for any of the health facilities or facilities that provide similar health care that are the subject of the agreement or transaction.

N/A

11 Cal. Code Reg. Section 999.5(d)(11)(C)

Copies of all Requests for Proposal sent to any potential transferee, and all responses received thereto.

N/A

11 Cal. Code Reg. Section 999.5(d)(11)(D)

All documents reflecting the deliberative process used by the applicant and any related entity in selecting the transferee as the entity to participate in the proposed agreement or transaction.

Book Club is a code word that was used for Chapters Health Systems in meetings prior to announcement. Attached to this Section are the following:

- A copy of the Strategic Planning Committee Minutes dated March 5, 2024
- A copy of the Board of Directors Minutes dated March 7, 2024
- A copy of the Board of Directors Minutes dated April 25, 2025
- A copy of the Board of Directors Minutes dated May, 21 2024
- A copy of the Board of Directors Minutes dated July 15, 2024
- A copy of the Board of Directors Minutes dated August 26, 2024
- A copy of the Strategic Planning Committee Minutes dated October 14, 2024

Hospice East Bay
Here when it's time to talk

Group Name: EBIC STRATEGIC PLANNING COMMITTEE Minutes

Date: March 5, 2024

Time: 11:00am-12:00pm

Location: Zoom

Facilitator: Marcia Gerg

Note Taker: Bill Musick

Board Committee Members: Marcia Gerg, Sue Burroughs, Frank Puglisi, Cindy Silva

Emeritus Committee Members: Lynn Brady, Sharon Iversen

HEB Staff: Bill Musick

Guests: Karen Rubel – CEO, Nathan Adelson Hospice (Las Vegas), Cathy Conway – CEO, Hospice of Santa Cruz

Ground Rules:

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- Come prepared
- Everyone listens
- Focus on solutions
- Respect and honor ideas
- Silence means agreement

Agenda Topics	Time	Leader	Discussion	Action/Timelines/Responsible
Welcome/Introduction of Guests		Marcia Gerg	Marcia Gerg called the meeting to order at 11:03am	
CEO Perspectives on Affiliation		Bill Musick, Karen Rucbel, Cathy Conway	Karen Rubel and Cathy Conway discussed why their organizations are considering affiliation as a subsidiary of a parent sole member and why they consider Chapters Health to be an option worth exploring. Both answered questions from the committee members.	
Strategic Planning Committee Meeting Minutes Approval for January 24, 2024		Marcia Gerg	Motion: *Move to approve minutes of the January 24, 2024 meeting without corrections.*	Motion to approve the Strategic Planning Committee Meeting Minutes for January 24, 2024 **Motion:** Frank Puglisi **Second:** Sue Burroughs **Vote:** Unanimously approved

Submitted by: Bill Musick Date: 03.11.2024

Strategic Filters/Criteria for Member Substitution Model		Bill Musick	Review 2017 document with an eye toward addressing a merger in which HEB becomes a subsidiary of a larger organization. Proposed Motion: *Recommend revised criteria document as discussed to the full board.*	This item was tabled
Actively pursue Book Club Project?		All	The committee discussed the Book Club opportunity. Motion: *Recommend to the full board that HEB continue to participate in Western States exploration of the Book Club opportunity.*	**Motion:** Marcia Gerg **Second:** Frank Puglisi **Vote:** Approved unanimously
mmittee Charter Update		Bill Musick	The committee's charter was updated during our committee transition process that included Sue Burroughs, Marcia Gerg and Bill Musick. The revised version is provided to the full committee for review and approval. Proposed motion: *to recommend revised charter to the Governance Committee.*	**Motion:** Cindy Silva **Second:** Frank Puglisi **Vote:** Approved unanimously
Future Meeting Schedule			- June 4th – Retreat Planning	-
a. Adjournment			The meeting was adjourned at 12:22pm	

*Governance Committee: Vote to approve Give AND Get Policy	5 min	Cindy Silva	- Mechanism for follow up- at end of every year, we would ask board members to self-evaluate; we would provide them with the information on meeting attendance, giving, getting, etc. and having conversation with each board member to discuss where we might be able to provide assistance. - At the end of year, management will send out report showing what each board member (no name listed) has contributed monetarily, volunteering, amount of "get". - Will send out the report of min, max, avg and median for past 3 years.	Motion to approve the Give AND Get Policy as presented **Motion:** Cindy Silva **Second:** Lori McAdams **Vote:** Approved unanimously
*Finance Committee – May Financials (Intro PPT/Overview PPT)	20 min	John Kopchik	Introduction regarding financials provided by Bill Musick. - July 2024 financial update provided by Rahel Legesse	-
Other Committee Reports - *Investment – Eric Rudney - *Audit – Cindy Silva - Strategic Planning – Marcia Gerg - Bruns House – Cindy Silva - *Quality, Safety & Compliance– Lindsay Duggan - Retail Ops– Dennis Ross - *Development– Lorna Lee	20 min	Michelle Lopes	*Committee has met since the last board meeting, draft minutes attached. - *See draft minutes beginning at pp. 23* - Investment- Investment committee meeting held and we are doing very well with an approximate $29 million in our portfolio. We did our review of John Pogue and decided to continue working with him. - Audit Financial audit presented and approved earlier in today's agenda - Strategic Planning- deferred to CEO Update- Book Club - Bruns House- No update - Quality, Safety & Compliance- Discussion regarding audits (Advance directives, pulse, etc)... moving to audit in real time so that we can make adjustments accordingly. - Retail Ops- No update - Development MoTown in Rossmoor event taking place on August 8th. Hops for Hospice in Moraga on September 26th. Working on the next gala and looking for venue. As part of engagement activities we have partnered with a company to publish a Hospice Information guide, which is free to us, with the costs being subsidized by advertisers. Will be used as a marketing tool for us.	- Lorna will have Mats send info on Hops for Hospice and MoTown to the Board members

CEO Update: HR Concerns (PPT)	10 min	Bill Musick	- Standby pay investigation update provided by Bill Musick.	
CEO Update: Book Club (PPT)	20 min	Bill Musick	- Book Club update provided by Bill Musick Schedule Committee meeting prior to August 26th Board meeting to discuss succession planning/local leadership recommendation - It would be critical for Bill to know if there are certain things that board members would like to know or have before the August 26th board meeting so that we can, potentially, make yes/no decision at that meeting. - Quality of care for patients - Level of employee satisfaction Financials of all affiliates on par - Bruns House research any contracts/agreements in place with the Bruns family and/or stipulations that we want to put in place in definitive agreement. - What types of losses are we willing to incur if we continue to have losses at Bruns House (internal decision)?	- Education session/assessment on whether there should be any restrictions in agreement re: Bruns House and specialty programs prior to August meeting? - Lynn and Sharon to talk to Bruns family to see if there are any agreements in place Bill- What has Chapters done with other hospice houses to "turn them around"? Track record on other IPU's within th system. Rahel- Financials for Bruns for the past few years for its performance.
Future Meeting Schedule	5 min	Michelle Lopes	- August 26th, 1pm- 5pm- potential vote on definitive agreement (could require special meeting if timing does not align) – in person	Mexico timeshare decision
Meeting Review a. What worked? b. What needs to be done differently?			-	Motion to adjourn meeting at 9:22pm **Motion**: Cindy Silva **Second**: John Kopchik

				Vote: Approved unanimously

Hospice East Bay	**Group Name: BOARD OF DIRECTORS MEETING MINUTES**
Date: March 7, 2024 **Location**: HEB Offices, 3470 Buskirk Avenue, Pleasant Hill, CA 94523	**Facilitator**: Michelle Lopes **Note Taker**: Bill Musick **Board Committee Members:** Michelle Lopes, Marcia Gerg, Sue Burroughs, John Kopchik, Frank Puglisi, Lindsay Duggan, Lorna Lee, Anneke Reza, Cindy Silva, Paulina Van **Board Emeritus Members**: Lynn Brady **HEB Staff**: Bill Musick, Rahel Legasse (Virtual), Emma Baron, Dr. Mina Chang, Stacey Manley, Marlo Johnston **Guest**: Andrew Molosky, CEO – Chapters Health System

und Rules:

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- **Focus on solutions**
- **Respect and honor ideas**
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Agenda Topics	Time	Leader	Discussion	Action/Timelines/Responsible
Welcome/Mission Moment/ Award		Michelle Lopes	- The meeting was called to order by Michelle Lopes at 5:31pm	
Introductions of New Leaders and Guests		Bill Musick	Bill Musick introduced Rahel Legesse, Interim CFO, and Stacey Manley, VP – Community Engagement	
Approval of December 12, 2023 Board meeting minutes		Michelle Lopes	-	**Motion:** Cindy Silva **Second:** Frank Puglisi **Vote:** Unanimously approved
Approval of Consent Calendar **- Mexico Timeshare**		Michelle Lopes	- East Bay Integrated Care Board of Directors Resolution Change of "Designated Ownership" of Vindanta Timeshare - RESOLVED, that this Board of Directors authorizes and directs Mats Wallin, Chief Development Officer to	**Motion:** Marcia Gerg **Second:** Frank Puglisi **Vote:** Approved unanimously

Submitted by: Bill Musick Date: 03.26.2024

		replace former Chief Executive Officer, Cynthia Hatton, as the designated owner of the Vindanta Timeshare on behalf of East Bay Integrated Care, Inc for communications, reservations, etc.	
Hard Start at 5:45pm Chapters Health System	Andrew Molosky	- Bill Musick introduced Andrew Molosky, CEO – Chapters Health System, who provided an overview of Chapters Health and Care Nu, and provided thoughts about the creation of a Western Region of Chapters. - Andrew responded to questions from those in attendance	
Board Chair Report	Michelle Lopes	- Michelle Lopes ceded the time for other discussion	
CEO Update	Bill Musick	- Bill Musick alluded to the CEO Report in the board packet and asked for questions. He noted that the Value Based Insurance Design pilot to carve in hospice will be terminated early on 12/31/2024.	
Annual Quality & Safety Update	Emma Baron	- Bill Musick called attention to the Annual Quality and Safety Update in the board packet and asked for questions that Emma Baron responded to.	
Committees - * Investment – Eric Rudney - * Finance – John Kopchik - Audit – Cindy Silva - * Strategic Planning – Marcia Gerg - * Governance - Frank Puglisi * Human Resources / Compensation – Sue Burroughs	Michelle Lopes	- Rahel Legesse reported that the Investment Committee met in February and that the committee will be reviewing the investment manager's performance at its next meeting. - John Kopchik reported that the committee was working on revising the content and format of the financial reports to the board, and that January net operating income was lower than anticipated due to high labor costs. - Cindy Silva reported that the Audit Committee would be meeting March 14 for a kick-off meeting with HEB's external auditors - Marcia Gerg deferred discussion to the next item on the agenda	

- *Quality, Safety & Compliance– Lindsay Duggan - * Development– Lorna Lee			- Frank Puglisi reported that the committee had met to discuss a Give/Get Policy and was expecting to arrive at a policy that including expectations for a meaningful financial contribution and participation in fund development activities to get contributions from others. He reported that he and Bill Musick are scheduling a meeting with a board candidate identified by Lindsay Duggan. - Sue Burroughs reported that virtual interviews were being scheduled with four candidates for the CEO position next week. - Lindsay Duggan reported that the Quality, Safety & Compliance Committee had met and referenced the Annual Report discussed earlier. Lorna Lee called the board's attention to the Giving in the Garden Event on May 18, and reminded board members to drop off bottles of wine for a Board "Cellar" auction item, to purchase tickets and share information with others. Stacey Manley will ensure that ticket information is sent to all board members.	
Book Club Project	45 min	Marcia Gerg/Bill Musick	- Bill Musick led a discussion of the pros and cons of this project. - Motion: To continue to explore this opportunity and participate in the April 16 meeting in Las Vegas.	**Motion:** Cindy Silva **Second:** Frank Puglisi **Vote:** Approved unanimously
Future Meeting Schedule			- Next meeting: April 25 (Virtual)	-
Adjournment			- Motion to adjourn at 7:41pm	**Motion:** Frank Puglisi **Second:** Marcia Gerg **Vote:** Approved unanimously

Hospice East Bay
Here When You Need Us

Group Name: BOARD OF DIRECTORS MEETING

Date: April 25, 2024

Time: 5:30pm-8:30pm

Location: Zoom

Facilitator: Michelle Lopes

Note Taker: Cynthia Lo

Board Members Present: Michelle Lopes, Marcia Gerg, Sue Burroughs, John Kopchik, Frank Puglisi, Lindsay Duggan, Lorna Lee, Anneke Reza, Eric Rudney, Paulina Van, Larry Sly

Board Absent: Cindy Silva

Emeritus Board Present: Lynn Brady, Jamie Gerson,

Emeritus Board Absent: Burt Bassler, Sharon Iversen, Dennis Ross, Ernie Wintter

Staff Present: Bill Musick, Rahel Legesse, Emma Baron, Dr. Mina Chang, Stacey Manley, Marlo Johnston, Debra Batten

Ground Rules:

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Agenda Topics	Time	Leader	Discussion	Action/Timelines/Responsible
Welcome/Mission Moment			- Meeting called to order at 5:30pm by Michelle Lopes - Mission moment reflected on the volunteer appreciation dinner that was held last night.	-
Approval of the March 7, 2024 Board meeting minutes		Michelle Lopes	-	Motion to approve the March 7, 2024 minutes **Motion**: Marcia Gerg **Second**: Frank Puglisi **Vote:** Approved unanimously
The Board's Role in an Effective Compliance Program	15 min	Debra Batten	- Debra Batten gave presentation on the Board's Role in an Effective Compliance Program	**Marlo**- Send Standards of Business Conduct to all Board members.
Committees	30 min	Michelle Lopes	*Committee has met since the last board meeting, draft minutes attached. - See draft minutes beginning at pp. 7	

Submitted by: Cynthia Lo Date: 04.25.2024

- Investment – Eric Rudney - Finance – John Kopchik - * Audit – Cindy Silva - Strategic Planning – Marcia - * Governance- Frank Puglisi - * Human Resources / Compensation – Sue Burroughs - Quality, Safety & Compliance– Lindsay Duggan - Development- Lorna Lee			- **Investment**- Last 15 months have been a good time for the equity and fixed income market. We have been able to grow our endowment to a very encouraging amount. - **Finance**- To be reported in 1st quarter finances topic below. - **Audit**- Financial audit 1st draft was due on April 15th which is being reviewed by Rahel. 403b audit is going very smoothly this year and will be completed on time. - **Strategic Planning**-tabled until later in meeting - **Governance**- Has met several times and has a recommendation on the agenda tonight to approve a new director. Working on give/get policy and anticipate it will be presented at the July board meeting for approval. - **HR/Compensation** - CEO recruitment will be discussed later in the agenda. Committee met with labor attorney to review bargaining strategy. - **Quality, Safety & Compliance**- Committee met in February 2024. Quality measures look good and there is nothing further to report. - **Development**- Gearing up for Giving in the garden on May 18th. All Board members are encouraged to attend and invite friends. Bottles of wine need to be turned into Mats/Fund Development. 2 Board donations received for a Board match challenge.	
Board Chair Report	5 min	Michelle Lopes	- No report as everything is later in the agenda to be discussed.	
CEO Update	10 min	Bill Musick	- Nothing additional to add to the CEO report in the agenda packet	
1st Quarter Financials	15 min	Rahel Legesse / John Kopchik	March YTD financials (See attachment at pp. 21) reviewed and discussed.	
Vote to elect new Director	10 min	Frank Puglisi / Bill Musick	Discuss and vote on Governance Committee recommendation to elect Lori McAdams as a director of EBIC. (bio attached at pp. 15)	Motion to elect Lori McAdams as a director of EBIC. **Motion**: John Kopchik **Second**: Lindsay Duggan **Vote:** Approved unanimously

Book Club Decision	45 min	Michelle Lopes / Sharon Iversen / Bill Musick	Recommendation from the Executive Committee to: authorize the Executive Committee to negotiate a Letter of Intent with Book Club. Meeting notes: pp. 28; Slides: pp. 35	Motion to authorize the Executive Committee to negotiate a Letter of Intent with the Book Club **Motion:** Anneke Reza **Second:** Eric Rudney **Vote:** Approved unanimously
CEO Search Decision	20 min	Sue Burroughs	Recommendation from the Executive Committee: to pause the CEO Search while the Book Club project remains under consideration.	Motion to pause the CEO Search while the Book Club project remains under consideration. **Motion**: Anneke Reza **Second:** Eric Rudney **Vote:** Approved unanimously
Future Meeting Schedule		Michelle Lopes	Next scheduled meeting: July 15th via Zoom Proposal to set a meeting in late May to vote on final LOI. Cynthia will send out a Doodle poll to see if the time scheduled for an Executive Committee meeting on Tues May 21st 5:00pm-6:00pm will work for others. If so, an Executive Committee meeting will be rescheduled.	**Cynthia**- poll Board members for availability for meeting on 5/21/24 at 5pm (complete)
Meeting Review **a.** What worked? **b.** What needs to be done differently?				Motion to adjourn meeting at 8:13pm **Motion:** Marcia Gerg **Second:** Sue Burroughs **Vote:** Approved unanimously

Hospice East Bay
There When You Need Us

Group Name: BOARD OF DIRECTORS MEETING- SPECIAL MEETING ON BOOK CLUB LOI

Date: May 21, 2024

Time: 5:00pm-6:00pm

Location: Zoom

Facilitator: Michelle Lopes

Note Taker: Cynthia Lo

Board Members Present: Michelle Lopes, Sue Burroughs, John Kopchik, Frank Puglisi, Lorna Lee, Anneke Reza, Eric Rudney, Larry Sly, Lori McAdams, Paulina Van

Board Absent: Cindy Silva, Marcia Gerg, Lindsay Duggan

Emeritus Board Present: Sharon Iversen

HEB Staff Present: Bill Musick, Mina Chang

Guests: Robert Miller, Hooper Lundy

Ground Rules:

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Agenda Topics	Time	Leader	Discussion	Action/Timelines/Responsible
Welcome/Mission Moment			- Meeting called to order by Michelle Lopes at 5:01pm - Introduction of our newest Board member, Lori McAdams	-
Board of Directors Meeting Minutes Approval for April 25, 2024	2 min	Michelle Lopes	-	Motion to approve the April 25, 2024 minutes. **Motion:** Eric Rudney **Second:** Frank Puglisi **Vote:** Approved unanimously
Book Club Update	15 min	Bill Musick	- Bill provided an update on the Book Club project. Meeting scheduled in Tampa with the hospice CEO's, Andrew Molosky and the Book Club leadership. One day of this meeting will be to work out details of leadership and governance for a Western Region	-

Submitted by: Cynthia Lo Date: 05.21.2024

LOI	20 min	Bill Musick	- Bill reviewed the key items/key terms that have been discussed and included in the LOI sent via email on 5/20/24. - The Book Club has set a desired timeline to have all LOI's signed by May 31st. The next step would be all due diligence completed by end of July/beginning of August. A Definitive Agreement would then follow. The next step would be regulatory approvals. The timeline for regulatory approvals is more an unknown as it is out of our control. We could close the deal after we receive regulatory approvals. The first three months following the close are planned as an assessment period with no changes, with a focus on integrating functions across the local, regional or parent level. Bill referred to the draft due diligence request that was sent out with the draft LOI. There were no comments. He will plan to send that with the signed LOI.	Motion to approve the LOI (sent via email by Bill Musick on 5/20/24). **Motion:** Frank Puglisi **Second:** Larry Sly **Vote:** Approved unanimously
Preview for July 15 Board Meeting	5 min	Bill Musick	Bill provided a quick review of the proposed agenda topics for the July 15 board meeting. - 2023 Audit Presentation - Guest Speaker: The Board's Fiduciary Responsibilities - May YTD Financials - Give AND Get Policy - Labor Strategy/Update - Book Project Update - Decision on August Meeting (planned as retreat – likely to change with Book Club project)	
Future Meeting Schedule			- July 15th at 5:30pm - There was consensus that this meeting be held In-Person (with Zoom option)	Motion to adjourn meeting at 6: 02pm **Motion**- Frank Puglisi **Second**- John Kopchik **Vote**: Approved unanimously

Hospice East Bay
Here When You Need Us

Group Name: BOARD OF DIRECTORS MEETING

Date: July 15, 2024

Time: 5:30pm 8:30pm

Location: HEB Offices/ Zoom

https://us06web.zoom.us/j/87687625755?pwd=7as87uubO8eAccEQ8IibwEDmUaypL.1
Meeting ID: 876 8762 5755
Passcode: 615018

Facilitator: Michelle Lopes

Note Taker: Cynthia Lo

Board Members Present in Person: Michelle Lopes, Sue Burroughs, John Kopchik, Lindsay Duggan, Lorna Lee, Cindy Silva, Larry Sly, Lori McAdams, Anneke Reza

Board Members Present via Zoom: Eric Rudney, Paulina Van

Board Members Absent: Marcia Gerg, Frank Puglisi

Board Emeritus Present via Zoom: Lynn Brady, Sharon Iversen

HEB Staff: Bill Musick, Emma Baron, Stacey Manley, Rahel Legesse, Mina Chang, Marlo Johnston, Stacie Chin

Guests: Noel Caughman, Best, Best & Krieger LLP; Renee Gravalin, Eide Bailey

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Agenda Topics	Time	Leader	Discussion	Action/Timelines/Responsible
Welcome/Mission Moment	2 min	Michelle Lopes	- Moment of silence for Catherine McLanahan (Jamie Gerson's mother) - Congratulations- Paulina Van-Luminary Fellowship	-
Guest Speaker: The Board's Fiduciary Responsibilities (PPT)	30 min	Noel Caughman	- Noel Caughman presented.	Cynthia Send out documents & PPT provided by Noel to board members
Financial Audit presentation	20 min	Renee Gravalin	- Renee Gravalin presented the financial audit. - On the balance sheet what/who are "Funds held for others"? - That line is related to stale dated checks as part of the escheatment process. They are held in that account until we need to send them to the state	Motion to accept the 2023 financial audit, as presented. **Motion:** Cindy Silva **Second**: Sue Burroughs **Vote:** Approved unanimously

Submitted by: Cynthia Lo Date: 07.15.2024

Board of Directors Meeting Minutes Approval for May 21, 2024	2 min	Michelle Lopes	-	Motion to approve the May 21, 2024 minutes **Motion**: Sue Burroughs **Second**: Cindy Silva **Vote**: Approved anonymously
Board Chair Comments	5 min	Michelle Lopes	- Deferred comments for discussion on topics later on the agenda	
HR Committee: Vote on recommendation to approve 403b audit	5 min	Sue Burroughs	- Sue Burroughs gave an overview of the 403b audit and letter of corrections for 5 findings. - We will be going back to review all employees to ensure that all corrections needed are made. We will report back to the board once we have developed the action plan and how we will be moving forward.	Motion to approve the 403b audit as presented **Motion:** Cindy Silva **Second**: Larry Sly **Vote:** Approved unanimously
Authorization for Task Force to Set PAGA Negotiating Cap	5 min	Bill Musick	- Mediation currently scheduled for August 2nd for PAGA case.	Motion to authorize Miche Lopes, Sue Burroughs and John Kopchik to work with HEB staff to set PAGA negotiating cap and strategy on behalf of the Board **Motion:** Cindy Silva **Second**: Linday Duggan **Vote:** Approved unanimously
Governance Committee: Vote to elect Marta Hudson as director with term Jul 15,2024 – Dec 31, 2026	5 min	Cindy Silva	- Reminder: Buddies for Lori McAdams and Marta Hudson - Lori McAdams- Cindy Silva - Marta Hudson- Bill will follow up with Board	Motion to elect Marta Hudson as Director for term of July 15, 2024-December 31, 2026 **Motion:** Cindy Silva **Second**: Anneke Reza **Vote:** Approved unanimously

Hospice East Bay
Here When You Need Us

Group Name: BOARD OF DIRECTORS MEETING DRAFT

Date: August 26, 2024

Time: 12:00pm-5:00pm

Location: Hospice East Bay, 3470 Buskirk Avenue, Pleasant Hill, CA / Zoom

Join Zoom Meeting

https://us06web.zoom.us/j/82943543767

Meeting ID: 829 4354 3767

Facilitator: Michelle Lopes

Note Taker: Cynthia Lo

Board Members Present In person: Michelle Lopes, Sue Burroughs, John Kopchik, Frank Puglisi, Lorna Lee, Anneke Reza, Cindy Silva, Larry Sly, Lori McAdams, Marta Hudson

Board Members Present via Zoom: Eric Rudney, Paulina Van, Marcia Gerg

Board Absent: Lindsay Duggan

Emeritus Board Present in person: Sharon Iversen, Lynn Brady

Emeritus Board Present via Zoom: Jamie Gerson

HEB Staff: Bill Musick, Rahel Legesse, Emma Baron, Dr. Mina Chang, Stacey Manley, Marlo Johnston

Guests: Robert Miller- Hooper Lundy; Andrew Molosky-CHS

Agenda Topics	Time	Leader	Discussion	Action/Timelines/Responsible
In-Person Lunch	12:00	All	- Meeting called to order at 12:19pm by Michelle Lopes	-
Welcome/Mission Moment/Chair Comments	12:20	Michelle Lopes	- Moment of Silence in acknowledgement of the passing of Patricia Joyce Sobeck (Sue Burrough's mother) - Congratulations to Marcia Gerg and Larry Sly on the births of their grandchildren.	-
Role Call/Quorum of Active Members	12:25	Cynthia Lo	- 14 active voting members (11 in person, 3 via Zoom Marcia Gerg had to leave meeting at 1:45pm) - 3 emeritus members (2 in person, 1 via Zoom) - 5 members of the HEB leadership team - We have met quorum	
Board of Directors Meeting Minutes Approval for July 15, 2024	12:30	Michelle Lopes	-	Motion to approve the July 15, 2024 minutes **Motion**: Frank Puglisi

Submitted by: Cynthia Lo Date: 08.26.2024

				Second: Cindy Silva **Vote:** Approved unanimously
Committee Reports Investment - Eric Rudney - Finance – John Kopchik - Audit – Cindy Silva - Strategic Planning – Marcia - Human Resources / Compensation – Sue Burroughs - Quality, Safety & Compliance– Lindsay Duggan * Development– Lorna Lee * Governance – Frank Puglisi	12:35	Michelle Lopes	*Committee has met since the last board meeting, draft minutes attached (Governance & Development). See draft minutes beginning at pp. 11 Investment- will be meeting tomorrow. Market increases recently have us in a very good position. We have made the decision to continue with John Pogue of KCM Investment Advisors for another 3 years. - Finance have not met since last Board meeting. Census is still low but we can see improvements in rate of expenditures. Bruns House is having one of its better years financially. - Audit Nothing to report Strategic Planning- Nothing to report - HR/Comp- have not met since last Board meeting. Issues reported in CEO Report - QSC- will be meeting tomorrow - Development Upcoming events include Hops for Hospice, Bruns Brick Ceremony, Tree Of Lights. Gala planning has started for 2025. - Governance- Conflict of interest vote below	
Governance Committee: Conflict of Interest Policy	12:55	Frank Puglisi	Move to approve Conflict of Interest Policy (see Governance Committee draft minutes)	Motion to approve Conflict of Interest Policy **Motion**: Cindy Silva **Second:** Anneke Reza **Vote:** Approved unanimously
Overview of Affiliation Documents and Process	1:00 – 1:30	Robert Miller	Review of affiliation documents (provided in the agenda packet) by Robert Miller. - Robert explained membership substitution and what that means for HEB in this situation. - Affiliation agreement may have additional future changes based on the resolution of final issues with Book Club and what other members of the Western Region might propose. - The updated bylaws act just like our current bylaws. The key difference relates to the reserved rights as Book Club as the sole member.	

			- Discussion related to pros and cons of HEB signing the definitive agreement earlier than the other potential affiliates. HEB will need to go through regulatory approvals process that the other potential affiliates are not required to do. If we sign sooner than the other affiliates, we may be able to start this process sooner so that there is a better chance that all affiliates will close at the same time. The risk of starting this process and seeking regulatory approval from the Attorney General before closing is that the transaction information will become public and could be disclosed through a public records request. We would request a confidentiality clause in place so that it would not become public and if not agreed upon, we will likely wait until we have made our public announcement when all affiliates have signed definitive agreements.	
Questions by Category	1:30 – 1:45	All	- Discussion surrounding projections of future financial implications being done by the other affiliates. The results will be shared with HEB. - Sharing of potential revisions to the definitive agreement are being shared between the affiliates. - Discussion regarding the restrictions on use of Hospice East Bay assets: maintenance of specialty programs. - Discussion regarding the makeup of the Board of Directors under the potential affiliation as well as the Western Region advisory council. Discussion regarding the use of HEB investment dollars designated for use in the local service area.	
Break	1:45 – 2:00			
Remarks from and Questions for CHS CEO	2:00 – 3:00	Andrew Molosky	Introduction, background, and general comments by Andrew Molosky - Questions by Board members of Andrew and follow up discussion.	
Additional Discussion	3:00 – 3:30	All / Robert Miller	Reactions from Q & A with Andrew Molosky - Andrew comes across as very consistent. He doesn't change his answers based on how the question is asked or who asks it. - Discussion about the Book Club leadership team. - Employee engagement scores are impressive - Pleased with Andrew's responses around payroll and benefits - Very encouraging in terms of support of specialty programs as long as we cover any expenses due to them being unprofitable.	

			- It felt like we would be joining a "family" and not being bought out and overshadowed.	
Consensus poll on approval of Affiliation Resolution	3:30 – 3:40	Michelle Lopes	For all board members, emeritus members, and leadership staff, what is your sense? (no vote from Eric Rudney or Marcia Gerg who were not available at this time in the meeting) - Fully Approve - 19 - Approve with Reservations - 1 - Serious Reservations - 0	
Break	3:40 – 3:50		-	
Any further discussion from voting members?	3:50 – 4:10	Voting Members	- None	
Vote on resolution to approve affiliation	4:10 – 4:20	Michelle Lopes	- Further Board action would be needed if there is material change to the definitive agreement. - The Board would like a communication from Bill Musick prior to signing of the agreement as to whether there have been any changes or updates to the document. <u>Official Vote</u> - Bill Musick- yes - Michelle Lopes- yes Frank Puglisi- yes - Marta Hudson- yes - Cindy Silva- yes - John Kopchik- yes - Larry Sly- yes - Sue Burroughs- yes Anneke Reza- yes - Lori McAdams - yes - Lorna Lee- yes - Dr. Paulina Van- yes	Motion to approve the affiliation resolution, as presented (gives Bill Musick the authority to sign the definitive agreement and bylaws, with the date of signing being at his discretion) **<u>Motion</u>**: Cindy Silva **<u>Second</u>**: Frank Puglisi **<u>Vote:</u>** Approved unanimously
Governance Committee Recommendation on West Region Council Representatives	4:20 – 4:30	Frank Puglisi	- Proposal is that each of the new affiliates would each nominate 2 members from their current board. Discussion took place at the Governance committee about who those 2 members should be, if this proposal is adopted.	Motion to nominate Michelle Lopes and Paulina Van as the Hospice East Bay representatives to the

			- Survey was sent out to Board members about their desire to be on the Western Regions Advisory Board and strong interest was shown by Michelle Lopes and Paulina Van.	Western Region Advisory Council, should the most recent proposal for the Western Region Council be approved by Book Club **Motion**: Frank Puglisi **Second**: Sue Burroughs **Vote:** Approved unanimously
Executive Committee recommendation on CEO succession	4:30 – 4:45	Michelle Lopes / Sue Burroughs	At what point do we transition to Executive Director to replace Bill? - One suggestion is to have a bridge period with Bill Musick remaining as CEO, bring on COO/ED apparent. Bill would cut back on his time and salary and the reporting structure would change so that the COO would take on the areas they would have reporting to them as the Executive Director - Of the two previously vetted finalists for the CEO position, one is still interested but is actively interviewing. The second candidate is no longer interested. - The Executive Committee felt that we should have on-site interviews for at least 2 candidates. - Our recruiter suggested that we interview 2 candidates that we didn't interview for the CEO position but that may be good candidates for the Executive Director position. - Suggestion to bring Keith Everrett in for an onsite interview while screening other candidates. - HR/CEO Search committee will reengage recruiter, meet to discuss, narrow down candidates, and begin interviews for the COO/ED position, once candidates identified. - Bill has committed to stay full time through December and through June part time.	**Cynthia**- set up CEO Search Committee meeting within the next week
Communications Plan/Confidentiality	4:45 – 4:55	Bill Musick	Holding off on any communication until all of the affiliates have signed definitive agreements. - Meeting tomorrow with Book Club leadership to discuss our future communications plans.	

Future Meeting Schedule			- October 8th – 5:30pm (virtual)	-
Meeting Review a. What worked? b. What needs to be done differently?			Motion to adjourn meeting at 3:54pm **Motion**: Frank Puglisi **Second**: John Kopchick **Vote:** Approved unanimously	

Hospice East Bay
Here When You Need Us

Group Name: EBIC STRATEGIC PLANNING COMMITTEE DRAFT

Date: October 14, 2024

Time: 3:00pm-4:00pm

Location: Zoom

https://us06web.zoom.us/j/84926921274?pwd=xmzjJadCoAiYvf1xjQM75O4e8bnNLr.1

Meeting ID: 849 2692 1274

Passcode: 284726

Facilitator: Marcia Gerg

Note Taker: Cynthia Lo

Board Present: Marcia Gerg, John Kopchik, Cindy Silva, Lori McAdams

Board Absent: Sue Burroughs, Frank Puglisi

Emeritus Board Present: Lynn Brady, Jamie Gerson

Staff Present: Bill Musick, Rahel Legesse, Emma Baron

und Rules:

- **Start and end meetings on time**
- **One person talks**
- **Come prepared**
- **Everyone listens**
- **Focus on solutions**
- **Respect and honor ideas**
- **Silence means agreement**

Agenda Topics	Time	Leader	Discussion	Action/Timelines/Responsible
Welcome/Mission Moment			-	-
Strategic Planning Committee Meeting Minutes Approval for March 5, 2024	2 min	Marcia Gerg	-	Motion to approve the March 5, 2024 meeting minutes **Motion**: Cindy Silva **Second**: Marcia Gerg **Vote:** Approved – Lori McAdams and John Kopchik abstained
Hospice CARE Act – Rep Blumenauer	10 min	Bill Musick	Bill provided an overview of the Hospice Care Accountability, Reform and Enforcement (CARE) Act that was introduced in Congress this month. It would be a major reform of the Medicare Hospice Benefit and associated regulations. He highlighted some key areas that could impact HEB if it is passed in its current form.	-
Bruns House and Specialty Programs	30 min	Bill Musick	Bill gave an overview of the information that was discussed by a small task force (Bill, Cindy, John, Lori) that met after discussions about language specific to the Bruns House in the affiliation agreement. The intent in this meeting is to help ensure that there is a common understanding of the current programs (Veterans	

Submitted by: Cynthia Lo Date: 10.18.2024

			Program, Bruns House, Bridge Program, Music Therapy) and determine what next steps, if any, the board would like to take.
			- Criteria to use when looking at whether or not to continue these programs:
			  - Review programs in terms of which ones help make a difference in terms of referral sources/patients and families would be more likely to use HEB than another hospice program.
			  - Which programs are more likely to be supported by grants if we make a concerted effort moving forward?
			- Suggestion to invest in someone that is good at grant writing to work with the Fund Development department.	

2025 Goals	15 min	Bill Musick	For 2025, Bill proposed that we continue our 2024 goals with the addition of an Affiliation goal and caveat in that regard. 1. Adopt goals that are timely markers for achieving a CMS Four-Star Rating of Service Quality 2. Achieve turnover rate of 22% or less (as a marker for employee engagement)* 3. Exhibit financial discipline by a net operating margin equal to or better than budget* 4. Formulate affiliation integration plan and successfully implement regional priorities ** Subject to impact by #4*	
Future Meeting Schedule			- Meeting adjourned at 4:05pm	
Meeting Review **a.** What worked? **b.** What needs to be done differently?			-	

MEDICAL SERVICES AGREEMENT

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MEDICAL SERVICES AGREEMENT

Between

ALAMEDA ALLIANCE FOR HEALTH

and

East Bay Integrated Care, Inc. DBA Hospice of the East Bay

This Medical Services Agreement is entered into between **East Bay Integrated Care, Inc. DBA Hospice of the East Bay** ("Medical Group") and **ALAMEDA ALLIANCE FOR HEALTH** (referred to as "Alameda Alliance") to be effective on May 1, 2022.

RECITALS

A. Alameda Alliance for Health is a public entity licensed by the California Department of Managed Health Care ("DMHC") as a health care service plan in the State of California pursuant to the Knox-Keene Health Care Service Plan Act of 1975 as amended (California Health and Safety Code Sections 1340 et seq.), and the regulations promulgated thereunder (collectively, the "Knox-Keene Act").

B. Alameda Alliance for Health has entered into an agreement with the California Department of Health Care Services ("DHCS"). Alameda Alliance has entered into an agreement(s) with the Public Authority of Alameda County for In-Home Supportive Services Workers ("Public Authority").

C. Pursuant to Alameda Alliance Agreements, Alameda Alliance has agreed to provide or arrange for the provision of specified covered health care services and supplies to eligible Alameda Alliance Program Members who enroll in an Alameda Alliance Program, including primary and specialty care professional, clinic, inpatient and outpatient hospital and Ancillary Services.

D. Medical Group represents that it is licensed and qualified to provide or arrange for the delivery of the health care services contemplated herein either directly or through contracting providers.

E. Alameda Alliance desires to engage Medical Group to render certain professional health care services to Members and Medical Group desires to provide such health care professional services to Members, subject to the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of these premises and the mutual covenants set forth in this Agreement, Alameda Alliance and Medical Group agree as follows:

(Remainder of page left intentionally blank.)

SECTION 1: DEFINITIONS

In addition to terms defined elsewhere in this Agreement, the following capitalized terms shall be defined as follows:

1.1 "**Alameda Alliance Agreement(s)**" means the agreement or agreements between Alameda Alliance and DHCS under the Two-Plan Model for Medi-Cal Managed Care as the Local Initiative Plan in the County of Alameda ("Medi-Cal Agreement"), Public Authority of Alameda County for In-Home Supportive Services Workers ("Public Authority Agreement") and/or with such other entities that Alameda Alliance may enter into an agreement with to provide or arrange for the provision of Covered Services and supplies.

1.2 "**Alameda Alliance Program(s)**" means the program or programs under the applicable Alameda Alliance Agreement to provide or arrange for the provision of Covered Services and supplies to eligible Members and/or such other programs Alameda Alliance may establish.

1.3 **"Ancillary Services"** means those support services other than physician services that are provided by an Ancillary Services Provider and include but are not limited to laboratory, radiology, and physical therapy.

1.4 **"Ancillary Services Provider"** means an individual or entity that provides certain medical services dispensed by order or prescription from a provider with the appropriate prescribing authority.

1.5 "**Applicable Requirements**" means the following legal, regulatory and contractual requirements as they may be revised during the term of this Agreement: (i) applicable Federal, State, and local laws and regulations (including, but not limited to, applicable provisions of the Knox-Keene Act; the Medicare and Medi-Cal Managed Care laws, regulations, guidelines, programs and instructions as well as laws governing the use of Federal and State funds, such as the fraud and abuse prevention and detection laws, anti-kickback laws, the Civil Rights Act, the Americans with Disabilities Act, age discrimination laws, criminal laws, and the Veteran's Preference law); (ii) the provisions of Alameda Alliance Agreements, Alameda Alliance Programs and their associated Evidence of Coverages applicable to agreements; (iii) Medicare and Medi-Cal certification requirements; (iv) applicable accreditation requirements and (v) The Provider Manual. The following agencies have jurisdiction over Alameda Alliance and are responsible for enforcing the Applicable Requirements and the terms of this Agreement: DHCS, CMS, DMHC, the Government Accountability Office, the Office of Inspector General, the U.S. Department of Health and Human Services and the County of Alameda.

1.6 **"Attachment"** means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to any Sections, all of which are hereby incorporated herein by reference and may be amended from time to time as provided herein.

1.7 "**Authorization**" means the procedure for obtaining the prior approval of Alameda Alliance for the provision of Covered Services when such approval is required by Alameda Alliance, as further described in this Agreement and the Provider Manual.

1.8 "**Capitated Services**" means those Covered Services that Medical Group is responsible for providing to Medical Group Members for which Medical Group receives Capitation, as set forth in the Provider Manual.

1.9 "**Capitation**" or "**Capitated**" means the single fixed monthly payment paid by Alameda Alliance to Medical Group for each Medical Group Member to provide the Covered Services.

1.10 "**Centers for Medicare and Medicaid Services**" or "**CMS**" shall mean the federal agency that administers the Medicare program and is part of the U.S. Department of Health and Human Services.

1.11 "**Center(s) of Excellence**" means a health care facility that is a Participating Provider and has been designated as a facility where services to Members requiring specialized Covered Services shall be provided.

1.12 "**Claims Processing**" means the processing of a request for payment for the provision of Covered Services not covered in Capitation to Medical Group.

1.13 "**Clean Claim**" means, for purposes of this Agreement, a claim, or portion thereof, if separable, for Covered Services which contains all of the UB-04, CMS 1500, or electronic claim forms data elements, includes any attachments and supplemental information or documentation, if applicable, which provides relevant and necessary information to determine payer liability, and is submitted within the timeframes set forth herein.

1.14 "**Coordination of Benefits**" means the determination of whether Covered Services provided to a Member will be paid for, either in whole or in part, under any other private or government health benefit plan or any other legal or contractual entitlement, including, but not limited to, a private group indemnification or insurance program.

1.15 "**Copayment**" means those charges for Covered Services, if any allowed under the applicable Alameda Alliance Agreement and associated Evidence of Coverage, which may be collected directly by a Medical Group Provider from a Member as payment in addition to the compensation paid hereunder.

1.16 "**Contracted Provider**" means a physician, hospital, health care professional or any other provider of items or services that is (i) is an employee by or has a contractual relationship with Medical Group, and (ii) has been approved for participation by Alameda Alliance. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider for which Provider has been approved for participation by Alameda Alliance.

1.17 "**Covered Services**" means all of the Medically Necessary supplies and health care services including services by primary and specialty providers, clinic, inpatient and outpatient hospital, ancillary and telemedicine services which a Member is entitled to receive from Alameda Alliance under the applicable Alameda Alliance Agreement and Evidence of Coverage, and/or applicable law as determined by Alameda Alliance. Covered Services shall include any other health care services required to be covered by Alameda Alliance Programs, or other law or by Alameda Alliance Agreements, including but not limited to autism services that are not the responsibility of a separate behavioral health program/vendor. Final determination of whether or not a service is covered will be made by Alameda Alliance in accordance with the Member's applicable Evidence of Coverage and Alameda Alliance Agreement.

1.18 "**Covering Physician**" means a Participating Physician (including a locum tenens physician) approved by Alameda Alliance who is engaged by a Participating Physician to provide Covered Services on behalf of that Participating Physician when that Participating Physician is not able to provide such services.

1.19 "**Credentialing**" means the process for validating the qualifications of licensed professionals to provide services to Members. It includes an objective evaluation of the providers' current licensure, training or experience, competence, and ability to provide or perform particular services or procedures. Alameda Alliance follows National Committee on Quality Assurance (NCQA) guidelines in conjunction with special Credentialing guidelines required by State regulation and policy.

1.20 "**DHCS**" means the California Department of Health Care Services.

1.21 "**DMHC**" means the Department of Managed Health Care which is the California State agency responsible for the administration of the Knox-Keene Act.

1.22 "**Emergency Services**" means those Covered Services provided for a medical condition including emergency labor and delivery manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to a bodily function, or (iii) serious dysfunction of any bodily organ or part. Emergency Services shall mean those medical and hospital services required that are furnished by a physician, physician assistant or other person qualified to provide Emergency Services and needed to evaluate, provide consultation or stabilize emergency medical conditions as described above. Emergency

Services shall include screenings, examinations and evaluations for the purpose of determining whether a psychiatric emergency medical condition exists, and whether treatment is necessary to relieve or eliminate the psychiatric emergency medical condition.

1.23 **"Eligibility Verification System"** means the system set forth in the Alameda Alliance Provider Manual for the Participating Physician to verify the eligibility of Members to receive Covered Services.

1.24 "**Evidence of Coverage**" means the Combined Evidence of Coverage and Disclosure Form and any amendments thereto, issued to Members by Alameda Alliance in connection with the applicable Alameda Alliance Program.

1.25 "**Fee-For-Service**" means the direct payment by Alameda Alliance to Medical Group for Covered Services or Non-Capitated Services that Medical Group Provider provides to Members. The lowest allowable Fee-For-Service Medi-Cal payment that is permitted by DHCS.

1.26 "**Medi-Cal Fee Schedule**" refers to the rates or fee schedule published by the DHCS for services provided under the state's Medi-Cal Fee-For-Service program.

1.27 "**Medical Group Member**" means a Member who chooses Medical Group and/or is assigned to a Medical Group Provider.

1.28 "**Medical Group Physician**" means a physician who is licensed by the State of California and certified to participate in the Medicare and/or Medi-Cal Programs and is, (i) employed by or under contract with Medical Group, and (ii) credentialed by Alameda Alliance or Medical Group as applicable to furnish Covered Services to Medical Group Members pursuant to this Agreement.

1.29 "**Medical Group Provider**" means a Medical Group Physician or a non-physician medical practitioner, employed by or under contract with Medical Group, collectively or individually, and credentialed by Alameda Alliance or Medical Group as applicable to furnish Covered Services to Medical Group Members pursuant to this Agreement.

1.30 "**Medical Group Subcontract**" means the written contract between Medical Group and each Medical Group Provider, in a form approved by Alameda Alliance and Medical Group pursuant to which Medical Group Providers agree to provide services to Medical Group Members.

1.31 "**Medically Necessary**" or "**Medical Necessity**" means those health care services and supplies which are provided in accordance with recognized professional medical and surgical practices and standards which are determined by Alameda Alliance or by Medical Group to be: (i) appropriate and necessary for the symptoms, diagnosis or treatment of Member's medical condition; and (ii) provided for the diagnosis and direct care and treatment of such medical condition; and (iii) not furnished primarily for the convenience of Member, Member's family, or the treating provider or other provider; and (iv) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (v) consistent with Alameda Alliance policies. If there are two or more Medically Necessary services that may be provided for the illness, injury, or medical condition, Alameda Alliance will provide benefits based on the most cost-effective service.

1.32 "**Medicare Rates**" refers to the rates published by CMS for Alameda County for the services provided under the Medicare program.

1.33 "**Member**" means an Alameda Alliance Program beneficiary who meets Alameda Alliance's enrollment qualifications and who is enrolled in and identified by Alameda Alliance as a member of an Alameda Alliance Program and eligible to receive Covered Services.

1.34 "**Member Grievance**" means any written or oral expression of dissatisfaction made by a Member or the Member's representative.

1.35 "**Member Grievance Procedures**" means the provisions of the applicable Evidence of Coverage that describe the procedures for the receipt, handling and disposition of Member Grievances. A summary of Alameda Alliance's typical grievance process is set forth in the Provider Manual. However, the

procedure set forth in Member's Evidence of Coverage or required by law shall control the grievance process as to that Member, if different from the procedures set forth in the Provider Manual.

1.36 "**Non-Capitated Services**" means those Covered Services for which Medical Group is not Capitated as set forth in the Provider Manual.

1.37 "**Non-Covered Services**" means those services excluded from coverage pursuant to the applicable Alameda Alliance Agreement and the applicable Evidence of Coverage under Medi-Cal and Group Care.

1.38 "**Non-Medical Group Member**" means any Member who is not assigned to Medical Group.

1.39 "**Participating Hospital**" means an institution licensed by the State of California as an acute care hospital, skilled nursing facility, or other licensed facility, which has an agreement with Alameda Alliance to furnish Covered Services to Members.

1.40 "**Participating Physician**" means a credentialed Physician certified or authorized to render health care services and who has an agreement with Alameda Alliance or a delegated medical group to furnish Covered Services to Members.

1.41 "**Participating Provider**" means any credentialed health professional, entity or institution certified or authorized to render health care services and who has an agreement with Alameda Alliance or a delegated medical group to furnish Covered Services to Members. Participating Provider includes but is not limited to nurse practitioners, physician assistants, and nurse midwives.

1.42 "**Primary Care Physician**" or "**PCP**" means a Participating Physician selected by a Member or who has been assigned by Alameda Alliance to render first contact medical care and to provide covered primary care services. Primary Care Physicians may include general and family practitioners, internists, pediatricians, and may also include Physicians in other areas of practice or organized groups of Primary Care Physicians (e.g. professional corporations, Community Health Centers, Federally Qualified Health Centers, etc.), to the extent permitted by Alameda Alliance and applicable law.

1.43 "**Provider Grievance**" means Participating Provider's written notice to Alameda Alliance challenging, appealing or requesting reconsideration of a claim, or requesting resolution of billing determinations, such as bundling/unbundling of claims/procedure codes or allowances; or Participating Provider's written notice to Alameda Alliance disputing administrative policies and procedures, administrative terminations, retroactive contracting, or any other contract issue.

1.44 "**Provider Grievance Procedures**" means the procedures for the receipt, handling and resolution of Provider Grievances.

1.45 "**Provider Manual**" means Alameda Alliance manual and bulletins which have been prepared to be consistent with Applicable Requirements which are provided from time to time by Alameda Alliance to Participating Providers. The Provider Manual describes Alameda Alliance Programs, policies, procedures, terms and conditions of the agreement between Alameda Alliance and the Participating Provider for the provision of Covered Services to Members.

1.46 "**Quality Improvement**" or "**Quality Improvement Program**" means the policies and procedures adopted by Alameda Alliance to conduct ongoing quality assessment and improvement to comply with Applicable Requirements including but not limited to California Health and Safety Code Section 1370, and Title 28 CCR Section 1300.70. The policies and procedures that govern the program are set forth in the Provider Manual.

1.47 "**Referral**" means the process by which a Participating Provider directs a Member to seek and obtain specialist services or other Covered Services from a health professional, a hospital, or any other provider of Covered Services.

1.48 "**Self-Referred Sensitive Services**" means services provided by other Participating Providers for Medical Group Medi-Cal Members related to (i) sexual assault; (ii) drug or alcohol abuse for Medical Group Members 12 years or older; (iii) pregnancy; (iv) family planning; (v) sexually transmitted diseases designated by DHCS for Medical Group Members 12 years or older.

1.49 "**Service Area**" means the geographic area within which Alameda Alliance is licensed to operate.

1.50 "**Specialist Physician**" or "**SCP**" means a Participating Physician who is duly licensed and meets Alameda Alliance qualifications to practice his/her designated specialty and who has agreed pursuant to a written agreement with Alameda Alliance or Medical Group to provide Covered Services in his/her designated specialty for Members, pursuant to a Referral from Member's Primary Care Physician, if required.

1.51 "**State**" means the State of California.

1.52 "**Surcharge**" means an additional fee, other than approved Copayments and deductibles, which is charged to a Member for a Covered Service, but which is not approved by the applicable State and Federal regulatory authority, and is neither disclosed nor provided for in the applicable Alameda Alliance Agreement and associated Evidence of Coverage.

1.53 "**Third Party Liability**" means the legal obligation of a third party i.e. individuals, entities or programs to pay all or part of the expenditures for medical assistance furnished under an Alameda Alliance Program.

1.54 "**Timely Access**" means the required time frame for Member access to Covered Services as set forth in Applicable Requirements.

1.55 "**Utilization Management**" or "**Utilization Management Program**" means the programs and processes established by Alameda Alliance to authorize and monitor the utilization of Covered Services provided to Members.

SECTION 2: MEDICAL GROUP REPRESENTATIONS AND WARRANTIES

2.1 Representations/Warranties/Qualifications

Medical Group shall meet the qualifications set forth below throughout the term of this Agreement. Medical Group, on behalf of itself and each Medical Group Provider, hereby represents and warrants the following:

2.1.1 **Qualifications**. Each Medical Group Provider shall possess a current valid license, or other certification in the State of California and maintain a current federal DEA registration, as applicable, to provide the services, equipment, or supplies contemplated in this Agreement and shall not be the subject, either before or during the term of this Agreement, of any disciplinary actions or proceedings under the entity authorized to grant such license or certification; be the subject of any indictments, disciplinary actions or proceedings under the terms of any Alameda Alliance Program; or be the subject of any indictments, disciplinary actions or proceedings by any government entity. Medical Group shall maintain at all times, during the term of this Agreement, the administrative, managerial and financial capacity to perform its obligations hereunder.

2.1.1.1 Board Certified, as applicable, according to the current American Board of Medical Specialties in area of medical practice;

2.1.1.2 Remain eligible to participate in Medicare and Medi-Cal Programs and such other third party payor programs as Alameda Alliance may reasonably require, and accept and continue to accept assignment of patient benefits under each such payor program; and

2.1.1.3 Willing and able to comply with the terms and conditions of this Agreement.

2.1.2 **Credentialing Medical Group**. Each Medical Group Provider and Participating Provider, as further defined in Provider Manual, who are providing Covered Services on behalf of Medical Group under this Agreement shall be approved through the Credentialing process by Alameda Alliance.

2.1.3 **Admitting Privileges**. Each Medical Group Physician shall possess admitting privileges at one or more Participating Hospital or possess formal coverage arrangements with another Participating Physician for admission of Medical Group Members.

2.1.4 **Facility**. Medical Group shall and shall require each Medical Group Provider to maintain a suitable facility for medical treatment of Medical Group Members pursuant to the requirements of Alameda Alliance Programs and acceptable to Alameda Alliance. Accessibility to such facilities shall be in compliance with the requirements of the Americans with Disabilities Act.

2.1.5 **Program Participation**. Medical Group and each Medical Group Provider shall be certified and eligible to participate in the Medi-Cal and/or Medicare Programs in order to participate in such programs. All Medical Group Providers, employees and subcontractors who provide health care services, utilization review, medical social work services, and administrative services shall be eligible to participate in the Medi-Cal or Medicare Program and shall not be excluded from such programs. Medical Group shall maintain any additional qualifications that may be required by law or as deemed appropriate by DHCS, CMS, DMHC, Public Authority or other appropriate government entity, or Alameda Alliance for the enhancement of access to or quality of care.

SECTION 3: MEDICAL GROUP RESPONSIBILITIES FOR PROVISION OF SERVICES

3.1 Covered Services.

Medical Group shall provide or arrange for the provision of all Covered Services to Medical Group Members for Alameda Alliance Programs set forth in Exhibit A through Medical Group Providers who have been credentialed as required by this Agreement and as more fully described in the Provider Manual. Nothing expressed or implied herein shall require Medical Group to provide to the Medical Group Member, or order on behalf of the Medical Group Member, Covered Services which, in the professional opinion of Medical Group Provider, are not Medically Necessary. Medical Group shall be responsible for the management of each Medical Group Member's medical care as follows:

3.1.1 **Provision of Covered Services**. Medical Group shall promote and maintain the health of Medical Group Member by providing all Covered Services within the scope of Medical Group's practice and managing other Covered Services provided to each Medical Group Member through face-to-face, telephonic contacts or email interface with Medical Group Member. In a manner consistent with existing professional standards, Medical Group and Medical Group Providers shall be responsible for: (i) the diagnosis and treatment of medical conditions; (ii) the coordination of inpatient Covered Services (including discharge planning); (iii) the provision of preventive health services to which a Medical Group Member is entitled; and (iv) making available to Medical Group Members those health education programs routinely provided by Medical Group and Medical Group Providers at no charge to their patients. Alameda Alliance shall not intervene in any way or manner with the provision of health care services by Medical Group Provider; it being understood and agreed that the traditional relationship between provider and patient will be maintained. Notwithstanding the foregoing, Alameda Alliance retains the right to review the care provided to Members by Medical Group Providers as part of Alameda Alliance's Quality Improvement and Utilization Management Programs.

3.1.2 **Covering Physician**. If, from time to time, Participating Physician is for any reason unable to provide covered services due to illness, vacation or other absence, Participating Physician shall engage another qualified Participating Physician to perform such Covered Services in Participating Physician's (Covering Physician). Participating Physician shall ensure that any such Covering Physician shall (a) accept and abide by all of the terms and conditions of this Agreement and Alameda Alliance Agreement; and (b) not bill Alameda Alliance or any person other than Participating Physician for the performance of services to Members. Participating Physician shall be solely responsible for compensating all such Covering Physicians.

3.1.3 **After hours On Call**. Participating Physician shall provide or make arrangements for Members to receive Covered Services twenty-four (24) hour-per-day, seven (7) day-per-week including after business hours, weekends and holidays as specified.

3.1.4 **Medical Necessity**. Medical Group shall make Medical Necessity determinations for Medical Group Members and shall determine the method, details and means of performing Covered Services pursuant to the terms of this Agreement. When those determinations are appealed, Medical Group will assist Alameda Alliance by providing relevant medical records and participating in grievance,

arbitration, and other proceedings. Moreover, Medical Group agrees to cooperate with and abide by the Medical Necessity determination of any external review entity to which Alameda Alliance is obligated by law.

3.1.5 **Final Decisions and Exchange of Medical Group Member Information.** All final decisions regarding coverage are reserved to Alameda Alliance, and Medical Group shall refer Medical Group Members who have inquiries or disputes regarding such coverage to Alameda Alliance for response and resolution. This provision, however, does not and shall not be construed to prohibit any Medical Group Provider from providing any medical treatment, or other advice which such Medical Group Provider believes to be in the best interest of the patient. No provision of this Agreement shall be construed to prohibit, nor shall any provision in any contract between Medical Group and its employees or subcontractors prohibit, the free, open and unrestricted exchange of any and all information of any kind between Medical Group Providers and Medical Group Members regarding the nature of Medical Group Member's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under Medical Group Member's health plan, and Medical Group Member's right to appeal any adverse decision made by Medical Group or Alameda Alliance regarding coverage of treatment which has been recommended or rendered.

3.1.6 **Performance Standards**. All Covered Services provided to Medical Group Members shall meet professionally recognized standards of practice including those set forth in the Provider Manual.

3.1.7 **Non-Discrimination.** Medical Group Providers shall treat all Medical Group Members, in a non-discriminatory manner, pursuant to Section 12.1 of the Agreement and in the same manner as their other patients, except as limited by this Agreement.

3.1.8 **Advance Health Care Directive**. Medical Group Providers shall document in a prominent place in medical record if Member has executed an Advance Health Care Directive.

3.2 Availability

Medical Group Providers shall be available to provide Timely Access to Covered Services so that Medical Group Members, in accordance with the policy and procedures of Alameda Alliance and Applicable Requirements, may be appropriately served by medical advice and supervision seven (7) days a week and twenty-four (24) hours a day, either directly or through adequate coverage arrangements. Medical Group Providers shall be available for telephone consultations with Medical Group Members and other Participating Providers as may be appropriate to meet the needs of Medical Group Members and other Participating Providers.

3.2.1 **Timely Access.** Medical Group will provide Covered Services in compliance with timely access standards outlined in Title 28 CCR Section 1300.67.2.2, the Provider Manual and as follows, as applicable:

3.2.1.1 Prenatal care appointments shall be offered within fourteen (14) days.

3.2.1.2 Non-urgent care appointments with primary care physicians shall be offered within ten (10) business days of request.

3.2.1.3 Non-urgent care appointments with specialist physicians shall be offered within fifteen (15) days of request.

3.2.1.4 Urgent care appointments that do not require authorization shall be offered within forty-eight (48) hours of request.

3.2.1.5 Non-urgent appointments for Ancillary Services (for diagnosis of treatment of injury illness, or other health condition) shall be offered within fifteen (15) days of request.

3.2.1.6 Non-urgent appointments with a non-physician mental health provider shall be offered within ten (10) days of request.

3.3 Eligibility Verification and Procedures

3.3.1 **Eligibility Verification System**. Medical Group shall and shall require each Medical Group Provider to utilize the eligibility verification system as set forth in the Provider Manual to confirm the eligibility of Medical Group Members.

3.3.2 **Eligibility and Identification Verification**. Prior to offering services or obtaining a Referral or Authorization for Covered Services, Medical Group and/or Medical Group Providers are required to verify identification and eligibility of Medical Group Members on the date of service as follows:

3.3.2.1 By electronic or telephonic contact with Alameda Alliance or via the Alameda Alliance website; and

3.3.2.2 By the examination of Alameda Alliance Member identification card and a form of photo identification, or if no Member identification card has yet been issued, two (2) other forms of identification, one of which shall be a photo identification. If Member is a minor, parent's identification will be acceptable if Member's eligibility is verified with Alameda Alliance.

3.3.3 **Improper Verification**. Alameda Alliance assumes no responsibility, financial or otherwise, for patients misrepresenting themselves as Members where eligibility is not properly verified by Medical Group.

3.3.4 **Member Ineligibility**. For any Member who became ineligible, but whose ineligibility was not properly noted on Alameda Alliance's eligibility list at the time of ineligibility, and for whom Medical Group inappropriately received such payments, Alameda Alliance shall have the right to deduct from payment to Medical Group amounts equal to any payments made. Alameda Alliance shall have no obligation to compensate Medical Group for such services in the event that such deleted Member is covered during the period of retroactive deletion by another government program, health care service plan, insurer, or third party payor.

3.4 Referrals and Authorizations

Medical Group may refer Medical Group Members for Medically Necessary Covered Services that are not within the Medical Group Provider's scope of practice to Participating Providers in accordance with Alameda Alliance's Referral and Authorization procedures set forth in Provider Manual. As required by law, PCP referrals include, but are not limited to referrals to Alameda Alliance behavioral health program/vendor for autism services.

3.4.1 **Alameda Alliance Authorization**. Medical Group PCPs may make Referrals to Participating Providers without Authorization from Alameda Alliance. Specialist Physician may refer Members to Participating Providers in accordance with Alameda Alliance's Referral and Authorization procedures set forth in Provider Manual. Alameda Alliance shall provide Medical Group with a list of Participating Providers to whom Referrals may be made. Referrals outside of the Alameda Alliance contracted network shall require an Authorization by Alameda Alliance. Prior Authorization shall not be required for Emergency or Self-Referred Sensitive Services.

3.4.2 **Hospital Admissions**. Except for Emergency or Self-Referred Sensitive Services, Medical Group shall obtain a written Authorization prior to any elective hospital admission. Medical Group Providers shall admit Members requiring inpatient hospital or other covered inpatient health care services only to a Participating Hospital or other facility authorized by Alameda Alliance and shall comply with the hospital admissions procedures established by Alameda Alliance as set forth in the Provider Manual.

3.5 Emergency Services

3.5.1 **Compliance with Emergency Room Regulations**. In the event that a Medical Group Member presents to an emergency room for medical care, Medical Group and Medical Group Providers shall comply with DHCS, CMS, and DMHC regulations as applicable regarding emergency and urgent care.

3.5.2 **Monitoring of Emergency Services**. Medical Group and Medical Group Providers shall be responsible for the monitoring of all health care services rendered to Medical Group Members including, at all times, situations where an attending physician or other health care provider furnishes urgent care or Emergency Services or actively engages in the treatment or evaluation of a Medical Group Member's condition.

3.5.3 **Post Stabilization Care/Transfer.** Medical Group will provide services to treat Members, then call the Alliance for authorization once the Medical Group determines a Member is stable for transfer or to obtain authorization for post stabilization care in accordance with the Alameda Alliance's Provider Manual policies and procedures.

3.6 Provision of Equipment/Supplies/Personnel

Medical Group and/or Medical Group Providers shall supply all equipment, supplies and personnel necessary to perform this Agreement and provide Covered Services to Members. Each Medical Group Provider shall be responsible, at Medical Group's sole cost and expense, for providing licensed persons or technicians to assist Medical Group Providers to provide Covered Services. Medical Group Providers shall supervise all personnel used to provide Covered Services and shall ensure that they possess and maintain current/valid licenses and certifications required by law for the performance of the services provided. Medical Group agrees upon the request of Alameda Alliance to provide current practice information regarding such licensed persons and technicians to Alameda Alliance. Medical Group and each Medical Group Provider agree to not employ or contract with individuals excluded from participation in State- or Federally-funded programs. Medical Group shall immediately notify Alameda Alliance if it or one of its Medical Group Providers or any of its or the Medical Group Providers' employees or subcontractors is debarred from any State or Federal program.

3.7 Outpatient Drug Formulary and Pharmacy Information

3.7.1 **Compliance with Outpatient Drug Formulary**. Medical Group and Medical Group Providers shall comply with the outpatient drug formulary, drug authorization forms and requirements, and pharmacy benefit design (including maximum supplies, use of generics, and mail order for maintenance drugs), as adopted and periodically modified by Alameda Alliance and as set forth in the Provider Manual.

3.7.2 **Use of Prescription Data.** Medical Group agrees that data regarding prescriptions obtained by and drugs supplied to Medical Group Members are provided for the limited and restricted purpose of Utilization Management. Under no circumstances may Medical Group or Medical Group Providers copy or share such data with others, or utilize such data, in whole or in part, directly or indirectly, to negotiate rebates, discounts, or contracts with pharmaceutical manufacturers or other suppliers of pharmaceuticals.

3.7.3 **Pharmacy Information.** Medical Group acknowledges that Alameda Alliance and its designees retain sole authority to perform, in relationship to outpatient pharmacy, pharmacy claims processing, formulary development, an Authorization program, selection and contracting of a pharmacy network, and determination of pharmacy benefit design.

3.8 Utilization Management

Medical Group and Medical Group Providers shall cooperate with Alameda Alliance in the implementation of the Utilization Management Program established by Alameda Alliance set forth in the Provider Manual which has been established to review and manage the utilization of health care services, provide procedures for the coordination and monitoring of a Medical Group Member including, but not limited to medical evaluation of Medical Group Members' health condition, referral, consultation, admission to hospitals, follow up care and coordination of referred health care services in order to make sure that Medical Group Member receives cost effective, quality care. Alameda Alliance will share with Medical Group utilization data that DHCS has provided to Alameda Alliance to assist Medical Group with Member care coordination.

SECTION 4: MEDICAL GROUP ADMINISTRATIVE RESPONSIBILITIES

4.1 Conduct

4.1.1 **Prohibition of Coercion of Members**. Medical Group and Medical Group Providers shall not coerce, threaten or intimidate Members into making a particular choice of health care coverage. Medical Group Providers shall not influence Members to change health care coverage for the purpose of financial gain to Medical Group or Medical Group Providers. Medical Group and Medical Group Providers may freely communicate with Members regarding the treatment options available to them, including medications and alternative medications and/or Non-Covered Services, regardless of benefit coverage limitations.

4.1.2 **Representation of Benefits**. Medical Group and Medical Group Providers shall not discuss reimbursement or knowingly make inaccurate or misleading statements about Alameda Alliance Program benefits.

4.1.3 **Non-Solicitation**. Medical Group and Medical Group Providers shall not solicit Members on behalf of any other independent practice association, medical group, health maintenance organization or insurance company. Solicitation shall mean conduct by Medical Group, Medical Group Providers, office staff, agent, or employee of Medical Group, which may be reasonably interpreted as designed to persuade Members to discontinue their membership with Alameda Alliance.

4.2 Membership

4.2.1 **Member Selection or Assignment**. Members may select any PCP within Member's applicable Alameda Alliance Program. For Members who do not make a selection, Alameda Alliance shall assign Members to a PCP in a systematic and appropriate manner in accordance with Alameda Alliance procedures which may consider factors including, but not limited to, the PCP's language capabilities, office location and the specialty type of the PCP. Medical Group shall and shall require each Medical Group Provider to accept all Members who select, or are assigned to Medical Group Provider, unless Medical Group requests in writing to close Medical Group Provider's practice to all new Members. Medical Group Providers shall accept and maintain Medical Group Members without regard to health status, frequency of visits, costs of care or cultural or linguistic factors. Medical Group acknowledges that a Member may request transfer between Medical Group Physicians in accordance with Member's applicable Alameda Alliance Program and Evidence of Coverage.

4.2.2 **Member Reassignment**.

4.2.2.1 **Member Reassignment Upon Medical Group Provider Termination**. In the event that a Medical Group Provider's employment or contractor relationship with Medical Group is terminated, or Medical Group Provider is removed from service to Medical Group Members pursuant to section 4.2.3, Alameda Alliance shall notify Member of such termination. Member shall have the right to select another Medical Group Provider or another Participating Provider not affiliated with Medical Group. In the event that Member does not select a new Participating Provider, Alameda Alliance shall assign Member to a new Participating Provider. Reassignment of Medical Group Members shall be in accordance with the provisions set forth in the Provider Manual.

4.2.2.2 **Member Reassignment Upon the Request of Medical Group**. Medical Group and/or a Medical Group Provider shall not request reassignment of a Medical Group Member to another Participating Provider due to a Medical Group Member's medical condition, frequency of visits, costs of care, or cultural or linguistic factors. Medical Group may request in writing that a Medical Group Member be reassigned to a different Participating Provider only if Medical Group can show just cause in writing, to the satisfaction of Alameda Alliance, that health care services can no longer be successfully provided for reasons other than health status, frequency of visits, costs of care or cultural or linguistic factors. Reassignment of Medical Group Members shall be in accordance with the provisions set forth in the Provider Manual.

4.2.2.3 **Right to Reassign**. Notwithstanding the foregoing, when the consent of a governmental agency to the termination of a physician-patient relationship is required pursuant to its rules

and regulations, neither Medical Group nor a Medical Group Provider may terminate the physician-patient relationship with a Member without first obtaining the consent of Alameda Alliance and the applicable governmental agency.

4.2.3 **Termination of Medical Group Provider at the Request of Alameda Alliance**. Alameda Alliance may require that Medical Group remove from service to Medical Group Members any Medical Group Provider, based upon a finding by Alameda Alliance that Medical Group Provider is in non-compliance with this Agreement. Alameda Alliance retains the right to (i) suspend the assignment or selection of new Members to Medical Group or Medical Group Providers; or (ii) reassign all or part of a Medical Group Provider's Members to any Participating Providers upon a finding that a Medical Group Provider is in non-compliance with this Agreement. In the event that Alameda Alliance takes any action permitted by this section, this Agreement shall continue in effect as to the Medical Group and other Medical Group Providers unless terminated by either party as set forth in section 12 of this Agreement.

4.2.4 **Provider Preventable Condition (PPC)**. Provider Preventable Conditions are defined in federal obligations as Other Provider Preventable Conditions (OPPCs) in all health care settings and Health Care Acquired Conditions (HCACs) in inpatient hospital settings. Within five (5) calendar days of discovering a PPC, and confirming the patient is an Alameda Alliance Member, the Medical Group will complete the regulatory form and submit it to Alameda Alliance's Quality Department.

4.3 Provider Network and Practice Information

Medical Group shall provide Alameda Alliance with the current practice information for each Medical Group Provider as set forth in Exhibit G and shall comply with the following:

4.3.1 **Credentialing of Providers**. Medical Group Providers, Covering Physicians and Participating Providers shall meet the Credentialing requirements of Alameda Alliance and shall be subject to the Credentialing process and NCQA requirements set forth in the Provider Manual prior to providing any health care services to Members. Only credentialed Medical Group Providers, Covering Physicians and Participating Providers may provide health care services to Medical Group Members. Medical Group shall submit to Alameda Alliance sufficient Credentialing data to enable Alameda Alliance to determine that Medical Group Provider meets Alameda Alliance's minimum qualifications. Failure to provide re-credentialing information or meet Alameda Alliance's minimum standards may result in the termination of Medical Group Provider as a Participating Provider. Each credentialed Medical Group Provider shall be re-credentialed every three (3) years or as requested by Alameda Alliance.

4.3.2 **Change in Medical Group Status**. The composition of Medical Group may change from time to time and Medical Group may add Medical Group Providers at its discretion so long as any such new Medical Group Providers agree to comply with the terms of this Agreement before rendering any Covered Services or being assigned any Medical Group Members. Medical Group shall make best efforts to provide written notification to Alameda Alliance at least sixty (60) calendar days in advance of the termination of a Medical Group Provider or any material change in the provider composition of Medical Group, any change of name, address, telephone number, office hours, tax identification number, NPI, license status or number. Medical Group and Medical Group Providers shall, at the request of Alameda Alliance, assist Alameda Alliance in preparing regulatory filings relating to provider composition of Medical Group and Medical Group Providers in accordance with section 5.1 of this Agreement.

4.3.3 **Complaints or Disciplinary Action**. Medical Group shall immediately report all findings of liability in any civil, criminal or administrative action involving professional competency or any felony of a Medical Group Provider. Medical Group shall immediately notify Alameda Alliance of: (i) any written complaint filed against any Medical Group Provider which would be reportable under Section 805 of the California Business and Professions Code or the National Practitioner Data Bank; (ii) any disciplinary action taken against a Medical Group Provider as an individual by any hospital, medical facility, medical group or association, State or Federal licensing body, or other entity; (iii) any Medical Group Provider who has become a defendant in a lawsuit filed by a Member or is required or agrees to pay damages to a Member for any reason; (iv) any Medical Group Provider has been disbarred from any federal program, or v) any other findings of liability in any civil, criminal or administrative action involving professional competency or commission of any felony. Immediately upon their availability, Medical Group shall submit to Alameda Alliance copies of any adverse findings from any State or Federal entity reviewing or auditing

any Medical Group or any Medical Group Provider. Findings may be subject to Alameda Alliance peer review.

4.4 Provider Dispute Resolution

4.4.1 **Dispute and Post Dispute Procedures**. Medical Group shall establish and maintain a fast, fair, and cost-effective mechanism to process and resolve Medical Group Provider disputes in accordance with all applicable requirements of the Knox-Keene Act, including but not limited to California Health and Safety Code Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations. Except for matters that are subject to other grievance procedures as described in section, in the Provider Manual, and excluding any dispute arising out of, relating to, or in connection with any malpractice or professional liability claim (unless expressly consented to by the parties insurance carriers) if the parties hereto are unable to resolve any dispute arising out of, relating to or in connection with this Agreement, or the construction of interpretation of this Agreement, and the internal dispute resolution process has been exhausted without achieving a resolution, then both parties agree to continue to engage for a period of no less than thirty (30) calendar days, in good faith effort to resolve prior to moving with litigation. No claim arising under this Agreement shall accrue until such time as the thirty (30) calendar day period has expired.

4.4.2 **Failure to Comply with Dispute Procedures**. Medical Group agrees that, in the event Medical Group's provider dispute resolution procedures fail to comply with the obligations set forth in section 4.4.1 above, Alameda Alliance may, as required by applicable State and Federal law, assume responsibility for the administration of Medical Group's provider dispute resolution process and for the resolution of provider disputes relating to Alameda Alliance Members.

4.4.3 **Provider Appeal Rights**. Medical Group agrees that, if a provider submits a dispute in accordance with the Medical Group Provider dispute resolution process which involves an issue of Medical Necessity or utilization review relating to an Alameda Alliance Member, such Medical Group Provider shall have an unconditional right to appeal that dispute to Alameda Alliances Provider Grievance Procedures for a de novo review and resolution of the dispute. Such an appeal must be submitted to Alameda Alliance within sixty (60) calendar days from the date of Medical Group communicated its denial of the appeal to the Medical Group Provider.

4.4.4 **Medical Group Provider Agreements**. Medical Group shall be responsible for each Medical Group Provider's performance under this Agreement and shall ensure that each Medical Group Provider is aware of and compliant with the terms of this Agreement. Each Medical Group Provider furnishing services on behalf of Medical Group Providers shall be subject to all terms and conditions of this Agreement. Medical Group shall have a written employment or subcontractor agreement that complies with the terms of this Agreement and all Applicable Requirements, with each Medical Group Provider who will provide Covered Services to Medical Group Members pursuant to this Agreement.

4.4.5 All future model forms of written employment or subcontractor agreements shall be submitted to Alameda Alliance and Medical Group shall make available to Alameda Alliance any individual written employment or subcontractor agreement upon the request of Alameda Alliance.

4.4.6 **Disclosure of Provider Profiling**. Medical Group shall, upon request from Alameda Alliance, provide Alameda Alliance with information regarding any economic profiling of Medical Group Providers by Medical Group in order to permit Alameda Alliance to comply with the provisions of Section 1367.02 of the California Health and Safety Code. Further, to the extent that group utilizes economic profiling as defined in Section 1367.02 of the California Health and Safety Code, Medical Group shall provide copies of economic profiling information to Medical Group Providers in accordance with the requirements of Section 1367.02.

4.5 Quality Improvement

It is understood by the parties hereto that the Alameda Alliance has established a Quality Improvement Program in order to assure a standard of care consistent with California Health and Safety Code Section 1370, Title 22 California Code of Regulations Section 53280, and Title 28 California Code of Regulations

Section 1300.70, and with Alameda Alliance policies and standards. Medical Group shall cooperate with and participate in Alameda Alliance Quality Improvement Program as set forth in the Provider Manual. Medical Group shall comply with the Quality Improvement Program, Utilization Management Program, and credentialing and re-credentialing activities, including Facility Site Reviews (FSR). Medical Group shall provide timely documentation for Healthcare Effectiveness Data and Information Set (HEDIS) and other quality improvement activities.

4.6 Culturally and Linguistically Appropriate Services (CLAS) Program

Alameda Alliance established and maintains an ongoing CLAS Program, and maintains ongoing administrative and financial responsibility for implementing and operating such program, to ensure access to care for limited and non-English speaking Medical Group Members and/or Members who are sensory impaired, as required by Applicable Requirements relating to language assistance regulations. Medical Group shall and shall require each Medical Group Provider to cooperate and comply with Alameda Alliance's CLAS Program as described in Provider Manual and Applicable Requirements regarding cultural and linguistic services. Such services shall be available at all Medical Group locations where Members receive services from Medical Group Providers. Medical Group shall provide its employees training on cultural competency, sensitivity and diversity training.

4.7 Facility Site Review

Facilities used by Medical Group and/or each Medical Group Provider to provide Covered Services shall comply with provisions of Title 22, CCR, Section 53230 and Title 28, Section 1300.80. Medical Group Providers agree to allow access to the facilities used in the provision of Covered Services pursuant to the terms and conditions of this Agreement to Alameda Alliance, and all State and Federal agencies that have statutory or regulatory authority to inspect and license or certify health facilities. In the event that government officials or Alameda Alliance find any deficiencies in such facilities or records, Medical Group or Medical Group Provider, as applicable, shall have thirty (30) calendar days to substantially correct such deficiencies which are identified by such government officials or Alameda Alliance. If Medical Group or Medical Group Provider fails to substantially correct such deficiencies, Alameda Alliance may at its sole discretion (i) suspend the assignment of selection of new Members to Medical Group; (ii) reassign all or part of Medical Group Members to another Participating Provider; or (iii) terminate this Agreement.

4.8 Required Disclosure

4.8.1 **Articles of Incorporation and Bylaws**. Medical Group shall provide to Alameda Alliance, if applicable and upon request, a copy of the Articles of Incorporation and Bylaws of Medical Group, and all amendments thereto.

4.8.2 **Disclosure Statement**. Medical Group shall, if applicable and upon request, provide Alameda Alliance with a disclosure statement listing major creditors individually holding more than five percent (5%) of the debt of Medical Group. Medical Group shall provide to Alameda Alliance an updated disclosure statement in the event of a change in creditors as described above.

4.8.3 **Material Adverse Effects**. Medical Group shall notify Alameda Alliance immediately in writing when Medical Group becomes aware of the occurrence of any of the following events: (i) Medical Group's or a Medical Group Provider's professional and general liability insurance is canceled, terminated, not renewed, or materially modified; (ii) an act of nature or any event occurs which has a materially adverse effect on Medical Group's ability to perform Medical Group's obligations hereunder; (iii) a petition is filed to declare Medical Group bankrupt or for reorganization under the bankruptcy laws of the United States or a receiver is appointed over all or any portion of Medical Group's assets; or (iv) Medical Group is sued, or suit is threatened in writing, by a healthcare provider for nonpayment of compensation; or (v) any other situation arises which could reasonably be expected to materially affect Medical Group's ability to carry out Medical Group's obligations under this Agreement.

4.8.4 **Medical Group Changes**. Medical Group shall also provide Plan with thirty (30) calendar days advance notice of (i) any proposed material change in the ownership of Medical Group, (ii) a change in its management services organization (if any), or (iii) the sale of all or substantially all of the assets of

Medical Group. Medical Group shall obtain Alameda Alliance's prior approval of same, which approval shall not be unreasonably withheld.

4.8.5 **Financial Statement**. Upon request, Medical Group shall provide to Alameda Alliance a copy of its financial statements which may include the auditor's opinion letter, annual income statement, balance sheet, and statement of cash flow, and notes to the financial statements.

4.9 Certification Regarding Lobbying

If applicable and upon request, Medical Group shall provide Alameda Alliance with a certification regarding lobbying. Such certification shall be in a form acceptable to Alameda Alliance and include the following terms:

4.9.1 **Federally Appropriated Funds**. No Federally appropriated funds have been paid or will be paid, by or on behalf of Medical Group or Medical Group Providers, to any person influencing or attempting to influence an officer or employee of an agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into this Agreement and the extension, continuation, renewal, amendment, or modification of this Agreement.

4.9.2 **Non-Federally Appropriated Funds**. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Agreement, Medical Group and/or Medical Group Provider shall complete and submit any additional forms that may be required to comply with Applicable Requirements.

4.10 Liability and Responsibility for Employees and/or Subcontractors

Medical Group shall and shall require each Medical Group Provider to be solely responsible for the satisfaction of any and all obligations it assumes with respect to any person it retains, employs or subcontracts with to assist in its performance under this Agreement. Such obligations shall include, but not be limited to, payment of all Federal and State withholding taxes applicable to employees, compliance with Federal and State wage-hour obligations (including overtime), workers compensation obligations, unemployment insurance obligations, and other applicable taxes and contributions to government-mandated employment-related insurance and similar programs. Under no circumstances shall Alameda Alliance, the Federal Government, the State of California or the County of Alameda incur any liability under this section.

4.11 Compliance

Without limiting any of Medical Group's other obligations under this Agreement, Medical Group shall comply with all Applicable Requirements as they may from time to time be amended or superseded, including but not limited to physician incentives and Federal stop loss requirements. Any provision required to be in this Agreement by the Applicable Requirements, whether or not provided in the contract, shall bind Alameda Alliance and Medical Group. In the event of any conflict or inconsistency between the Provider Manual, this Agreement, and/or any State or Federal laws and regulations, the provision which governs shall be determined by the following order of precedence: Federal law, regulations, and instructions; State law, regulations and instructions including, but not limited to the Knox-Keene Act; this Agreement; and then the Provider Manual. Unless a change is required by State or Federal law, notice of Material changes will be given in accordance with California Health and Safety Code Section 1375.7 the Provider Bill of Rights.

4.12 Other Programs

Medical Group shall participate in all Alameda Alliance Programs which may be offered to Medical Group in Alameda Alliance's sole discretion, under financial terms comparable to those contained herein. Medical

Group shall be governed by the terms specified for each Program as described herein and the Provider Manual.

4.13 Use of Name

Medical Group consents to the use of Medical Group's and Medical Group Provider names by Alameda Alliance for the purpose of promoting their association with Alameda Alliance in any reasonable manner which Alameda Alliance considers to be beneficial to Alameda Alliance.

4.14 Alameda Alliance Committees

Medical Group Physicians shall serve on such committees of Alameda Alliance as Alameda Alliance may from time to time reasonably request.

4.15 Notification

Medical Group shall immediately notify Alameda Alliance of any actual or threatened malpractice demands, judgements, or any actual or threatened loss, suspension, probation, or limitation of (a) any license or registration, (b) any Payor certification or authorization, or (c) any medical staff membership or clinical privileges.

4.16 Provider Directory Updates.

Provider shall comply with SB137 amended Section 1367.27 of the Health and Safety Code and provide additional information on an ongoing basis for updating the Alameda Alliance's Provider Directory. This updated provider information will be listed in accordance with Exhibit G, Provider Directory Updates.

SECTION 5: ALAMEDA ALLIANCE RESPONSIBILITY

5.1 Administration

Notwithstanding the terms and provisions of this Agreement, Alameda Alliance maintains, under the terms of Alameda Alliance Programs and Agreements, full responsibility for adhering to and otherwise fully complying with all terms and conditions of Alameda Alliance Programs and Agreements. Alameda Alliance shall perform all necessary administrative, accounting and reporting requirements and other functions consistent with Applicable Requirements and Alameda Alliance Agreements and the administration of this Agreement. Alameda Alliance shall establish and maintain ongoing monitoring and oversight of Medical Group's performance of Medical Group's obligations in connection with the applicable Alameda Alliance Program. Medical Group agrees to cooperate with Alameda Alliance in its efforts to comply with the terms and conditions under the applicable Alameda Alliance Agreement(s).

5.2 Provider Manual/Provision of Protocols and Procedures

A Provider Manual shall be provided to Medical Group by Alameda Alliance. The Provider Manual, as may be amended from time to time, is incorporated herein by reference. To the extent of any conflict between this Agreement and the Provider Manual, the terms of this Agreement shall govern. Changes and updates to the operational policies in the Provider Manual shall be made periodically through provider bulletins and/or amendments to the Provider Manual. Alameda Alliance shall notify Medical Group with forty-five (45) calendar days written notice (or other mutually agreed upon time frame) prior to implementation of any changes or revisions to the Provider Manual, unless the change is necessary to comply with either State or Federal law or regulations, or accreditation requirements. Such changes shall not preclude Medical Group from exercising Medical Group's right to terminate this Agreement prior to implementation of said change(s) pursuant to SECTION 11: TERM, TERMINATION AND NOTICE.

5.3 Member Eligibility/Rosters

Alameda Alliance shall maintain a system for Member identification, including Member Identification Cards and electronic interface between Medical Group Provider and Alameda Alliance to enable Medical

Group Provider to promptly determine a Member's eligibility for services. Medical Group hereby consents to Alameda Alliance using Medical Group's address, phone number, office hours, language skills, type of practice, willingness to accept patients, such as Board Certification, availability of handicapped access, and availability of public transit to Medical Group's office(s).

5.4 Disclosure of Information

Alameda Alliance shall make available to Medical Group, upon contracting and upon written request as well as on-line, such information as is required by the regulations of Title 28 California Code of Regulations Sections 1300.71(l) and (o). Alameda Alliance shall make the information available in the Provider Manual and on the Alameda Alliance website.

5.5 Support Services

Alameda Alliance will assist Medical Group in all aspects of Medical Group's affiliation with Alameda Alliance and participation in Alameda Alliance.

SECTION 6: PAYMENTS

6.1 Payment for Covered Services Provided by Medical Group

In exchange for Covered Services and related administrative services provided in accordance with the terms of this Agreement, Alameda Alliance shall pay to Medical Group a monthly Capitation, if applicable, Fee-for-Service and other compensation as set forth in Exhibits B, B1, C, C1 and D.

6.1.1 Capitation

6.1.1.1 **Capitation and Other Payments**. As applicable, Alameda Alliance shall pay to Medical Group a Capitation, in the amount set forth in Exhibit B1.

6.1.1.2 **Encounter Data Submission**. Medical Group shall submit encounter data and claims for services in accordance with the Provider Manual and in a timely manner, not to exceed one hundred and eighty (180) calendar days from the date of service. At a minimum, encounter and claims submissions must include all requisite fields set forth in the Provider Manual and comply with all billing conventions for CMS-1500 forms or such other forms as may be requested by Alameda Alliance from time to time. Such submissions shall include the actual dates each claim was received and adjudicated. By submitting claims or encounter data to Alameda Alliance, Medical Group will be deemed to have certified the completeness and truthfulness of the claim or data.

6.1.1.3 **Offset of Capitation Payments**. As applicable, Alameda Alliance shall offset against Capitation payments to Medical Group for those payments made by Alameda Alliance for Capitated Services, when such payment is necessary (i) to provide timely Medically Necessary services to a Medical Group Member or (ii) to fulfill a statutory or regulatory obligation and thereby avoid an adverse impact on Alameda Alliance. It is understood that Alameda Alliance shall first request Medical Group make such appropriate payment, and Alameda Alliance may then make payment if Medical Group fails to do so in a timely manner.

6.1.2 **Fee-For-Service Payment**. For Non-Capitated Services, Medical Group shall bill Alameda Alliance for the provision of services in accordance with the procedures as set forth in the Provider Manual. Alameda Alliance shall pay Medical Group for complete claims for Covered Services provided in accordance with the terms of the Agreement at the rates set forth in Exhibits B, B1, C, C1 and D, as applicable, minus any applicable co-payment. In order to receive payment for services rendered, not included in Capitation payment, Medical Group shall submit claims to Alameda Alliance within one hundred and eighty (180) calendar days from the date of service for authorized health care services provided to Members. The claim must be submitted on a CMS 1500 claim form (or its successor forms) and shall include all information necessary to verify and substantiate the provision of and charges for health care services, including providing the Authorization number, as applicable. Alameda Alliance may deny payment for any bills not received by Alameda Alliance within one hundred and eighty (180)

calendar days of the date of service and in such event, neither Medical Group nor Medical Group Providers may bill Member for such services. If Alameda Alliance denies payment for failure of timely filing, Medical Group has only 365 calendar days of such denial to appeal following such denial.

6.1.2.1 **Payment Timeframe.** Upon submission of a complete and uncontested Clean Claim, payment or denial shall be made to Medical Group within forty-five (45) working days. An uncontested Clean Claim shall include all information needed to process the claim.

6.1.2.1.1 Alameda Alliance shall notify Medical Group in writing not later than forty-five (45) working days after receipt of a claim by Alameda Alliance if Alameda Alliance intends to contest or deny the claim. The notice shall identify the portion of the claim that is contested and the specific reason Alameda Alliance is contesting the claim. If the claim is contested because Alameda Alliance has not received the information necessary to determine Alameda Alliance liability for the claim, Medical Group shall have forty-five (45) working days from the date of the notice to provide the information requested. Thereafter, Alameda Alliance shall complete its consideration of the claim within forty-five (45) working days after Alameda Alliance receives the information requested by Alameda Alliance.

6.1.2.2 If Alameda Alliance identifies an overpayment it has made to Medical Group, it may request a refund of such overpayment within three hundred sixty-five (365) calendar days of the date the payment was made, unless the overpayment is the result of fraud or misrepresentation on the part of Medical Group. Alameda Alliance shall notify Medical Group in writing of such overpayment. Medical Group shall have thirty (30) calendar days to contest Alameda Alliance's notice in writing. Alameda Alliance shall process Medical Group's contest in accordance with the provisions of the Provider Manual. If Medical Group does not contest Alameda Alliance's notice, Medical Group shall have thirty (30) calendar days to reimburse Alameda Alliance or Alameda Alliance may offset such overpayment from amounts due to Medical Group with a written detailed explanation of such offset. Alameda Alliance's procedures for notification of overpayments and notification of recovery of overpayments shall be in accordance with Title 28 of the California Code of Regulations Section 1300.71(d).

6.1.3 **Pay for Performance.**

6.1.3.1 **Payment.** Alameda Alliance may pay Medical Group a performance based payment(s) according to the criteria communicated to all Alameda Alliance Participating Providers. Such payment(s) may include, but are not limited to, Medical Group's performance in administrative and quality measures reflective of the Healthcare Effectiveness Data Information Set (HEDIS) Reporting, patient satisfaction, site review scores, and timely reporting of encounter data. The performance based payment(s) shall be made no later than one hundred twenty (120) calendar days following the end of Alameda Alliance's fiscal year each June 30th.

6.1.3.2 **Performance Based Payment(s).** To be qualified to receive performance based payment(s), Medical Group shall be in good standing with Alameda Alliance (i) for the twelve month fiscal year and through the date of the payment distribution and (ii) for whom a Medical Services Agreement was in effect as of June 30 of the fiscal year for which the payment is being determined. The payment(s) may be decreased or eliminated at the sole discretion of Alameda Alliance.

6.1.3.3 **Timeliness.** The timeliness of payment by Alameda Alliance may be contingent upon and may be delayed or deferred as a result of non-payment or deferral of payment from the California Department of Health Care Services to Alameda Alliance. Once Alameda Alliance receives full payment from DHCS Alameda Alliance shall pay Participating Physician within ten (10) working days.

6.2 Payments for Non-Covered Services

To the extent permitted by law and subject to the obligation to coordinate benefits, Medical Group may seek payment directly from or on behalf of Medi-Cal and Group Care Members for Non-Covered Services at Medical Group's usual and customary charges for such services. Notwithstanding the above, in order to seek payment from a Member, Medical Group or Medical Group Provider must first have advised Member in writing, before the services were rendered, that the services in question will not be covered

and that, if Member decides to obtain the services, Member will be financially liable for payment for those services.

6.3 Third Party Liens

In the event a Member seeks and obtains a recovery from a third party or a third party's insurer for injuries caused to that Member, and only to the extent permitted by the Alameda Alliance Program applicable to Member, Member's Evidence of Coverage and by State and/or Federal law, Medical Group shall have the right to assert a third party lien for and to recover from Member the reasonable value of Covered Services provided to Member by Medical Group for the injuries caused by the third party. Medical Group acknowledges that recoveries on behalf of Medi-Cal Members are not permitted, such recoveries being due to the State of California. Medical Group's pursuit and recovery under third party liens shall be conducted in strict accordance with State and Federal laws and the procedures set forth in the Provider Manual. Alameda Alliance shall similarly have the right to assert a lien for and recover for payments made by Alameda Alliance for the treatment of such injuries. Medical Group shall cooperate with Alameda Alliance in identifying such Third Party Liability claims and in providing such information, within such time frames, as set forth in the Provider Manual. Medical Group shall cooperate with and assist Alameda Alliance and DHCS in obtaining said recoveries, including but not limited to, any claims or other records requested by DHCS and needed for the pursuit of recovery. Medical Group shall notify Alameda Alliance of any event or occurrence involving a Medical Group Member that is connected to a civil suit, worker's compensation claim or casualty insurance claim concerning Medical Group Member's health condition.

6.4 Coordination of Benefits

6.4.1 **Primary Payor**. When Alameda Alliance is primary under applicable Coordination of Benefits (COB) rules provided in Title 28 of the California Code of Regulations, Section 1300.67.13, Alameda Alliance shall pay Participating Physician as set forth is this Agreement in Exhibit B, B1, C, C1 and D, as applicable. In the event that Alameda Alliance is not the primary payor of Medical Group Member, Medical Group must first seek reimbursement from the primary payor in accordance with Alameda Alliance's policy and procedure on Coordination of Benefits, set forth in the Provider Manual before making any demand for payment from Alameda Alliance. Medical Group shall cooperate with and abide by Alameda Alliance's administration of Coordination of Benefit rules set forth in the contracts under this Agreement, as applicable, and the Coordination of Benefit rules set forth in the Provider Manual. Alameda Alliance's obligation hereunder with respect to such Covered Services shall be limited to the amount, if any, which when added to the amount obtained by Medical Group from such primary payors, equals the amount of compensation for which Medical Group is entitled under this Agreement for such services.

6.5 Member Billing

6.5.1 **Member Non-Liability**. Members will not be liable for payment of monies owed by Alameda Alliance or its delegates. Medical Group shall and shall require each Medical Group Provider to look only to Alameda Alliance, and, except as otherwise provided in this Agreement and, if applicable, its delegates, for compensation for Covered Services rendered to a Member. Medical Group shall and shall require each Medical Group Provider to look to the applicable Alameda Alliance Program for payment of any services covered under the Members Evidence of Coverage.

6.5.2 **Action Against Member**. Medical Group agrees and shall require each Medical Group Provider to agree that they will not, under any circumstances (including but not limited to nonpayment by or insolvency of Alameda Alliance) bill, charge, collect a deposit from, seek compensation from, seek remuneration from, seek reimbursement from, impose a Surcharge on or have any recourse against Member or persons acting on behalf of Member (other than Alameda Alliance), except to the extent that Copayments are specified in Member's applicable Alameda Alliance Program, its associated Evidence of Coverage and State and/or Federal law under this Agreement or for Non-Covered Services or as permitted under the Coordination of Benefits provision of this Agreement. Medical Group agrees and shall require each Medical Group Provider to agree not to maintain any action at law or in equity against a Member to collect sums that are owed by Alameda Alliance under the terms of this Agreement, even if Alameda Alliance fails to pay, becomes insolvent or otherwise breaches the terms and conditions of this

Agreement. Medical Group shall and shall require each Medical Group Provider to, whenever a Surcharge has occurred, refund, or ensure the subcontractor or Covering Physician refunds, the charge within fifteen (15) calendar days to Member, notifying Alameda Alliance of the action taken.

6.5.3 **Copayments for Group Care Members only.** Participating Physician shall bill and collect from Member any Copayments, co-insurance and deductibles specifically permitted in a Member's Evidence of Coverage or by regulatory agencies. Participating Physician shall use best efforts to arrange payment terms for any authorized Copayments, coinsurance and deductibles, if requested by a Member or Member's legal representative.

6.5.4 **Modification Limitations/Regulatory Approval**. No modification of this section 6.5 of the Agreement shall be effective until fifteen (15) calendar days after the appropriate State and/or Federal regulating entity has received written notification of the proposed changes, or any longer period that the State or Federal regulating entity may require.

6.6 Limitation of Action

Neither DHCS, CMS, DMHC, the State of California or the County of Alameda, or such other entities that Alameda Alliance may enter into an agreement with shall be liable for payment of monies owed by Alameda Alliance or its delegates.

6.7 Withhold and Adjustments of Payments

6.7.1 **Failure to Comply with Alameda Alliance Utilization Management and Quality Improvement Program.** Payments to Medical Group made pursuant to this Agreement may be withheld by Alameda Alliance in the event Medical Group or Medical Group Providers fail, after receiving appropriate notification, to materially comply with Alameda Alliance Utilization Management or Quality Improvement Program, including, but not limited to authorization procedures, site visits, re-credentialing, and corrective action plans, and Grievance Procedures until Medical Group complies. Upon Medical Group compliance, payments withheld to Medical Group will be reversed.

6.7.2 **Non-Payment to Alameda Alliance.** In the event DHCS, CMS, Public Authority and/or such other entities for whom Alameda Alliance contracts with to provide health care services fails to pay monthly premiums for such services, Alameda Alliance reserves the right to defer payments to Medical Group. To the extent that payments by DHCS, CMS, Public Authority and/or such other entities with whom Alameda Alliance contracts with to provide services cover all monthly premiums for which Alameda Alliance is owed, Alameda Alliance will pay deferred payment amounts covered by those monthly premiums to the provider.

6.7.3 **Administration of Payments**. Alameda Alliance agrees to transmit Capitation Payments and other payments to Medical Group in accordance with the terms and procedures set forth in the Agreement. All payments are subject to the availability of Federal congressional appropriation of funds. The State of California operates on a fiscal year from July 1 through June 30. The DHCS' funding is based on the budget and appropriations, and subject to the availability of Federal congressional appropriation of funds. In turn, payments to State contractors are tied to the scope of services in State law and amounts budgeted.

SECTION 7: RECORDS, AUDITS AND REPORTS

7.1 Records To Be Kept

7.1.1 **Financial**. Medical Group shall and shall require each Medical Group Provider to maintain on a current basis, books, records, documents, and other evidence, using accounting procedures and practices sufficient to reflect properly all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement in accordance with generally accepted accounting principles. Medical Group and Medical Group Providers shall keep separate records of the number and nature of visits by Medical Group Members. Medical Group agrees that the books and records of Medical Group may not be removed from the state of California without the prior consent of DMHC.

7.1.2 **Medical Group Member Medical Records**. Medical Group shall and shall require each Medical Group Provider to maintain in an accurate and timely manner the usual and customary records for Members in the same manner as for other patients of Medical Group and Medical Group Providers. Medical Group shall and shall require each Medical Group Provider to maintain medical records related to a Medical Group Member's eligibility for services, the service rendered, Medical Group Member to whom the service was rendered, the date of the service, the Medical Necessity of the service and the quality of the service provided. To the extent permitted by law, Medical Group and Medical Group Providers shall provide Alameda Alliance and regulatory agencies access to the member medical record at no cost, as well as all pertinent information relating to the health care for each Member.

7.1.3 **Transfer of Medical Group Member**. The obligation to maintain records shall not be waived by the transfer of Medical Group Members. As provided under Section 11.8.2, in the event of termination or suspension of this Agreement, Medical Group Members' medical records shall be maintained and accessible to Alameda Alliance or other Participating Providers at a reasonable location and within a reasonable time. Upon termination of this Agreement, or the re-assignment or transfer of Members, one copy of such records shall be provided without charge to Member's new Medical Group upon request.

7.2 Inspection Rights

7.2.1 **Availability of Records**. Medical Group at no cost shall require each Medical Group Provider to provide all of their books, subcontracts and records (including member medical records) pertaining to the goods and services furnished under the terms of this Agreement or pertaining to any threatened or pending litigation by or against DHCS, and make such records available for inspection, examination or copying in a timely manner by: Alameda Alliance, DHCS, CMS, DMHC, the United States Department of Justice, the Comptroller General, the Government Accountability Office, County of Alameda, or other governmental agency with jurisdiction over the parties to this Agreement, at all reasonable times at Medical Group's or Medical Group Providers' facility or at such other mutually-agreeable location in California. Such records shall be maintained in accordance with the general standards applicable to such book or record-keeping; and for a term of at least ten (10) years from the close of the most recent Alameda Alliance fiscal year in which this Agreement was in effect or for such longer period as may be required by law.

7.2.2 **Audit of Records**. Records may be audited and reviewed for purposes including, but not limited to, monitoring of the following areas: (i) level and quality of care, and the necessity and appropriateness of the services provided; (ii) internal procedures for assuring efficiency, economy, and quality of care; (iii) grievances relating to medical care and their disposition; (iv) financial records, status and reporting; and (v) the Medical Group subcontracts and Medical Group's compensation/finance records relating to such subcontract and compensation from Alameda Alliance when determined necessary by Alameda Alliance in order to comply with statutes, regulations or contractual obligations to assure accountability for public funds. If DHCS, CMS or the DHHS Inspector General determines there is a reasonable possibility of fraud of similar risk, DHCS, CMS, or the DHHS Inspector may inspect, evaluate and audit Medical Group at any time. Upon resolution of full investigation of fraud, DHCS reserves the right to suspend or terminate the Medical Group from participation in the Medi-Cal program, seek recovery of payments made to Medical Group; impose other sanctions provided under the State and terminate this Agreement.

7.2.3 **Transmittal of Medical Records**. Without limiting the foregoing, Medical Group shall, without charge, transmit Member's medical records information to a Member's other providers, to government officials, and to Alameda Alliance for administrative purposes.

7.2.4 **Member Access to Medical Records**. Medical Group shall and shall require each Medical Group Provider to ensure that Members without charge have access to their medical records in accordance with the requirements of Member's applicable Alameda Alliance Program and State and/or Federal law.

7.3 Reporting

Medical Group shall provide necessary information, which shall include but is not limited to encounter data, to support Alameda Alliance compliance with any regulatory requirements of the Member's applicable Alameda Alliance Program, its associated Member's Evidence of Coverage and by State and/or Federal law. Alameda Alliance shall provide Medical Group with formats and timeframes of such reports. Medical Group shall also provide ad hoc reports, upon request, to support Alameda Alliance compliance with Applicable Requirements.

7.4 Required Changes

Medical Group and Medical Group Providers agree to implement any changes reasonably required as a result of any such inspection, examination or audit.

SECTION 8: INSURANCE AND INDEMNIFICATION

8.1 Professional Liability Insurance

Each Medical Group Provider who provides services pursuant to this Agreement, whether for compensation or voluntary, shall be covered by liability insurance of at least One Million Dollars ($1,000,000) per occurrence, and Three Million Dollars in annual aggregate ($3,000,000). Insurance coverage shall include professional errors and omissions (malpractice) in providing health care services to Medical Group Members. Medical Group or each Medical Group Provider shall purchase "tail coverage" in the same amounts for a period of not less than five (5) years following the effective termination date of the above mentioned policy in the event that said policy is a "claims made" policy. If Medical Group or a Medical Group Provider fails to purchase tail coverage as required herein, Alameda Alliance shall have the right to purchase said coverage and Medical Group and Medical Group Providers collectively shall be liable to Alameda Alliance for all costs and expenses incurred in said purchase. In addition to coverage for each Medical Group Provider, Medical Group shall have professional liability coverage for Medical Group as an entity in the One Million Dollar ($1,000,000), Three Million Dollar ($3,000,000) amounts set forth above and with the five (5) year tail coverage provided for above.

8.2 Other Insurance

Medical Group and each Medical Group Provider shall carry general liability insurance in at least the minimum amount of Three Hundred Thousand Dollars ($300,000) per occurrence and workers' compensation and employers' liability coverage to the extent required by law.

8.3 Certificates of Insurance

Medical Group at Medical Group's sole cost and expense shall provide to Alameda Alliance upon request certificates of insurance or verifications of required coverage, and shall provide a thirty (30) calendar day written notice to Alameda Alliance of any notice of cancellation or material change in coverage for any and all coverage required by this Agreement, and for subsequent renewals of all required coverage.

8.4 Notification of Modification/Termination of Material Terms

Medical Group shall provide timely notification to Alameda Alliance of Medical Group's and/or Medical Group Provider's insurance coverage termination or modification.

8.5 Indemnification of Alameda Alliance

Medical Group and Medical Group Providers agree to indemnify, to defend at their sole expense, to save and hold harmless Alameda Alliance, the Federal Government, State of California, and County of Alameda, and their respective directors, supervisors, officers, agents, and employees, from any and all liability in addition to any and all losses, claims, actions, lawsuits, damages, judgments of any kind whatsoever arising out of the breach of contract, negligent acts, omissions or intentional misconduct of

Medical Group or, Medical Group Providers, their employees, including but not limited to court costs and reasonable attorneys' fees, in connection with the performance of this Agreement.

8.6 Indemnification of Medical Group

Except as limited by, and subject to, any privileges and immunities that may apply to Alameda Alliance as a county public agency under the California Welfare and Institutions Code Section 14087.35, Title 1 of the California Government Code and other applicable provisions granting privileges and immunities to public agencies, Alameda Alliance agrees to indemnify, to defend at its sole expense, to save and hold harmless Medical Group and Medical Group's respective directors, supervisors, officers, agents, and employees, from any and all liability in addition to any and all losses, claims, actions, lawsuits, damages, judgments of any kind whatsoever arising out of the breach of contract or intentional misconduct of Alameda Alliance or Alameda Alliance's employees, including but not limited to court costs and reasonable attorneys' fees, in connection with the performance of this Agreement.

8.7 Non-Exclusivity

The parties acknowledge that Medical Group will not render professional services exclusively on behalf of Alameda Alliance or Members. However, Medical Group shall be willing and able to accept and serve as the Primary Care Physician for Alameda Alliance Members who select or are assigned to Medical Group as their Primary Care Physician. Members have the right at all times to designate whether they shall be served by Medical Group and Alameda Alliance does not represent or warrant that any particular number or type of Member(s) shall select Medical Group to service as their Primary Care Physician. Medical Group shall neither represent nor imply in any way that such services are being rendered by or on behalf of Alameda Alliance.

SECTION 9: MEMBER GRIEVANCES

9.1 Submission of Member Grievance

All Member complaints and grievances received by Medical Group or Medical Group Providers must be forwarded immediately to Alameda Alliance. In the event a Member files a complaint or grievance regarding Medical Group or any Medical Group Provider, Medical Group and Medical Group Provider agree to cooperate with and participate in Alameda Alliance Member Grievance Procedures as they pertain to complaints and grievances filed by Members including those Member Grievance Procedures set forth in the Provider Manual in accordance with the time limits required by the Member's applicable Alameda Alliance Program and State and/or Federal law.

9.2 Resolution of Member Grievance

Medical Group and Medical Group Providers shall comply with Alameda Alliance's resolution of any such complaints or grievances including specific findings, conclusions and orders of DMHC. Medical Group shall adhere to these procedures for the prompt receipt, processing, and resolution of such matters in accordance with all Applicable Requirements.

SECTION 10: PROVIDER GRIEVANCES AND DISPUTE RESOLUTION

10.1 Provider Grievances

10.1.1 **Provider Grievance Procedures**. Alameda Alliance's Provider Grievance Procedures described in the Provider Manual comply with Sections 1367(h), 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the California 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. Medical Group has the right to file a grievance in accordance with Alameda Alliance's formal grievance and formal dispute resolution process.

10.1.2 **Complaints Regarding Alameda Alliance Oversight.** Should Medical Group have complaints or concerns related to any action taken by Alameda Alliance with respect to the oversight and administration of Medical Group or Medical Group Provider's provision of health care services, including, but not limited to, scope of service determinations, Authorization decisions, and the assignment or reassignment of Medical Group Members, such complaints or concerns shall be fully resolved according to the Provider Grievance Procedures as set forth in the Provider Manual.

10.1.3 **Binding Decision.** In executing this Agreement, Medical Group and Alameda Alliance agree to be bound by the decisions and resolutions on such issues that emerge from the Provider Grievance Procedures except as otherwise provided by law.

10.1.4 **Complaints Regarding Contractual Obligations**. Medical Group complaints related to performance by the parties of their respective contractual obligations herein, other than those covered in section 10.1.2, shall be resolved pursuant to the Dispute Resolution Procedure set forth in section 10.2 of this Agreement.

10.2 Dispute Resolution

If a dispute arises relating to the performance by the parties of their respective obligations under this Agreement, which cannot be settled through negotiation, the parties agree first to try in good faith to settle the dispute through the Provider Grievance Procedures as set forth in the Provider Manual. Except for matters that are subject to Member or other Grievance Procedures as described in sections 9.1 and 9.2 and in the Provider Manual and excluding any dispute arising out of, relating to, or in connection with any malpractice or professional liability claim (unless expressly consented to by the parties' insurance carriers) if the parties hereto are unable to resolve any dispute arising out of, relating to or in connection with this agreement, or the construction of interpretation of this Agreement, and the internal dispute resolution process has been exhausted without achieving a resolution, then such dispute shall be resolved as follows:

10.2.1 **Binding Arbitration.** Medical Group and Alameda Alliance shall submit the dispute to binding arbitration. If the parties cannot agree on an arbitrator within ten (10) working days after either party has requested that the dispute be submitted to arbitration, then the parties agree that the arbitrator shall be a retired judge from the San Francisco panel of JAMS/Endispute.

10.2.2 **Shared Costs.** The parties shall share all costs of arbitration. The prevailing party shall be entitled to reimbursement by the other party of such party's reasonable attorneys' fees, costs and any arbitration fees hereunder.

10.2.3 **Substantive Law.** The substantive law of the State of California and Federal substantive law where State law is preempted, shall be applied by the arbitrator. The parties shall have the rights of discovery as provided for in Part 4 of the California Code of Civil Procedure and as provided for in Sections 1283 and 1283.05 of said Code. The California Code of Evidence shall apply to testimony and documents submitted to the arbitrator. The arbitrator shall have the power to enforce the rights, remedies, duties, liabilities, and obligations of discovery by the imposition of the same terms, conditions and penalties as can be imposed in like circumstances in a civil action by a Superior Court of the State of California. Copies of all exhibits and demonstrative evidence to be used at the arbitration shall be duly exchanged in advance. However, rebuttal and impeachment evidence need not be exchanged until presented at the arbitration hearing.

10.2.4 **Arbitration Location.** Arbitration shall take place in Alameda, California unless the parties otherwise agree. As soon as reasonably practical, a hearing with respect to the dispute or matter to be resolved shall be conducted by the arbitrator. As soon as reasonably practicable thereafter, the arbitrator shall arrive at a final decision, which shall include factual findings and legal reasoning, which the decision is based, which shall be reduced to writing, signed by the arbitrator and mailed to each of the parties and their legal counsel.

10.2.5 **Arbitrator Powers.** The arbitrator shall have the power to grant all legal and equitable remedies and award compensatory damages provided by California law, except that punitive damages

may not be awarded. The arbitrator shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or correct pursuant to California Code of Civil Procedure Sections 1286.2 or 1286.6 for any such error.

10.2.6 **Arbitration Decisions.** All decisions of the arbitrator shall be final, binding and conclusive on the parties and shall constitute the only method of resolving disputes or matters subject to arbitration pursuant to this Agreement. The arbitrator or court of appropriate jurisdiction may issue a writ of execution to enforce the arbitrator's judgment. Judgment may be entered upon such a decision in accordance with applicable law in any court having jurisdiction thereof.

10.2.7 **Injunctive Relief.** Notwithstanding the above, in the event either party wishes to obtain injunctive relief or a temporary restraining order, such party may initiate an action for such relief in a court of law and the decision of the court of law with respect to the injunctive relief or temporary restraining order shall be subject to appeal only through the courts of law. The courts of law shall not have the authority to review or grant any request or demand for damages or declaratory relief.

10.2.8 **Conditions of Arbitration.** Notwithstanding the forgoing, any and all arbitration proceedings are conditional upon such proceedings being covered within the parties' respective risk insurance policies. Notwithstanding the foregoing, however, neither party shall be required to arbitrate malpractice or other third party claims.

10.2.9 **Alleged Injury or Death.** Notwithstanding the foregoing, should the parties agree to arbitrate any dispute arising out of or connected to the alleged injury or death of a Member or any action described in Section 340.5 of the California Code of Civil Procedure, such arbitration shall be subject to the California Medical Injury Compensation Reform Act of 1975, as amended from time to time, as if the arbitration were an action filed in State court, and shall be deemed time barred and unenforceable, and not subject to arbitration, unless a written demand for arbitration to such dispute has been delivered to the applicable party hereto, within the time allowed to commence an action under Section 340.5 of the California Code of Civil Procedure.

SECTION 11: TERM, TERMINATION AND NOTICE

11.1 Term

The effective date of this Agreement shall be as stated in the opening paragraph of this Agreement. The Agreement shall have an initial term of one year (the "Initial Term") and shall automatically renew for subsequent periods of one (1) year until such time as this Agreement is terminated pursuant to the terms set forth herein.

11.2 Termination Without Cause

Following the Initial Term, Medical Group or Alameda Alliance may terminate this Agreement at any time without cause upon providing the other party with sixty (60) calendar days prior written notice. The termination shall become effective the first day of the month following the expiration of the notice period.

11.3 Termination for Material Breach

Either party may, subject to the cure period set forth in Section 11.3.3, terminate this Agreement for material cause after written notice as set forth hereinafter. The following shall constitute a material cause for termination.

11.3.1 **Medical Group.** Medical Group may terminate for material cause if: (i) Alameda Alliance fails, except as provided in Section 6.7, to consistently make payments by the dates such payments are due; or, (ii) revocation of Alameda Alliance's license necessary for the performance of this Agreement; or, (iii) Alameda Alliance breaches any material term, covenant, or condition of this Agreement.

11.3.2 **Alameda Alliance.** Alameda Alliance may terminate for material cause if: (i) there is a filing of bankruptcy by Medical Group, a parent or subsidiary or substantial deterioration in the financial condition of Medical Group, a parent, affiliate or subsidiary, or, (ii) Medical Group fails to provide quality health care services consistent with the standards set forth in this Agreement; or, (iii) Medical Group breaches any material term, covenant, or condition of this Agreement, including but not limited to: (a) failure of Medical Group or Medical Group Providers to comply with Alameda Alliance's policies and procedures including Member Grievance or Quality Improvement Committee decisions, Applicable Requirements, the provisions of the Provider Manual or other requirements of Alameda Alliance; or (b) expiration or earlier termination of applicable Alameda Alliance Agreement.

11.3.3 **Notice and Cure Period.** A party seeking to terminate this Agreement for material breach shall notify the other party in writing of the nature of the breach and the other party shall have thirty (30) calendar days from the receipt of such notice to cure or otherwise eliminate such cause. If the other party does not remedy the breach, to the reasonable satisfaction of the non-breaching party, this Agreement shall terminate at the end of the thirty (30) calendar day period.

11.4 Additional Bases for Termination

Medical Group or Alameda Alliance may terminate this Agreement upon providing the other party with sixty (60) calendar days prior written notice in the event there are: (i) changes affecting (or resulting from) Alameda Alliance Agreement; or (ii) substantial changes under other public or private health care programs or policies, which will have a material detrimental financial effect on the operations of Medical Group or Alameda Alliance. In any case where such notice is provided, both parties shall negotiate in good faith during such sixty (60) calendar day period in an effort to develop a revised agreement, which, to the extent reasonably practicable under the circumstance, will adequately protect the interests of both parties in light of the change(s) which constituted the basis for the exercise of this termination provision.

11.5 Immediate Termination

Notwithstanding any provision of section 11.3.3 to the contrary, Alameda Alliance may immediately terminate this Agreement in the event that Medical Group is excluded from participation in applicable Alameda Alliance Program, or if Medical Group and Medical Group Physician or Participating Provider fails to maintain all insurance required herein, or if Alameda Alliance, after consulting with Medical Group, determines in good faith that continuation of this Agreement may reasonably be expected to jeopardize the health, safety, or welfare of Members, or if Alameda Alliance reasonably determines, after consulting with Medical Group, that Medical Group is likely to be financially unable to provide and/or pay for, in a competent and timely manner, Covered Services.

Additionally, Alameda Alliance may immediately terminate this agreement upon the suspension or revocation of Medical Group's license to practice medicine in the State of California; the suspension or termination of Medical Group's membership on the active medical staff of any hospital; or the suspension, revocation or reduction in Medical Group's clinical privileges at any hospital; or suspension from the State Medi-Cal or Medicare program, or if Medical Group's name is found on the following Medi-Cal Suspended and Ineligible Provider list posted at http://files.medi-cal.ca.gov/pubsdoco/Sandiland.asp; or if Medical Group is subject of any indictments, disciplinary actions or proceedings under the terms of any Alameda Alliance Program or by any government agency; or failure to meet Alameda Alliance's re-credentialing criteria.

11.6 Termination for Anticipatory Breach

If Alameda Alliance reasonably determines that Medical Group will fail to fulfill its obligations as set forth in this Agreement, or will violate any of the covenants as set forth in this Agreement, Alameda Alliance shall thereupon have the right to terminate the Agreement upon thirty (30) calendar days written notice to Medical Group of such termination and specifying the effective date of such termination. Based upon Alameda Alliance's reasonable determination, should Medical Group cure the anticipatory failure or violation, Alameda Alliance shall rescind its notice of termination.

11.7 Termination Not an Exclusive Remedy

The termination of this Agreement by either party pursuant to this SECTION 11: TERM, TERMINATION AND NOTICE is not an exclusive remedy and such terminating party retains whatever rights in law or equity as may be necessary to enforce its rights under this Agreement. Alameda Alliance may, in lieu of termination of this Agreement, withhold new Member assignment, suspend this Agreement, reassign Members or suspend payment.

11.8 Effect of Termination

As of the date of termination, this Agreement shall be considered of no further force or effect whatsoever, and each of the parties shall be relieved and discharged here from, except under the conditions set forth below.

11.8.1 **Rights or Obligations.** Termination shall not affect any rights or obligations hereunder which have previously accrued, or shall hereafter arise with respect to any occurrence prior to termination, and such rights and obligations shall continue to be governed by the terms of this Agreement.

11.8.2 **Termination of This Agreement.** In the event of termination of this Agreement, Medical Group shall and shall require each Medical Group Provider to comply with all applicable requirements of the Knox-Keene Act and the regulations promulgated thereunder, including but not limited to those set forth in California Health and Safety Code Section 1373.65.

11.8.3 **Continuity of Care.** Medical Group agrees and shall require each Medical Group Provider to agree to continue rendering Covered Services for completion of such Covered Services under California Health and Safety Code Section 1373.96(c) and Section 422.504 of the Code of Federal Regulations after the termination of this Agreement to Medical Group Members at the rates in effect immediately prior to the date of termination, for the duration of Alameda Alliance Agreements in effect with Alameda Alliance through which Members are enrolled with Alameda Alliance, or until such time as Alameda Alliance has arranged for the provision of such services through another Participating Provider. Alameda Alliance shall be financially responsible for Covered Services provided by Medical Group Provider under this Continuity of Care provision.

11.8.4 **Transition of Care.** Medical Group shall and shall require each Medical Group Provider to cooperate with Alameda Alliance to facilitate a smooth transition of care for Medical Group Members to other Participating Providers. This cooperation shall include, at a minimum, an orderly transfer of medical records of Medical Group Members to Participating Providers. Without limiting the foregoing, Participating Physician shall be responsible for the following: (a) coordination of referrals of Members to other Participating Providers; (b) preventive services (c) health risk assessments; (d) treatment planning; and (d) monitoring of continuity of care and appropriateness of services.

11.8.5 **Professional Rights Upon Termination.** Medical Group shall be entitled to a fair hearing regarding Alameda Alliance actions of denial, termination, sanction, or reduction of participation when the cause of the action is related to clinical competency or professional conduct. Medical Group must exhaust the remedies afforded by the Alameda Alliance's Credentialing and re-credentialing policies. Otherwise, the Medical Group shall have waived the hearing appeal rights of Alameda Alliance and shall have to accept the plan's denial, termination, sanction, or reduction of participation.

11.8.5.1 Notification will be promptly made to Medical Group, via certified mail, of all actions made by Alameda Alliance, which constitute grounds for a hearing as listed herein.

11.8.5.2 Medical Group has thirty (30) calendar days for the date of receipt of notification of action in which to request a hearing.

11.8.5.3 Alameda Alliance's termination of this Agreement in accordance with its termsshall be final and Medical Group shall have no right to a fair hearing or other procedure to appeal Alameda Alliance's decision through any formal or informal administrative hearing or review process of any kind, except when the grounds for termination is due to medical disciplinary action or due to reasons of clinical competency or professional conduct. Notwithstanding the foregoing, Alameda Alliance shall comply with all applicable termination notice and appeal requirements as may be provided in applicable law.

11.8.6 **Alameda Alliance Insolvency**. Medical Group shall and shall require each Medical Group Provider to, in the event of Alameda Alliance's insolvency, continue rendering Covered Services to any Member who is an inpatient of a hospital until such Member's discharge or transfer to another appropriate facility.

11.8.7 **Survival of Terms**. The following sections of this Agreement shall survive the termination of this Agreement, whether such termination is the result of rescission or otherwise: Sections 1.31, 3.1.4, 3.1.5, 3.7.2, 4.1.3, 6.5, 7.1, 7.2, 7.3, 7.4, 8.5, 8.6, 9.1, 9.2, 10.1, 10.2, 11.8.3, 11.8.4, 12.6.

11.9 Member Communications Concerning Termination

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

11.10 Notification

Alameda Alliance and/or Medical Group as appropriate shall, as required, notify DHCS, CMS, DMHC, or other appropriate governmental agencies if this Agreement is terminated. Notification shall be provided in writing and sent through the United States Postal Service via first-class registered or certified mail.

SECTION 12: GENERAL PROVISIONS

12.1 Non-Discrimination/Equal Employment.

Medical Group and Medical Group Providers' primary consideration shall be the quality of the health care services rendered to Members. Medical Group and Medical Group Providers shall not discriminate against any Member in the provision of Covered Services on the basis of sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, income level, disability, health status, genetic characteristics, health insurance coverage, utilization of medical or mental health services of supplies or other unlawful basis including without limitation, the filing by such Member of any compliant, grievance or legal action against Medical Group or Medical Group Providers. Without limiting the foregoing, Medical Group and Medical Group Providers shall comply with all Applicable Requirements regarding non-discrimination and equal employment.

12.2 Assignment/Subcontracting

12.2.1 **Accountability**. Medical Group understands that Alameda Alliance may be held accountable by regulatory agencies if Medical Group or Medical Group Providers or their subcontractors or assignees fail to perform its duties under this Agreement or any subcontract amendment thereto. Subject to the restrictions set forth herein, this Agreement shall be binding upon and shall inure to the benefit of the parties and their respective heirs (as applicable), legal representatives, and permitted successors and assigns. Medical Group Members shall not be included in any transfer of ownership or control of Medical Group or a Medical Group Provider and shall not be automatically reassigned to any purchaser of same.

12.2.2 **Subcontracting Rights and Obligations**. This Agreement is one for the personal services of Medical Group and may not be assigned by Medical Group without the prior written consent of Alameda Alliance and DHCS. Any attempt by Medical Group to assign this Agreement without prior consent shall be null and void. Medical Group and Medical Group Providers shall not assign, transfer, delegate or subcontract (collectively "Subcontract") Medical Group's rights or obligations hereunder without the prior written consent of Alameda Alliance, DHCS and/or the appropriate government agency, if applicable. Any agreement to Subcontract Medical Group's rights or obligations shall be void unless such approvals are obtained. All agreements between Medical Group and Medical Group Providers and any assignee, transferee, or subcontractor (the "Subcontractor") shall be in writing and shall require Subcontractor to comply with all terms of this Agreement, including but not limited to the following:

12.2.2.1 **Availability of Records**. Make all applicable books and records available at all reasonable times for inspection, examination, or copying by Alameda Alliance, CMS, DHCS, DMHC, or

any other governmental agency with jurisdiction over the parties to this Agreement as set forth in Section 4.11.

12.2.2.2 **Records Retention.** Retain such books and records for a term of at least ten (10) years from the close of Alameda Alliance's fiscal year during which the Covered Services were provided pursuant to the Subcontract as set forth in Section 7.2.1.

12.2.2.3 **Surcharge.** Not Surcharge for Covered Services provided to a Medical Group Member.

12.2.2.4 **Compliance.** Comply with all Applicable Requirements.

12.2.2.5 **Submission of Claims.** Submit Claims data in the manner consistent with the terms of this Agreement, Provider Manual and Applicable Requirements.

12.2.2.6 **Medical Group Responsibilities.** Medical Group shall be responsible for each assignee or subcontractor performance under such assignment or subcontract. Alameda Alliance may require Medical Group to remove from service any assignee or subcontractor who fails to comply with the terms of this Agreement.

12.3 Waiver

A forgiveness by either party of any one or more defaults or performance failures on the part of the defaulting party herein, shall not be construed to operate as a waiver by the forgiving party of its rights to pursue legal remedies with respect to future defaults or performance failures of the same or similar nature or the defaults or performance failures related to other obligations of the defaulting party as set forth in this Agreement.

12.4 Severability

In the event any part of this Agreement is found to be unlawful or is otherwise stricken, all other provisions shall remain in full force and effect and the parties shall continue to perform with respect thereto.

12.5 Relationship of Parties

None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other herein solely for the purpose of affecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, the employee or the representative of the other.

12.6 Confidentiality

12.6.1 **Peer Related Information**. Alameda Alliance and Medical Group Providers shall maintain the confidentiality of peer related information to the fullest extent permitted by law. Medical Group does not waive the provisions of California Evidence Code Section 1157 and other applicable laws with regard to peer review records.

12.6.1.1 **Financial Information**. Alameda Alliance agrees that it shall treat as confidential all financial information provided by Medical Group in accordance with section 4.8.5 unless such information is publicly available, and shall not disclose such information to others except as required by law or as requested by Alameda Alliance's regulators.

12.6.2 **Member Information and Records**. Notwithstanding any other provision of this Agreement, any and all types of information, oral or written, pertaining to Medical Group Members is confidential and shall be protected by Medical Group and Medical Group Providers from unauthorized disclosure in accordance with Applicable Requirements, including but not limited to, the Confidentiality of Medical Information Act ("CMIA"), Title42, Code of Federal Regulations, Section 431.300 et seq., Section

14100.2, California Welfare and Institutions Code, the Health Insurance Portability and Accountability Act (HIPAA) and regulations adopted thereunder.

12.6.2.1 **Identifiable Information**. Identifiable information in Medical Group and Medical Group Provider's possession regarding Medical Group Members will not be used for any purpose other than carrying out the express terms of this Agreement and will not be disclosed to any party other than Alameda Alliance except as otherwise permitted by State and Federal law.

12.6.2.2 **Disclosure of** Information. All requests for disclosure of such information will be promptly transmitted to Alameda Alliance.

12.6.3 **Trade Secrets/Compensation**. Except as otherwise required by the Public Records Act or by applicable regulatory agencies, the compensation terms of this Agreement and all terms relating to compensation shall be confidential. Medical Group shall and shall require each Medical Group Provider to not disclose such terms (other than to government officials) except with the prior written consent of Alameda Alliance. However, nothing herein shall prohibit Medical Group or Medical Group Providers from disclosing to Members and others the method by which they are compensated (e.g. Capitation, Fee-For-Service, etc.); it is the precise compensation amounts for which confidential treatment is required by this provision.

12.6.4 **Public Records**. Medical Group acknowledges and agrees that information, communications and documents given by or to Alameda Alliance and meetings involving Alameda Alliance management may be subject to public records and meetings laws and regulations, and Medical Group shall use best efforts to cooperate with Alameda Alliance in order that it may fully comply with the requirements of such laws and regulations.

12.7 Third-Party Rights

This Agreement is entered into by and between the parties hereto and for their benefit. There is no intent by either party to create or establish a third-party beneficiary status or rights in a third party to this Agreement, except for such rights expressly created and set forth in this Agreement. Except for such parties, no such third party shall have any right to enforce or any right to enjoy any benefit created or established under this Agreement.

12.8 Remedies

The remedies provided in this Agreement are not exclusive and are in addition to those provided by law. Both parties recognize that monetary damages alone would be an insufficient remedy for a breach of confidentiality pursuant to section 7.1 and 12.6. In the event of such a breach, the non-breaching party shall be entitled to appropriate injunctive relief, in addition to all remedies, including monetary damages, to which it is entitled by law. In the event that a party breaches this Agreement, the non-breaching party shall be entitled to the expenses, including reasonable attorney fees and arbitration and/or court costs, the non-breaching party incurs as a result.

12.9 Force Majeure

Neither party will be responsible for failure of performance, other than for an obligation to pay money, due to causes beyond its control, including without limitation, acts of God or nature; terrorists acts; sovereign acts of any Federal, State or foreign government; or shortage of materials.

12.10 Ambiguities

In the event of any ambiguity in this Agreement, this Agreement shall be interpreted according to its fair intent and not for or against any one party on the basis of which party drafted the Agreement.

12.11 Captions

The captions herein are for convenience only and shall not affect the meaning or interpretation of this Agreement.

12.12 Governing Law

The validity, enforcement, and interpretation of this Agreement shall be determined and governed by reference to the laws of the State of California and where applicable, the laws of the United States.

12.13 Change in Law

Should legislation affect the entitlement of Medical Group Members or otherwise effect the terms of this Agreement, this Agreement shall be interpreted in a manner consistent with Alameda Alliance's reasonable interpretation of the effect of the legislation.

12.14 Amendments

Alameda Alliance and/or Medical Group shall, notify DHCS and, if appropriate, CMS, DMHC, Public Authority or other appropriate government agencies regarding any amendments made pursuant to terms set forth below if required. Parties acknowledge that the consent of DHCS and, under certain circumstances CMS, DMHC, Public Authority or other appropriate government agencies shall be required for an amendment to be effective which may take up to sixty (60) calendar days. Alameda Alliance will submit the amendment to the DHCS at least thirty (30) calendar days prior to the proposed effective date. The parties agree to cooperate in obtaining such consent. Except as provided in this section, this Agreement may be amended only by mutual, written consent of Alameda Alliance and Medical Group's duly authorized representatives. Notwithstanding the foregoing, if Alameda Alliance's legal counsel determines in good faith that this Agreement must be modified to be in compliance with applicable State or Federal law or to meet the requirements of accreditation organizations which accredit Alameda Alliance and its providers, Alameda Alliance may amend this Agreement by delivering to Medical Group (the "Notice Date") a written amendment to this Agreement incorporating the legally required modifications (the "Legally-Required Amendment"), along with the reasons therefore. Such Legally-Required Amendment shall be deemed accepted by Medical Group and an amendment to this Agreement if Medical Group does not, within thirty (30) calendar days following said Notice Date, deliver to Alameda Alliance its written objection of such Legally-Required Amendment. In the event that Medical Group timely objects to such Legally-Required Amendment, then Medical Group and Alameda Alliance shall confer in good faith regarding the amendment. In the event Medical Group and Alameda Alliance cannot resolve Medical Group's objection, Medical Group may terminate this Agreement on ninety (90) calendar days prior written notice to Alameda Alliance and the Legally-Required Amendment to which Medical Group objected shall not be effective as to Medical Group during the termination notice period.

12.15 Prospective Requirements

In instances where Alameda Alliance is contractually obligated by DHCS to revise its contracts with providers to add newly prospective requirements to the Agreement, Medical Group or Subcontractor agrees to comply with the new requirements within thirty (30) calendar days from the effective date of the proposed change.

12.16 Notice

Whenever it shall become necessary for either party to notify the other party as provided for herein, such notice shall be in writing and shall be served by overnight courier; or registered or certified mail, return receipt requested, addressed as follows:

12.16.1 **Served on Alameda Alliance.** If served on Alameda Alliance, written notice shall be addressed to the Chief Operating Officer at the address which appears on the signature page of this Agreement unless another notice is specified in writing. If required by law or regulation, Medical Group shall serve a separate notice to another party whose name and address have been provided by Alameda Alliance in writing to Medical Group.

12.16.2 **Served on Medical Group.** If served on Medical Group, written notice shall be addressed to Medical Group at the address which appears on the signature page of this Agreement unless another notice address is specified in writing.

12.16.3 **Timeframe.** Any such notice so mailed shall be deemed to have been served upon and received by the addressee forty-eight (48) hours after the same has been deposited in registered or certified United States mail, return receipt requested; or twenty-four (24) hours after deposit before the daily deadline time with a reputable overnight courier or service. The party which dispatches the notice shall have the burden of proving the date and time of deposit into the United States mail should the issue arise.

12.16.4 **Change of Notice Location.** Either party shall have the right to change the place to which notice is to be sent by giving forty-eight (48) hours written notice to the other of any change of address.

12.17 Entire Agreement

This Agreement, together with all Schedules and Exhibits attached hereto and the Provider Manual, contains the complete and exclusive Agreement between the parties relating to the rights herein granted and the obligations herein assumed. It is the express intention of the parties that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Agreement which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

12.18 Counterparts

This Agreement, and any amendments thereto, may be executed in counterparts, each of which shall constitute an original document, but which together shall constitute one and the same instrument.

12.19 Peer Review

The parties acknowledge and agreed that any Alameda Alliance committee that reviews the quality of medical services rendered by Medical Group or Medical Group Provider shall act in the capacity of a peer review committee for the purposes of applicable law. For purposes of this section, "quality of medical services" shall include, without limitation, matters involving utilization management and review and compliance with requirements, rules or regulations of Alameda Alliance relating the delivery, quality or appropriateness of medical care provided to Members. Except as otherwise provided by law, the immunities provided to peer review committees under applicable provisions of the California Civil and Health and Safety Code shall apply to any such Alameda Alliance committee, including Alameda Alliance's governing body, when performing the function described in the first sentence of this section 12.19.

12.20 Independent Contractor

Medical Group acknowledges and agrees that he or she is an independent contractor under this Agreement and is a solely responsible for all compensation, benefits and withholds for his or her employees and agents.

12.21 Proprietary Information

Medical Group acknowledges and agrees that all information received from Alameda Alliance in connection with Members and this Agreement, including without limitation, eligibility Member lists, marketing materials, Quality Improvement Plan, telephone numbers, Provider Manuals, records, and agreements are proprietary information and trade secrets of Alameda Alliance, except to the extent available as public records.

12.22 Government Claims Act

Nothing in this Agreement modifies, amends or abridges the parties' rights and obligations under Government Code Section 900 *et seq.*, and all resolution, policies, and regulations of the Alameda Alliance for Health that implement Government Code section 900 *et seq.*

SIGNATURE PAGE

IN WITNESS WHEREOF, the parties hereto have executed this Agreement to be effective on the date first mentioned above.

PROVIDER

[redacted]

signature

Name: DAVID CALDWELL

Title: CFO

Address: 3470 Buskirk Ave.
Pleasant Hill, CA. 94523

Fax:

Email: davidc@hospicecastbay.org

Date: 4/28/2022

Tax ID #: 94-2515405

NPI #: 1205946555

Medi-Cal # (if applicable):

Medicare # (if applicable):

Notice contact/address if different from above:

Name:

Title:

Address:

ALAMEDA ALLIANCE FOR HEALTH

[redacted]

signature

Matthew Woodruff

Chief Operating Officer

1240 South Loop Road

Alameda, California 94502

Date: 05/05/2022

EXHIBIT A

COVERED SERVICES AND NON COVERED SERVICES

C. Covered Services

A. Participating Physician shall provide Covered Services to all Members who receive care from Participating Physician as medically necessary.

B. Final determination of whether or not a service is covered will be made by Alameda Alliance in accordance with the applicable program's Evidence of Coverage, DHCS Medi-Cal manual, DOFR and/or Provider Manual.

2. Medi-Cal Carve Out Benefits

In accordance with Alameda Alliance's Agreement with DHCS, there are some Medi-Cal benefits which are not within the scope of Alameda Alliance's Covered Services for Medi-Cal Members. Subject to the conditions of the California Medi-Cal program, they may be covered outside Alameda Alliance with or without the necessity of dis-enrolling. For a complete list of these benefits please refer to the Member's Evidence of Coverage and Disclosure Forms located on the Alameda Alliance web site listed under Carve-Out Benefits.

3. Benefit Exclusions and Limitations

There are certain services that Alameda Alliance does not cover, or has set limitations to the service. For a complete list of these benefits, please refer to the Member's Evidence of Coverage and Disclosure Forms for the applicable program located on the Alameda Alliance website listed under Benefit Exclusions and Limitations.

Applicable Alameda Alliance Program(s):

☒ Medi-Cal (DHCS)

☒ Alliance Group Care (IHSS)

EXHIBIT B

REIMBURSEMENT – MEDI-CAL PRIMARY CARE PHYSICIAN

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EXHIBIT B-1
REIMBURSEMENT – GROUP CARE PRIMARY CARE PHYSICIAN

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EXHIBIT C
REIMBURSEMENT – MEDI-CAL (SPECIALIST)

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EXHIBIT C-1

REIMBURSEMENT – GROUP CARE (SPECIALIST)

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EXHIBIT D
ANCILLARY SERVICES-REIMBURSEMENT- MEDI-CAL/GROUP CARE

Scope: Hospice

Hospice services provided to members will be reimbursed at one-hundred percent (100%) of the prevailing Medi-Cal rate.

If there is no prevailing Medi-Cal rate for a valid covered service or supply and the service is billed with a valid Current Procedural Terminology (CPT) or Healthcare Common Procedural Coding System (HCPCS) code, the reimbursement will pay at twenty five percent (25%) of billed charges.

Scope: Palliative Care

Covered Services	Reimbursement Rate
99343	$120.09
99344	$134.75
99349	$90.30
99350	$140.18
99497	$121.78
99498	$109.62
G0299- Registered Nurse	$165.00 per visit
G0155- Social Worker	$190.00 per visit
G0162-Palliative Care Assessment- Initial Treatment Plan	$50.00 per visit

EXHIBIT E
INITIAL HEALTH ASSESSMENT "IHA"
Initial Health Assessments ("IHA")
[For Medi-Cal New Members]

An IHA is a comprehensive assessment completed during a patient's first visit with his/her PCP. The goal of the IHA is to assess acute, chronic and preventative health needs. The IHA is a California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid (CMS) requirement.

All new members over the age of 18 months must have an IHA completed by their PCP within o***ne hundred twenty (120) calendar days*** of Plan enrollment; newborns through 18 month-old members must have an IHA completed within sixty (***60) calendar days*** of Plan enrollment.
The IHA consists of:

1. A Member comprehensive history, physical and mental status, and where age appropriate, a developmental exam and immunizations;
2. An approved Individual Health Education Behavioral Assessment (IHEBA). The Alliance recommends using the Staying Healthy Assessment alamedaalliance.org/providers/medical-management/staying-healthy-assessment;
3. Appropriate guidance, health care coordination and referrals. Health Education information and a Resource Directory of community referrals can be found on the Alliance website at alamedaalliance.org/providers/health-education-and-wellness-resources.

Members excluded from the requirement:

1. Members who have been a patient of yours in the past year or more and for which documentation exists showing an IHA completed within the past 12 months.
2. Members who refuse the IHA. Refusal must be noted within the medical record.
3. Members who missed an appointment, where the provider documented two additional attempts to reschedule.

Codes that qualify for IHA include:

CPT Code	Description

99201- 99205	Office or other outpatient visit for the evaluation and management of new or established patient
99211-99215	Office or other outpatient visit for the evaluation and management of established patient with PCP but new to the Alliance
99381-99385	Comprehensive preventive visit and management of a new patient
99391-99395	Comprehensive preventive visit and management of an established patient with PCP but new to the Alliance
59400, 59510, 59610, 59618	Under vaginal delivery, antepartum and postpartum care procedures under cesarean delivery procedures, under delivery procedures after previous cesarean delivery, under delivery procedures after previous cesarean delivery
Nursing home- 99304-99306	New or established patient comprehensive nursing facility assessments

Please call Alameda Alliance for Health Provider Services if you have any questions.

EXHIBIT F
BILLING

1. Billing

a. All claims must be submitted within one hundred eighty (180) calendar days from the date of service or Alameda Alliance may refuse payment. If Participating Physician is diligently pursuing Coordination of Benefits with another carrier, Participating Physician may delay submission of that claim up to one hundred eighty (180) calendar days following the settlement with the primary carrier.

b. Interest shall be paid on any late payment of a clean, uncontested Medi-Cal claim as follows:

i. Late payment on a complete claim for emergency services and care, which is neither contested not denied, shall automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late.

ii. Late payments on all other complete claims shall automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late.

iii. Penalty for failure to automatically include the interest due on a late claims payment as set forth above. If Alameda Alliance fails to automatically include interest due on a late claim payment then Alameda Alliance shall pay Participating Physician a $10 penalty for that late claim in addition to any amounts due pursuant to this section.

c. If Member has Medicare or other insurance as their primary coverage then Participating Physician must bill Medicare or the other carrier first before submitting Medi-Cal claims to Alameda Alliance.

2. Payment

a. Alameda Alliance shall pay all of Participating Physician's Clean Claims for Covered Services within forty-five (45) working days of receipt; or within such shorter time period as is required by law.

3. Misdirected Claims

Misdirected claims received by Alameda Alliance shall be forwarded to the correct payer within ten (10) working days, except as otherwise permitted by DHCS or other applicable regulations.

4. Claim Review and Investigation / Contested Claims - Medi-Cal

In accordance with H&SC § 1371, Alameda Alliance shall have the right to question claims or items thereof, provided that Participating Physician is notified of the claims or items in dispute within forty five (45) working days from the date received; provided, further, that in any case involving possible fraud or abuse or other improper billing practice, Alameda Alliance will have the right to question the claims or items for a period of one (1) year after the discovery of the impropriety. If a claim or portion thereof is contested on the basis that Alameda Alliance has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided, pursuant to this section, Alameda Alliance shall have an additional forty five (45) working days after receipt of this additional information to complete reconsideration of the claim. If Alameda Alliance has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim it has determined to be payable within forty five (45) working days of receipt of that information, interest shall accrue and be

payable at a rate of fifteen percent (15%) per annum beginning with the first calendar day after the forty five (45) working day period. If claims are for emergency room services, interest shall accrue and be payable at $15.00 or 15%, whichever is higher.

5. Electronic Data Submission

Participating Physician shall submit clean claims to Alameda Alliance electronically through a contracted clearing house in a HIPAA standard ASC X12N 837 (005010X222) Professional and ASC X12N 837 (005010X223) Institutional transactions, unless otherwise agreed upon by the parties, and shall contain valid ICD 10, CPT and HCPCS codes, as applicable.

Alameda Alliance for Health Contracted Clearing Houses

Payor ID # 95327	Claims Net	

6. Prohibition on Upcoding, Unbundling, and Fraud

The following billing practices are prohibited. Such billing practices may be investigated and reported by Alameda Alliance as potential fraud and abuse to any of Alameda Alliance's Regulatory Agencies.

- Billing for services performed by an unlicensed provider or one who has been excluded from a federal health care program.
- Billing for services that were not performed at all or not performed as described.
- Submitting claims for medical equipment, supplies, or services that were not necessary.
- Double billing.
- Upcoding or assigning a code that secures a higher reimbursement, rather than the codes that match the services performed.
- Unbundling or billing parts of global fees separately.
- Knowingly misusing provider numbers.
- Failing to use coding modifiers accurately or appropriately.
- Preparing or submitting false cost reports.
- Accepting kickbacks or improper rebates in violation of applicable law.
- Falsely certifying medical necessity.

EXHIBIT G
PROVIDER DIRECTORY UPDATES LIST OF CONTRACTED PROVIDERS

Provider shall comply with SB137 amended Section 1367.27 of the Health and Safety Code and provide additional information on an ongoing basis for updating Alameda Alliance's Provider Directory. This provider information is mandated to be updated on a quarterly basis pursuant to the terms of this Alameda Alliance Agreement and shall comply with SB137 and the amended Section 1367.27 of the Health and Safety Code. In the event that government officials or Alameda Alliance find any incorrect information in the records provided by the Provider that have been identified by such government officials or Alameda Alliance, the Provider shall have thirty (30) calendar days to correct this formation.

Practice Information

Please provide the following information in an excel format:

1. Provider's first and last name in separate fields;
2. Practice name or names as applicable, e.g. Federally Qualified Health Care Center name, Primary Care Clinic name, Specialty Practice name;
3. Practice address or addresses if provider sees Alameda Alliance Members at multiple sites;
4. Practice telephone number(s);
6. 5.Provider Type, National Provider Identifier (NPI) number;
7. Drug Enforcement Administration (DEA) number;
8. California license number and type of license;
9. Area of specialty, including board certification, if any;
10. Provider's office email address(es) if available;
11. If applicable, the name of each affiliated provider group through which provider sees Alameda Alliance Members;
12. Hospital admitting privileges for in-network hospitals, as applicable;
13. Non-English language(s) spoken by provider;
14. Indicate whether a provider is accepting new patients or not;
15. Note Provider's affiliation with group i.e. contracted or employed; and
16. Provider office hours.

At least once every six (6) months, Alameda Alliance will make an attempt to verify all of Participating Physician's information in this schedule in accordance with Health and Safety Code Section 1367.27 (*l*). Participating Physicians shall respond to Alameda Alliance confirming receipt of request to verify information, and shall provide a response verifying the requested information within thirty (30) working days of initial attempt. If Participating Physician fails to respond to the initial request, Alameda Alliance will take appropriate steps to attempt to verify the requested information. Failure to provide a response verifying and/or updating information may result in removal from Alameda Alliance's Provider Directory and delay of payment. This requirement is in no way intended to limit the obligation of provider to update the alliance in accordance with section 4.3 of the Agreement.

SUBJECT TO REVIEW AND APPROVAL
BY DEPARTMENT OF MANAGED HEALTH CARE, DEPARTMENT OF INSURANCE
AND DEPARTMENT OF HEALTH CARE SERVICES

EXHIBIT H
ADDITIONAL PROVISIONS

For Covered Services provided to Medi-Cal Covered Persons, Alameda Alliance for Health shall pay PCP the lesser of: (i) the PCP's Allowable Charges for CPT codes; or (ii) one hundred twenty-five percent (125%) of the State's Medi-Cal fee schedule or AAH's equivalent fee schedule in effect on the date of service and specific to the services rendered.

Both parties agree to negotiate a mutually agreed upon reimbursement methodology and rates within thirty (30) calendar days of execution of this agreement.

Additional Provisions:

1.1 **Code Change Updates.** Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9/ICD-10, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) calendar days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claim processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

1.2 **Fee Change Updates.** Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) calendar days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

1.3 **Payment under this Exhibit.** All payments under this Exhibit are subject to the terms and conditions set forth in the Agreement and the Provider Manual.

EXHIBIT I
INFORMATION REGARDING OFFICERS, OWNERS, AND STOCKHOLDERS

List the names of the officers, owners, stockholders owning more than 5% of the stock issued by the physician, and major creditors holding more than 5% of the organization identified on the execution page of this Agreement. (This is a requirement of Title 22, CCR, Section 53250).

Contra Costa County
Standard Form L-1
Revised 2014

STANDARD CONTRACT
(Purchase of Services - Long Form)

Number 77-412
Fund/Org # As Coded
Account # As Coded
Other #

1. **Contract Identification**.

   Department: Health Services – Contra Costa Health Plan (CCHP)

   Subject: Hospice and Palliative Care Services

2. **Parties**. The County of Contra Costa, California (County), for its Department named above, and the following named Contractor mutually agree and promise as follows:

   Contractor: **EAST BAY INTEGRATED CARE, INC. (DBA HOSPICE OF THE EAST BAY)**

   Capacity: Corporation

   Address: 3470 Buskirk Avenue, Pleasant Hill, California 94523

3. **Term**. The effective date of this Contract is January 1, 2022. It terminates on December 31, 2024 unless sooner terminated as provided herein.

4. **Payment Limit**. County's total payments to Contractor under this Contract shall not exceed $1,950,000.

5. **County's Obligations**. County shall make to the Contractor those payments described in the Payment Provisions attached hereto which are incorporated herein by reference, subject to all the terms and conditions contained or incorporated herein.

6. **Contractor's Obligations**. Contractor shall provide those services and carry out that work described in the Service Plan attached hereto which is incorporated herein by reference, subject to all the terms and conditions contained or incorporated herein.

7. **General and Special Conditions**. This Contract is subject to the General Conditions and Special Conditions (if any) attached hereto, which are incorporated herein by reference.

8. **Project**. This Contract implements in whole or in part the following described Project, the application and approval documents of which are incorporated herein by reference: ***Not Applicable***

STANDARD CONTRACT
(Purchase of Services - Long Form)

Number 77-412

9. **Legal Authority**. This Contract is entered into under and subject to the following legal authorities: California Government Code §§ 26227 and 31000; Health and Safety Code § 1451, and all legal authorities cited in the Contra Costa Health Plan Requirements (Attachment A) and HIPAA Business Associate Addendum, which are attached hereto and incorporated herein by reference.

10. **Signatures**. These signatures attest the parties' agreement hereto:

COUNTY OF CONTRA COSTA, CALIFORNIA

BOARD OF SUPERVISORS	ATTEST: Clerk of the Board of Supervisors
By_____ ~~Chairman~~/Designee	By XXXXXXXXXXXXXXXXXXXXXXXXXXXXX ~~Deputy~~

CONTRACTOR

Signature A	Signature B
Name of business entity	Name of business entity
East Bay Integrated Care, Inc. (dba Hospice of the East Bay)	East Bay Integrated Care, Inc. (dba Hospice of the East Bay)
By DocuSigned by: [redacted] 1498C20CD7EA419 (Signature of individual or officer)	By DocuSigned by: [redacted] 886319EEA05B467 (Signature of individual or officer)
Cynthia Hatton President & CEO (Print name and title A, if applicable)	David Caldwell CFO (Print name and title B, if applicable)

Note to Contractor: For corporations (profit or nonprofit) and limited liability companies, the contract must be signed by two officers. Signature A must be that of the chairman of the board, president, or vice-president; and Signature B must be that of the secretary, any assistant secretary, chief financial officer or any assistant treasurer (Civil Code Section 1190 and Corporations Code Section 313). All signatures must be acknowledged as set forth on form L-2.

Contra Costa County
Standard Form L-2
Revised 2014.2

ACKNOWLEDGMENTS/APPROVALS
(Purchase of Services – Long Form)

Number 77-412

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA)
)
COUNTY OF CONTRA COSTA)

On _____ _____(Date), before me, _____(Name and Title of the Officer), personally appeared_____ _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS MY HAND AND OFFICIAL SEAL

_____
Signature of Notary Public

Place Seal Above

ACKNOWLEDGMENT (by Corporation, Partnership, or Individual)
(Civil Code §1189)

APPROVALS

RECOMMENDED BY DEPARTMENT

DocuSigned by:
[redacted]
By: _____
Designee

FORM APPROVED COUNTY COUNSEL

County Counsel approval not required
By: *per September 12, 2006 Board Order*
Deputy County Counsel

APPROVED: COUNTY ADMINISTRATOR

By:_____
Designee

Contra Costa County
Standard Form P-1
Revised 2014

PAYMENT PROVISIONS

(Fee Basis Contracts – Long Form)

Number 77-412

1. **Payment Amounts.** Subject to the Payment Limit of this Contract and subject to the following Payment Provisions, County will pay Contractor the following fee as full compensation for all services, work, expenses or costs provided or incurred by Contractor:

   ☐ a. $_____ monthly,

   ☐ b. $_____ per unit, as defined in the Service Plan,

   ☐ c. $_____ after completion of all obligations and conditions herein, *or*

   ☑ d. County shall pay Contractor in accordance with the provisions of Service Plan, Paragraph C. (Compensation), at the rates set forth in Attachment B (Compensation), which is attached hereto and is incorporated herein by reference.

2. **Payment Demands.** Contractor shall submit written demands for payment on County Demand Form D-15 in the manner and form prescribed by County. Contractor shall submit said demands for payment no later than 30 days from the end of the month in which the contract services upon which such demand is based were actually rendered. Upon approval of payment demands by the head of the County Department for which this Contract is made, or his designee, County will make payments as specified in Paragraph 1. (Payment Amounts) above.

3. **Penalty for Late Submission.** If County is unable to obtain reimbursement from the State of California as a result of Contractor's failure to submit to County a timely demand for payment as specified in Paragraph 2. (Payment Demands) above, County shall not pay Contractor for such services to the extent County's recovery of funding is prejudiced by the delay even though such services were fully provided.

4. **Right to Withhold.** County has the right to withhold payment to Contractor when, in the opinion of County expressed in writing to Contractor, (a) Contractor's performance, in whole or in part, either has not been carried out or is insufficiently documented, (b) Contractor has neglected, failed or refused to furnish information or to cooperate with any inspection, review or audit of its program, work or records, or (c) Contractor has failed to sufficiently itemize or document its demand(s) for payment.

5. **Audit Exceptions.** Contractor agrees to accept responsibility for receiving, replying to, and/or complying with any audit exceptions by appropriate county, state or federal audit agencies resulting from its performance of this Contract. Within 30 days of demand, Contractor shall pay County the full amount of County's obligation, if any, to the state and/or federal government resulting from any audit exceptions, to the extent such are attributable to Contractor's failure to perform properly any of its obligations under this Contract.

DS DS

Initials: _____ _____
Contractor County Dept.

SERVICE PLAN

Number 77-412

(A) **Definitions**. As used in this Contract, the following terms have the following meanings:

1. **Covered Services** are those medically necessary health care services, as determined by the Contra Costa Health Plan (CCHP), which a Member is entitled to receive pursuant to, as applicable, a State of California Prepaid Health CCHP Agreement (PHP) or a CCHP benefit agreement.
2. **Member** is a person who is enrolled and is entitled to receive Covered Services from or through CCHP.
3. **Participating Provider** shall mean a health care provider, including licensed physicians and surgeons, providers of ancillary services, hospitals, skilled nursing facilities, and any other provider of health care services which/who has entered into an agreement with CCHP to provide Covered Services to CCHP Members.
4. **Primary Care Physician** shall mean a CCHP physician responsible for coordinating and controlling the delivery of Covered Services to the Member.

(B) **Administrative and Compliance Obligations**.

1. **Provision of Health Services**. Contractor agrees to provide all authorized hospice and palliative services which are within the scope of the Contractor's qualifications to each Member who is referred to Contractor by the Member's Primary Care Physician, pursuant to the utilization management procedures and requirements of the CCHP, a copy of which is on file in the administrative office of CCHP and a copy of which has been furnished to Contractor. Except in an emergency, all such referrals must be preauthorized as required by the CCHP's utilization management procedures. Contractor's services shall be consistent with accepted standards of care in Contra Costa County for the specialty or field of practice in which Contractor is engaged.

2. **Scope of Services.** Upon request received by Contractor from CCHP Director (or designee), Contractor shall provide its employees, in the job classifications listed below, to provide hospice and palliative services for CCHP Members. Contractor's services shall be consistent with accepted standards of care in Contra Costa County for the specialty or field of practice in which Contractor is engaged. Contractor shall provide licensed and qualified individuals in the job classifications listed and Contractor's employees shall provide services for CCHP Members as follows:

   a. **Skilled Nursing**. Contractor shall provide part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse or Licensed Vocational Nurses to assess and evaluate Members' nursing needs and provide necessary treatment which are within the nurses' scope of qualifications. Services include evaluation visits, observation, monitoring, training, and other services requiring substantial specialized nursing skill.

   b. **Hospice Services**. Contractor shall provide the following hospice services to CCHP members:

      i. Registered Nurse visits;
      ii. Licensed Vocational Nurse visits;
      iii. Certified Home Health Aide visits;
      iv. Physical, Occupational, Speech and Respiratory therapies as needed;
      v. Medical Social Worker visits;
      vi. Counseling; and

Initials: [redacted] DS DS
Contractor County Dept.

vii. Volunteer support.

The following hospice services require pre-authorization:

i. Inpatient hospitalization;
ii. Palliative radiation;
iii. Infusion therapy;
iv. Any change in treatment or therapy frequencies;
v. Dietary consultation;
vi. Acute hospitalization; and
vii. Change in the hospice level of care for the Member.

The following services are excluded unless separately authorized and priced prior to utilization:

i. Custodial care;
ii. Room and board;
iii. Experimental therapy;
iv. In-home physician visit; and
v. Services unrelated to the terminal illness.

i. **Palliative Care Services**. Contractor's employees shall provide the following palliative care services to CCHP members:

i. Physician Visits;
ii. Registered Nurse Visits; and
iii. Social Worker Visits.

The following requires pre-authorization from the CCHP Director, or designee, before they are to be provided:

iv. Palliative Care visits; and
v. Any change in treatment therapy frequencies.

3. **Referral and Coordination**. Subject to CCHP's Utilization Review Unit's prior authorization and other applicable utilization review requirements, including coordination of approval of the Member's Primary Care Physician, Contractor shall, as medically necessary, refer Members to other specialist physicians, health care facilities, ancillary providers, and other health care providers. provided that such providers and/or facilities are Participating Providers.

4. **Referrals and Prior Authorization**.

a. Contractor shall comply with the utilization management procedures of the CCHP. Such procedures may be amended from time to time pursuant to Special Conditions Paragraph 7. (Modifications and Amendments). Contractor acknowledges that, except with an emergency, prior authorization is required with respect to:

i. The provision of all Contractor's hospice services pursuant to Paragraph (B) Administrative and Compliance Obligations, subparagraph 1. (Provision of Health Services), above; or,

ii. The referral of Members to other health care providers, including but not limited to health care facilities. for Covered Services.

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Initials: _____ _____
Contractor County Dept.

b. Except with the prior authorization of CCHP's Utilization Review Unit, Contractor shall refer Members only to Participating Providers.

c. Upon CCHP's Utilization Review Unit request, Contractor shall actively participate in CCHP's quality assurance and/or utilization committees.

5. **Contractor Licensure/Privileges**. Contractor shall:

a. Maintain a current, valid and unrestricted license to practice their profession in the State of California.

b. Continuously during the term of this Contract, satisfy all credentialing and professional standards of CCHP.

c. Be certified for participation in the Medicare and/or Medi-Cal Programs if Contractor's services are a Medi-Cal and/or Medicare Program benefit.

6. **Medi-Cal / Medicare Requirements**. Contractor shall:

a. Comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act 1973, and the Age Discrimination Act of 1975;

b. Not employ or contract with, directly or indirectly, entities or individuals excluded from participation in Medicare or Medi-Cal for the provision of health care, utilization review, medical social work, or administrative services in respect to Members;

c. Not condition treatment or otherwise discriminate on the basis of whether a Member has or has not executed an advance directive;

d. Comply with any other government requirements and rules imposed upon providers who provide services to Medicare or Medi-Cal beneficiaries;

e. Provide to the California Department of Health Services (DHS). Health Care Financing Administration (HCFA), and other State and Federal Agencies, such data, information, reports, and access which are required to be provided by State or Federal Regulations, or any contract between CCHP and DHS, or the CCHP and HCFA.

f. Contractor shall furnish to the Peer Review Organization (PRO) under contract to HCFA, on-site access to or copies of patient care records and other pertinent data, and permit the PRO or its sub-contractors to examine Contractor operations and records as necessary for the PRO to carry out its functions under applicable Federal Law.

7. **Grievance Process**. Contractor shall cooperate with the grievance process employed by the CCHP to respond to and resolve complaints from Members. Contractor shall comply with CCHP Member Services Department's resolution of any such complaints.

8. **Collection of Copayments**. CCHP shall notify Contractor of its copayment requirements, if any, and Contractor shall collect and retain such copayments. Contractor shall not waive CCHP Member Services Department's CCHP's copayment requirements.

9. **Directories**. Contractor consents to the listing of their name and address and area of medical practice in directories produced by CCHP's Utilization Review Unit. In the event of termination of this Contract, or if any such list information is incorrect, CCHP's Provider Relations Department shall have no obligation to delete or correct such listing information until such time as CCHP, in its sole discretion, reissues its directories.

10. **Quality Management Program**. Contractor shall cooperate with and participate in CCHP's Quality Management Program and provide to CCHP information reasonably requested pursuant thereto.

Initials: [redacted]
Contractor County Dept.

11. **Drug Formulary**. To the extent required by CCHP's Utilization Review Unit, Contractor shall comply with the drug formulary requirements as may be now in effect or adopted thereafter.

(C) **Compensation**.

1. **Reimbursement**.

a. Provided that Contractor has complied with all requirements of CCHP utilization management program and has obtained all required authorizations (including any required prior authorizations) and referrals for the provision of Contractor's services, then for the Covered Services provided by Contractor to Members hereunder, CCHP shall pay Contractor in accordance with the rates set forth in Attachment B (Compensation), minus any copayments required to be collected pursuant to Paragraph B (Administrative and Compliance Obligations), Subparagraph 8 (Collection of Copayments), above.

b. Contractor shall accept payment by CCHP in accordance with this Contract, along with any applicable Member copayments, as payment in full for all professional, administrative, and other services rendered by Contractor pursuant to this Contract.

c. Contractor acknowledges that CCHP reserves the right to amend the compensation formula as set forth herein pursuant to the amendment process set forth in Special Conditions Paragraph 7. (Modifications and Amendments) attached and incorporated herein by reference.

2. **Retroactive Additions / Deletions of Members**. In the event CCHP retroactively adds a Member who is a patient of Contractor, the compensation provisions of this Agreement shall apply from the effective date such person becomes a Member. In the event CCHP retroactively deletes a Member, CCHP shall compensate Contractor to the date CCHP acts to delete such Member, provided that prior authorization was granted in accordance with Paragraph B.4.a., above.

3. **No Billing of Members**.

a. In no event, including but not limited to non-payment by CCHP, the insolvency of CCHP, or breach of this Contract, shall any Member be liable for any sums owed to Contractor by CCHP. Contractor shall not bill, charge, balance bill, collect a deposit or other sum, seek compensation, or reimbursement from or maintain any action, or have any recourse against, or make any surcharge upon a Member or person acting on a Member's behalf. If CCHP receives notice of any action by Contractor in violation of this provision, it shall be entitled to take appropriate action, including the immediate termination of this Contract.

b. The obligations set forth in this paragraph shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of Members, and these provisions shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between Contractor and any Member or any persons acting on behalf of either of them.

c. Notwithstanding the foregoing, Contractor may bill a Member who is not a Medi-Cal beneficiary for the provision of Non-Covered Services, provided that Contractor has first disclosed to the Member, on a form approved by CCHP, that the services to be provided are Non-Covered Services for which the Member is to be financially responsible.

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Initials: _____ _____
Contractor County Dept.

(D) **Miscellaneous**.

1. **Provider Manual**. Contractor shall comply with the applicable provisions of CCHP's Provider Manual, which is hereby incorporated herein by reference, as amended from time to time. Manual is posted on-line at https://cchealth.org/healthplan/providers/manual.php, and is hereby incorporated by reference.
2. **Partial Invalidity**. If any provision of this Contract is held to be invalid, void, or unenforceable, the remaining provisions shall nevertheless continue in full force and effect, unless the provisions held invalid or unenforceable shall substantially impair the benefits of the remaining portions of this Contract.
3. **No Volume Guarantee**. CCHP does not represent, warrant, or guarantee any minimum enrollment of Members to Contractor under this Contract.
4. **Non-Exclusive Agreement**. Each party shall have at all times the right to enter into agreements comparable to this Contract with other persons or entities.
5. **Determination of Eligibility**. CCHP may issue identification cards to Members. Production of such identification card shall be indicative of a person's status as a Member, but shall not be conclusive of such status. At Contractor's request, CCHP shall verify Member's Status. If Contractor obtains such verification from CCHP, CCHP shall not retroactively deny payment if CCHP later determines Member's non-eligibility, subject to the provisions of Paragraph C. (Compensation) (2), above.
6. **Waiver**. The waiver of any breach of this Contract by either party shall not constitute a continuing waiver or a waiver of any subsequent breach of either the same or any other provision of this Contract.
7. **Non-Solicitation**. During the term of this Contract, and for one (1) year thereafter, Contractor shall not solicit, induce, or encourage any Member to disenroll from CCHP or discontinue obtaining health care services from or through CCHP.
8. **Marketing.** Nothing in this Contract shall prohibit, restrict or limit the Contractor from advertising as its own entity.
9. **HIPAA Requirements**. Contractor shall comply with the applicable requirements and procedures established by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and any modifications thereof, including but not limited to, the attached HIPAA Business Associate Addendum which is incorporated herein by reference.
10. **Contra Costa Health Plan Requirements**. Contractor shall be subject to the attached CCHP Requirements (Attachment A), which are incorporated herein by reference.
11. **Intellectual Property**. Contractor acknowledges and agrees that it owns no rights in any of the data gathered or generated as a result of the services or actions that it provides under this Contract.

DS DS

Initials: _____ _____
Contractor County Dept.

Contra Costa County
Standard Form L-4
Revised 2014

SPECIAL CONDITIONS

Number 77-412

1. **Compliance with Law**. Paragraph 1. (Compliance with Law) of the General Conditions is hereby deleted and replaced with a new paragraph to read as follows:

"1. **Compliance with Law**. Contractor is subject to and sha;; comply with all applicable federal, state and local laws and regulations with respect to its performance under this Contract, including but not limited to, licensing, employment and purchasing practices; and wages, hours and conditions of employment, including nondiscrimination; the Contra Costa Health Plan Requirements (Attachment A) which is incorporated herein by reference; and with all Rules of the California Medical Board applicable to Contractor's medical practice."

2. **Inspections**. Paragraph 2. (Inspection) of the General Conditions is hereby deleted and replaced with a new paragraph to read as follows:

"2. **Site Inspections**. To the extent required by law or CCHP's agreements with the California Department of Health Care Services ("DHCS") or the federal Center for Medicare and Medicaid Services ("CMS"), Contractor shall permit state and federal regulatory authorities to conduct periodic site evaluations and inspections of Contractor's facilities and records, and Contractor shall correct, as may be required by Law, any deficiencies in such facilities or records as determined by such evaluations and inspections."

3. **Insurance Requirements**. Paragraph 19. (Insurance) of the General Conditions, subparagraph a. (Commercial General Liability Insurance) is hereby deleted and replaced with a new subparagraph a. below, to read as follows:

"a. **Commercial General Liability Insurance.** For all contracts where the total payment limit of the contract is $500,000 or less, Contractor will provide commercial general liability insurance, including coverage for business losses and for owned and non-owned automobiles, with a minimum combined single limit coverage of $500,000 for all damages, including consequential damages, due to bodily injury, sickness or disease, or death to any person or damage to or destruction of property, including the loss of use thereof, arising from each occurrence. Said policies must constitute primary insurance as to County, the state and federal governments, and their officers, agents, and employees, so that other insurance policies held by them or their self-insurance program(s) will not be required to contribute to any loss covered under Contractor's insurance policy or policies. For all contracts where the total payment limit is greater than $500,000, the aforementioned insurance coverage to be provided by Contractor must have a minimum combined single limit coverage of $1,000,000."

4. **Insurance Requirements**. Paragraph 19. (Insurance) of the General Conditions is hereby modified by the addition of subparagraphs e. and f. below, to read as follows:

"e. **Professional Liability.** Throughout the term of this Contract, Contractor shall maintain all necessary insurance for services to be provided by Contractor hereunder, including but not limited to professional malpractice liability coverage. Malpractice liability insurance shall be in an amount no less than $1,000,000 per claim/$3,000,000 annual aggregate and shall be from a reputable insurance company acceptable to the County. Contractor shall provide the County with a valid certificate of insurance evidencing the coverage required by this clause and shall promptly advise County of any and all claims paid by the insurer(s) under said insurance.

DS DS
Initials: [redacted]
Contractor County Dept.

f. **Cyber Liability Insurance.** If Contractor will be hosting County data or software on Contractor's servers, Contractor shall provide commercial Cyber Liability Insurance, in form and substance satisfactory to County, including without limitation, coverage for loss of data, breaches of personally identifiable information, call center services, credit monitoring remedies, identity restoration services, and any penalties or fines that may be assessed. Contractor shall cause such insurance to be endorsed to include County and its officers and employees as additional insureds. Such policies must constitute primary insurance as to County and its officers, agents, and employees, so that other insurance policies held by them or their self-insurances programs will not be required to contribute to any loss covered under Contractors' insurance policy or policies."

5. **Termination**. Paragraph 5. (Termination and Cancellation) of the General Conditions, is hereby modified by the addition of a new subparagraph d., to read as follows:

"d. **Termination re: Credentialing**. In the event this Contract is effective prior to the completion of CCHP's credentialing of Contractor, this contract shall immediately terminate in the event that:

(1) CCHP determines that Contractor does not satisfy CCHP's credentialing requirements; *or*

(2) Contractor does not, as determined by CCHP, promptly provide to CCHP necessary and requested consents for the release of credentialing information or otherwise does not cooperate with CCHP's credentialing process."

6. **Payment Demand**. Paragraph 2. (Payment Demands) of the Payment Provisions is hereby deleted and replaced with a new Paragraph 2., to read as follows:

"(2) **Billing Forms**.

a. Contractor shall bill CCHP on a periodic basis in a manner and on such forms as are acceptable to CCHP. Such forms shall contain the same information as a fully completed UB.04 or CMS 1500 with complete CPT-4 or ICD-10 coding and the Member's Subscriber Number. CCHP shall advise Contractor of any objections to the bill or request additional information within thirty (30) days of receipt of the bill.

b. Contractor agrees to exchange all claims submissions through electronic transactions. Contractor shall conform all electronic transactions to the Department of Health Care Services (DHCS) Companion guide for EDI 274. DHCS may modify its Companion Guide for EDI 274 at any time without amending this agreement. Contractor is responsible for the accuracy, privacy and security of transactions it submits to CCHP and agrees to comply with state and federal laws, including the Administrative Simplifications requirements of HIPAA, as set out in the Code of Federal Regulations Title 45 Parts 160164, including all privacy and security requirements as set forth in HIPAA."

7. **Modifications and Amendments**. This Contract may only be amended as set forth in Paragraph 8 (Modifications and Amendments) of the General Conditions. However, it is expressly understood and acknowledged by Contractor that:

1. CCHP's Utilization Review Unit may, without Contractor's consent, from time to time, modify its utilization management procedures and requirements, including without limitation, its requirements regarding prior authorization for services, by providing written notice of such modification(s) to Contractor; and

DS DS

Initials: _____ _____
Contractor County Dept.

SPECIAL CONDITIONS

Number 77-412

2. CCHP may at any time amend any provision(s) of this Contract, including without limitation, the compensation provisions set forth in Paragraph (C) (Compensation) of the Service Plan, as follows: CCHP shall deliver a copy of the text of such amendment to Contractor, along with a summary of both the proposed amendment and the procedures by which Contractor may reject the proposed amendment. If Contractor wishes to reject the amendment, Contractor shall, within thirty (30) days following Contractor's receipt of the amendment, deliver to CCHP personally or by certified mail, return receipt requested, a written and signed notice of rejection. If Contractor does not so reject the amendment, it shall be deemed accepted by Contractor and shall be effective at the later occurring of: (A) the effective date contained in the amendment, and (B) at the expiration of the thirty (30) day period afforded Contractor to reject the amendment. In the event Contractor rejects the amendment, CCHP may, in its sole discretion, terminate this Contract on no less than thirty (30) days advance written notice to Contractor.

DS DS

Initials: _____ _____
Contractor County Dept.

Contra Costa County
Standard Form L-5
Revised 2016

GENERAL CONDITIONS
(Purchase of Services - Long Form)

1. **Compliance with Law**. Contractor is subject to and must comply with all applicable federal, state, and local laws and regulations with respect to its performance under this Contract, including but not limited to, licensing, employment, and purchasing practices; and wages, hours, and conditions of employment, including nondiscrimination.

2. **Inspection**. Contractor's performance, place of business, and records pertaining to this Contract are subject to monitoring, inspection, review and audit by authorized representatives of the County, the State of California, and the United States Government.

3. **Records**. Contractor must keep and make available for inspection and copying by authorized representatives of the County, the State of California, and the United States Government, the Contractor's regular business records and such additional records pertaining to this Contract as may be required by the County.

   a. **Retention of Records**. Contractor must retain all documents pertaining to this Contract for five years from the date of submission of Contractor's final payment demand or final Cost Report; for any further period that is required by law; and until all federal/state audits are complete and exceptions resolved for this Contract's funding period. Upon request, Contractor must make these records available to authorized representatives of the County, the State of California, and the United States Government.

   b. **Access to Books and Records of Contractor, Subcontractor**. Pursuant to Section 1861(v)(1) of the Social Security Act, and any regulations promulgated thereunder, Contractor must, upon written request and until the expiration of five years after the furnishing of services pursuant to this Contract, make available to the County, the Secretary of Health and Human Services, or the Comptroller General, or any of their duly authorized representatives, this Contract and books, documents, and records of Contractor necessary to certify the nature and extent of all costs and charges hereunder.

   Further, if Contractor carries out any of the duties of this Contract through a subcontract with a value or cost of $10,000 or more over a twelve-month period, such subcontract must contain a clause to the effect that upon written request and until the expiration of five years after the furnishing of services pursuant to such subcontract, the subcontractor must make available to the County, the Secretary, the Comptroller General, or any of their duly authorized representatives, the subcontract and books, documents, and records of the subcontractor necessary to verify the nature and extent of all costs and charges thereunder.

   This provision is in addition to any and all other terms regarding the maintenance or retention of records under this Contract and is binding on the heirs, successors, assigns and representatives of Contractor.

4. **Reporting Requirements**. Pursuant to Government Code Section 7550, Contractor must include in all documents and written reports completed and submitted to County in accordance with this Contract, a separate section listing the numbers and dollar amounts of all contracts and subcontracts relating to the preparation of each such document or written report. This section applies only if the Payment Limit of this Contract exceeds $5,000.

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5. **Termination and Cancellation**.

   a. **Written Notice**. This Contract may be terminated by either party, in its sole discretion, upon thirty-day advance written notice thereof to the other, and may be cancelled immediately by written mutual consent.

   b. **Failure to Perform**. County, upon written notice to Contractor, may immediately terminate this Contract should Contractor fail to perform properly any of its obligations hereunder. In the event of such termination, County may proceed with the work in any reasonable manner it chooses. The cost to County of completing Contractor's performance will be deducted from any sum due Contractor under this Contract, without prejudice to County's rights to recover damages.

   c. **Cessation of Funding**. Notwithstanding any contrary language in Paragraphs 5 and 11, in the event that federal, state, or other non-County funding for this Contract ceases, this Contract is terminated without notice.

6. **Entire Agreement**. This Contract contains all the terms and conditions agreed upon by the parties. Except as expressly provided herein, no other understanding, oral or otherwise, regarding the subject matter of this Contract will be deemed to exist or to bind any of the parties hereto.

7. **Further Specifications for Operating Procedures**. Detailed specifications of operating procedures and budgets required by this Contract, including but not limited to, monitoring, evaluating, auditing, billing, or regulatory changes, may be clarified in a written letter signed by Contractor and the department head, or designee, of the county department on whose behalf this Contract is made. No written clarification prepared pursuant to this Section will operate as an amendment to, or be considered to be a part of, this Contract.

8. **Modifications and Amendments**.

   a. **General Amendments**. In the event that the total Payment Limit of this Contract is less than $200,000 and this Contract was executed by the County's Purchasing Agent, this Contract may be modified or amended by a written document executed by Contractor and the County's Purchasing Agent or the Contra Costa County Board of Supervisors, subject to any required state or federal approval. In the event that the total Payment Limit of this Contract exceeds $200,000 or this Contract was initially approved by the Board of Supervisors, this Contract may be modified or amended only by a written document executed by Contractor and the Contra Costa County Board of Supervisors or, after Board approval, by its designee, subject to any required state or federal approval.

   b. **Minor Amendments**. The Payment Provisions and the Service Plan may be amended by a written administrative amendment executed by Contractor and the County Administrator (or designee), subject to any required state or federal approval, provided that such administrative amendment may not increase the Payment Limit of this Contract or reduce the services Contractor is obligated to provide pursuant to this Contract.

9. **Disputes**. Disagreements between County and Contractor concerning the meaning, requirements, or performance of this Contract shall be subject to final written determination by the head of the county department for which this Contract is made, or his designee, or in accordance with the applicable procedures (if any) required by the state or federal government.

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10. **Choice of Law and Personal Jurisdiction**.

    a. This Contract is made in Contra Costa County and is governed by, and must be construed in accordance with, the laws of the State of California.

    b. Any action relating to this Contract must be instituted and prosecuted in the courts of Contra Costa County, State of California.

11. **Conformance with Federal and State Regulations and Laws**. Should federal or state regulations or laws touching upon the subject of this Contract be adopted or revised during the term hereof, this Contract will be deemed amended to assure conformance with such federal or state requirements.

12. **No Waiver by County**. Subject to Paragraph 9. (Disputes) of these General Conditions, inspections or approvals, or statements by any officer, agent or employee of County indicating Contractor's performance or any part thereof complies with the requirements of this Contract, or acceptance of the whole or any part of said performance, or payments therefor, or any combination of these acts, do not relieve Contractor's obligation to fulfill this Contract as prescribed; nor is the County thereby prevented from bringing any action for damages or enforcement arising from any failure to comply with any of the terms and conditions of this Contract.

13. **Subcontract and Assignment**. This Contract binds the heirs, successors, assigns and representatives of Contractor. Prior written consent of the County Administrator or his designee, subject to any required state or federal approval, is required before the Contractor may enter into subcontracts for any work contemplated under this Contract, or before the Contractor may assign this Contract or monies due or to become due, by operation of law or otherwise.

14. **Independent Contractor Status**. The parties intend that Contractor, in performing the services specified herein, is acting as an independent contractor and that Contractor will control the work and the manner in which it is performed. This Contract is not to be construed to create the relationship between the parties, or between County and any Contractor employee, of agent, servant, employee, partnership, joint venture, or association. Neither Contractor, nor any of its employees, is a County employee. This Contract does not give Contractor, or any of its employees, any right to participate in any pension plan, workers' compensation plan, insurance, bonus, or similar benefits County provides to its employees. In the event that County exercises its right to terminate this Contract, Contractor expressly agrees that it will have no recourse or right of appeal under any rules, regulations, ordinances, or laws applicable to employees.

15. **Conflicts of Interest**. Contractor covenants that it presently has no interest and that it will not acquire any interest, direct or indirect, that represents a financial conflict of interest under state law or that would otherwise conflict in any manner or degree with the performance of its services hereunder. Contractor further covenants that in the performance of this Contract, no person having any such interests will be employed by Contractor. If requested to do so by County, Contractor will complete a "Statement of Economic Interest" form and file it with County and will require any other person doing work under this Contract to complete a "Statement of Economic Interest" form and file it with County. Contractor covenants that Contractor, its employees and officials, are not now employed by County and have not been so employed by County within twelve months immediately preceding this Contract; or, if so employed, did not then and do not now occupy a position that would create a conflict of interest under Government Code section 1090. In

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addition to any indemnity provided by Contractor in this Contract, Contractor will indemnify, defend, and hold the County harmless from any and all claims, investigations, liabilities, or damages resulting from or related to any and all alleged conflicts of interest. Contractor warrants that it has not provided, attempted to provide, or offered to provide any money, gift, gratuity, thing of value, or compensation of any kind to obtain this Contract.

16. **Confidentiality**. To the extent allowed under the California Public Records Act, Contractor agrees to comply and to require its officers, partners, associates, agents and employees to comply with all applicable state or federal statutes or regulations respecting confidentiality, including but not limited to, the identity of persons served under this Contract, their records, or services provided them, and assures that no person will publish or disclose or permit or cause to be published or disclosed, any list of persons receiving services, except as may be required in the administration of such service. Contractor agrees to inform all employees, agents and partners of the above provisions, and that any person knowingly and intentionally disclosing such information other than as authorized by law may be guilty of a misdemeanor.

17. **Nondiscriminatory Services**. Contractor agrees that all goods and services under this Contract will be available to all qualified persons regardless of age, gender, race, religion, color, national origin, ethnic background, disability, or sexual orientation, and that none will be used, in whole or in part, for religious worship.

18. **Indemnification**. Contractor will defend, indemnify, save, and hold harmless County and its officers and employees from any and all claims, demands, losses, costs, expenses, and liabilities for any damages, fines, sickness, death, or injury to person(s) or property, including any and all administrative fines, penalties or costs imposed as a result of an administrative or quasi-judicial proceeding, arising directly or indirectly from or connected with the services provided hereunder that are caused, or claimed or alleged to be caused, in whole or in part, by the negligence or willful misconduct of Contractor, its officers, employees, agents, contractors, subcontractors, or any persons under its direction or control. If requested by County, Contractor will defend any such suits at its sole cost and expense. If County elects to provide its own defense, Contractor will reimburse County for any expenditures, including reasonable attorney's fees and costs. Contractor's obligations under this section exist regardless of concurrent negligence or willful misconduct on the part of the County or any other person; provided, however, that Contractor is not required to indemnify County for the proportion of liability a court determines is attributable to the sole negligence or willful misconduct of the County, its officers and employees. This provision will survive the expiration or termination of this Contract.

19. **Insurance**. During the entire term of this Contract and any extension or modification thereof, Contractor shall keep in effect insurance policies meeting the following insurance requirements unless otherwise expressed in the Special Conditions:

    a. **Commercial General Liability Insurance.** For all contracts where the total payment limit of the contract is $500,000 or less, Contractor will provide commercial general liability insurance, including coverage for business losses and for owned and non-owned automobiles, with a minimum combined single limit coverage of $500,000 for all damages, including consequential damages, due to bodily injury, sickness or disease, or death to any person or damage to or destruction of property, including the loss of use thereof, arising from each occurrence. Such insurance must be endorsed to include County and its officers and employees as additional insureds as to all services performed by Contractor under this Contract. Said policies must constitute primary insurance as to County, the state and federal governments, and their officers, agents, and employees, so that other insurance policies held by

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them or their self-insurance program(s) will not be required to contribute to any loss covered under Contractor's insurance policy or policies. Contractor must provide County with a copy of the endorsement making the County an additional insured on all commercial general liability policies as required herein no later than the effective date of this Contract. For all contracts where the total payment limit is greater than $500,000, the aforementioned insurance coverage to be provided by Contractor must have a minimum combined single limit coverage of $1,000,000.

b. **Workers' Compensation**. Contractor must provide workers' compensation insurance coverage for its employees.

c. **Certificate of Insurance**. The Contractor must provide County with (a) certificate(s) of insurance evidencing liability and worker's compensation insurance as required herein no later than the effective date of this Contract. If Contractor should renew the insurance policy(ies) or acquire either a new insurance policy(ies) or amend the coverage afforded through an endorsement to the policy at any time during the term of this Contract, then Contractor must provide (a) current certificate(s) of insurance.

d. **Additional Insurance Provisions.** No later than five days after Contractor's receipt of: (i) a notice of cancellation, a notice of an intention to cancel, or a notice of a lapse in any of Contractor's insurance coverage required by this Contract; or (ii) a notice of a material change to Contractor's insurance coverage required by this Contract, Contractor will provide Department a copy of such notice of cancellation, notice of intention to cancel, notice of lapse of coverage, or notice of material change. Contractor's failure to provide Department the notice as required by the preceding sentence is a default under this Contract

20. **Notices**. All notices provided for by this Contract must be in writing and may be delivered by deposit in the United States mail, postage prepaid. Notices to County must be addressed to the head of the county department for which this Contract is made. Notices to Contractor must be addressed to the Contractor's address designated herein. The effective date of notice is the date of deposit in the mails or of other delivery, except that the effective date of notice to County is the date of receipt by the head of the county department for which this Contract is made.

21. **Primacy of General Conditions**. In the event of a conflict between the General Conditions and the Special Conditions, the General Conditions govern unless the Special Conditions or Service Plan expressly provide otherwise.

22. **Nonrenewal**. Contractor understands and agrees that there is no representation, implication, or understanding that the services provided by Contractor under this Contract will be purchased by County under a new contract following expiration or termination of this Contract, and Contractor waives all rights or claims to notice or hearing respecting any failure to continue purchasing all or any such services from Contractor.

23. **Possessory Interest**. If this Contract results in Contractor having possession of, claim or right to the possession of land or improvements, but does not vest ownership of the land or improvements in the same person, or if this Contract results in the placement of taxable improvements on tax exempt land (Revenue & Taxation Code Section 107), such interest or improvements may represent a possessory interest subject to property tax, and Contractor may be subject to the payment of property taxes levied on such interest. Contractor agrees that this provision complies with the notice requirements of Revenue & Taxation Code Section 107.6, and waives all rights to further notice or to damages under that or any comparable statute.

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24. **No Third-Party Beneficiaries**. Nothing in this Contract may be construed to create, and the parties do not intend to create, any rights in third parties.

25. **Copyrights, Rights in Data, and Works Made for Hire**. Contractor will not publish or transfer any materials produced or resulting from activities supported by this Contract without the express written consent of the County Administrator. All reports, original drawings, graphics, plans, studies and other data and documents, in whatever form or format, assembled or prepared by Contactor or Contractor's subcontractors, consultants, and other agents in connection with this Contract are "works made for hire" (as defined in the Copyright Act, 17 U.S.C. Section 101 et seq., as amended) for County, and Contractor unconditionally and irrevocably transfers and assigns to Agency all right, title, and interest, including all copyrights and other intellectual property rights, in or to the works made for hire. Unless required by law, Contractor shall not publish, transfer, discuss, or disclose any of the above-described works made for hire or any information gathered, discovered, or generated in any way through this Agreement, without County's prior express written consent. If any of the works made for hire is subject to copyright protection, County reserves the right to copyright such works and Contractor agrees not to copyright such works. If any works made for hire are copyrighted, County reserves a royalty-free, irrevocable license to reproduce, publish, and use the works made for hire, in whole or in part, without restriction or limitation, and to authorize others to do so.

26. **Endorsements**. In its capacity as a contractor with Contra Costa County, Contractor will not publicly endorse or oppose the use of any particular brand name or commercial product without the prior written approval of the Board of Supervisors. In its County-contractor capacity, Contractor will not publicly attribute qualities or lack of qualities to a particular brand name or commercial product in the absence of a well-established and widely accepted scientific basis for such claims or without the prior written approval of the Board of Supervisors. In its County-contractor capacity, Contractor will not participate or appear in any commercially produced advertisements designed to promote a particular brand name or commercial product, even if Contractor is not publicly endorsing a product, as long as the Contractor's presence in the advertisement can reasonably be interpreted as an endorsement of the product by or on behalf of Contra Costa County. Notwithstanding the foregoing, Contractor may express its views on products to other contractors, the Board of Supervisors, County officers, or others who may be authorized by the Board of Supervisors or by law to receive such views.

27. **Required Audit**.

    a. If Contractor expends $750,000 or more in federal grant funds in any fiscal year from any source, Contractor must provide to County, at Contractor's expense, an audit conforming to the requirements set forth in the most current version of Code of Federal Regulations, Title 2, Part 200, Subpart F.

    b. If Contractor expends less than $750,000 in federal grant funds in any fiscal year from any source, but the grant imposes specific audit requirements, Contractor must provide County with an audit conforming to those requirements.

    c. If Contractor expends less than $750,000 in federal grant funds in any fiscal year from any source, Contractor is exempt from federal audit requirements for that year except as required by Code of Federal Regulations, Title 2, Part 200, Subpart F. Contractor shall make its records available for, and an audit may be required by, appropriate officials of the federal awarding agency, the General Accounting Office , the pass-through entity and/or the County. If an audit is required, Contractor must provide County with the audit.

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d. With respect to the audits specified in sections (a), (b) and (c) above, Contractor is solely responsible for arranging for the conduct of the audit, and for its cost. County may withhold the estimated cost of the audit or 10 percent of the contract amount, whichever is greater, or the final payment, from Contractor until County receives the audit from Contractor.

28. **Authorization**. Contractor, or the representative(s) signing this Contract on behalf of Contractor, represents and warrants that it has full power and authority to enter into this Contract and to perform the obligations set forth herein.

29. **No Implied Waiver**. The waiver by County of any breach of any term or provision of this Contract will not be deemed to be a waiver of such term or provision or of any subsequent breach of the same or any other term or provision contained herein.

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ATTACHMENT A

CONTRA COSTA HEALTH PLAN REQUIREMENTS

Number: 77-412

These Contra Costa Health Plan Requirements are in addition to any and all other terms provided in the Contract referenced by number above. If any provision of these Contra Costa Health Plan Requirements conflicts with any of the terms provided in this Contract, then these Contra Costa Health Plan Requirements will prevail.

Pursuant to State Department of Health/County Contract #96-26103 (County #29-772), effective October 1, 1995, (or the latest revision); requirements of the Waxman-Duffy Prepaid Health Plan Act, (1972) and Knox-Keene Health Care Service Plan Act of 1975; Health and Safety Code §§ 1340 et seq.; Welfare and Institutions Code, §§ 14200 et seq.; Title 22, CCR, §§ 53250, et seq. and Title 28, CCR, §§ 1300.43, et seq., the following requirements are incorporated into the Contract referenced by number above.

1. Contractor is subject to and will comply with all applicable Medi-Cal contracts and, applicable local, state and federal laws and regulations, and contractual obligations incumbent upon the County under County Contract #29-772, and any subsequent amendments thereto. In addition, Contractor will comply with all applicable requirements of the State Department of Health Care Services (hereinafter "DHCS"), Medi-Cal Managed Care Program, including all applicable Medicaid laws, regulations, applicable state and federal laws. County agrees to inform the Contractor of prospective requirements added by DHCS to County's Contract with DHCS before the requirement would be effective, and Contractor agrees to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

2. A Contractor providing any basic health care service to Contra Costa Health Plan ("Plan") members must meet all of the requirements of Chapters 3 and 4, Subdivision 1, Division 3, Title 22, CCR, (commencing with § 51000) that relate to the services provided by the Contractor.

3. Contractor's compensation hereunder will not be based, in any way, on a percentage of the County's compensation from the State DHCS. This agreement does not preclude the establishment of Contractor's rate based upon Welfare and Institutions Code § 14453.

4. To the extent that Contractor is responsible for the coordination of care for members, County agrees to share with Contractor any utilization data that DHCS has provided to County, and Contractor agrees to receive the utilization data provided and use it as the Contractor is able for the purpose of Member care coordination. Contractor will provide reports and abstract of treatment records in relation to Plan members, as required by County. Contractor shall meet all applicable care coordination requirements for Medi-Cal members as required by DHCS, including but not limited to the following care coordination activities to assure availability and access to care, clinical services, specialty services and care management services, including comprehensive basic and complex case management. Contractor agrees to exchange available information and data, including member-level data, to facilitate care coordination activities in accordance with all applicable HIPAA requirements and other state and federal statutes and regulations.

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CONTRA COSTA HEALTH PLAN REQUIREMENTS

5. In addition to the requirements of Paragraph 3. (Records) of the General Conditions, Contractor will comply with the following additional requirements:

Records Disclosure and Access by Government Officials.

a. **Availability of Records.** Contractor must comply with all monitoring provisions of the County's contracts and any monitoring requests by DHCS. Contractor will allow the audit, inspection, or evaluation of its premises, physical facilities, equipment, examination, and copying of all books and records including, but not limited to, working papers, reports, financial records, medical records, encounter data, medical charts, computers or other electronic systems, and other documentation pertaining to services rendered to Plan members, by the County, the State DHCS, Centers for Medicare and Medicaid Services ("CMS"), the State Department of Managed Health Care ("State DMHC"), the U.S. Department of Health and Human Services ("DHHS") Inspector General, the U.S. Department of Justice ("DOJ"), and their duly authorized representatives. Such books and records, including encounter data, will be made available at all reasonable times at the Contractor's place of business, for a term of at least ten (10) years from the final date of the contract period, or from the date of completion of any audit, whichever is later. If DHCS, CMS or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate and audit the Contractor at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Contractor from participation in the Medicaid program; seek recovery of payments made to the Contractor, or impose other sanctions provided under the State plan or governing All-Plan letters. Contractor shall implement and maintain policies and procedures that are designed to detect and prevent fraud, waste and abuse. Upon request, and subject to legally-required patient consents, Contractor will provide copies of Plan members' medical records to the County and to Plan members' other treating physicians. County will reimburse Contractor for the cost of copying Plan members' medical records that are requested by County. Additionally, upon request, Contractor will timely gather, preserve, and provide to the DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Contractor's possession, relating to threatened or pending litigation by or against DHCS.

b. **Maintenance of Records.** Contractor must maintain clear and complete books and records that reflect all services rendered to Plan members in a form maintained in accordance with the general standards applicable to such book or record keeping. Contractor will further maintain records of the costs of services provided to Plan members and all co-payments and other payments received by Contractor from Plan members or others on their behalf. Contractor will maintain and submit encounter and provider data in the time, form, and manner required by the County and the State DHCS. Encounter and provider data shall be complete, accurate, reasonable and timely to allow County meet its encounter and provider data reporting requirements to DHCS.

c. Contractor must preserve its records for the longer of (i) seven (7) years after termination of this Contract, (ii) one (1) year after the Member reaches the age of majority, if the Member is a minor, (iii) the period of time required by applicable law, including the Medicare and Medi-Cal programs and contracts to which Plan is subject, or (iv) ten (10) years from the final date of the Contract or

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from the date of completion of any audit, whichever is longer, or such longer time period if so required by the federal Centers for Medicare and Medicaid Services ("CMS").

d. Contractor must also comply with all provisions of the Omnibus Reconciliation Act of 1980, the Balanced Budget Act of 1997, and the Medicare Prescription Drug, Improvement and Modernization Act of 2003, regarding access to books, documents, and records. Without limiting the foregoing, Contractor must maintain, provide access to, and provide copies of records, this Contract, and any other information, to Government Officials and such other officials entitled by law or by Plan Government Program Contracts, as may be necessary for compliance by Plan with the provisions of all applicable law and contractual requirements governing Plan. Such records must be available at all reasonable times at Contractor's place of business or at some other mutually agreeable location in California.

e. In the event that this Contract pertains to hospital-based physicians or that the Covered Services include any other physician services, County retains the sole right and responsibility to notify Members regarding the termination of this Contract, and the termination of any contract between Contractor and a subcontractor physician, as applicable.

f. Contractor must document in each Member's medical record whether or not the Member has executed an advance directive. Contractor is subject to the requirements in Title 42 of the Code of Federal Regulations §§ 2.1 et seq., relating to the maintenance and disclosure of Member Records received or acquired by federally assisted alcohol or drug programs.

g. Contractor acknowledges that County is required to provide CMS and other Government Officials with encounter data, as requested by such agencies. Such data may include medical records and other data necessary to characterize each encounter between a Member and Contractor. Contractor agrees to cooperate with County and provide it with all such information in such form and manner requested by County in order to meet such requirements.

h. Contractor acknowledges and agrees that Government Officials have the right to inspect, evaluate, and audit the quality, appropriateness, and timeliness of Covered Services.

i. **Subcontractor Records.** All of Contractor's subcontracts must be in writing. Contractor must maintain and make available, upon request, copies of all subcontracts and require that the subcontractor: 1. Make all applicable books and records available at reasonable times for inspection, examination, or copying by the State and federal DHCS, DHHS, DOJ, DMHC, and the County; and 2. Retain such books and records for a term of at least ten (10) years from the close of the last fiscal year.

6. General Conditions Paragraph 13. (Subcontract and Assignment) is hereby deleted in its entirety, and replaced with a new Paragraph, to read as follows:

"13. **Subcontract and Assignment.**

a. This Contract binds the heirs, successors, assigns and representatives of Contractor. Prior written consent of the County Administrator or his designee, subject to any required state or federal approval, is required before the Contractor may enter into subcontracts for any work contemplated

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under this Contract, or before the Contractor may assign this Contract or monies due or to become due, by operation of law or otherwise.

b. In addition to the consent of the County Administrator or designee, the prior written consent of DHCS is required before the Contractor may enter into any subcontract for any work contemplated under this Contract.

c. Any proposed amendments to any authorized subcontract must be approved in writing and in advance by DHCS. Any proposed amendment to a subcontract must be submitted, in writing, to DHCS, at least thirty (30) calendar days before the effective date of the proposed amendment to compensation, services, or the contract term. Proposed amendments that are neither approved nor disapproved by DHCS, will become effective by operation of law thirty (30) calendar days after DHCS has acknowledged receipt or upon the date specified in the Amendment, whichever date is later."

7. General Conditions Paragraph 8. (Modifications and Amendments), is hereby deleted in its entirety, and replaced with a new Paragraph, to read as follows:

"8. **Modifications and Amendments**.

a. General Amendments. In the event that the Payment Limit of this Contract is $200,000 or less, this Contract may be modified or amended only by a written document executed by Contractor and the County's Purchasing Agent or the Contra Costa County Board of Supervisors, subject to any required state or federal approval. In the event that the Payment Limit of this Contract exceeds $200,000, this Contract may be modified or amended only by a written document executed by Contractor and the Contra Costa County Board of Supervisors or, after Board approval, by its designee, subject to any required state or federal approval.

b. Minor Amendments. The Payment Provisions and the Service Plan may be amended by a written administrative amendment executed by Contractor and the County Administrator (or designee), subject to any required state or federal approval, provided that such administrative amendment may not increase the Payment Limit of this Contract or reduce the services Contractor is obligated to provide pursuant to this Contract.

c. Upon the request of DHCS, a copy of any amendment to this contract will be provided to DHCS."

8. **Limitations on Billing of Members and DHCS.**

a. Contractor will not seek payments from the State or Plan members in the event that County does not pay for services performed for Plan members pursuant to this Contract. Notwithstanding insufficient funding of the Medi-Cal Program or Medi-Cal contracts for Covered Services, Contractor will not bill or seek any reimbursement from any Plan member for services provided to that member pursuant to this Contract, except as expressly authorized by this Contract, applicable law, or DHCS. The terms of this provision (i) survive any termination of this Contract, regardless of the cause giving rise to such termination, and will be construed to be for the benefit of Plan

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members and DHCS; and, (ii) supersede any oral or written agreement to the contrary between the parties.

b. Contractor may bill a Plan member and collect payments from Plan members for services which are not Covered Services to which the Plan member is entitled from Plan or that are not authorized by the Plan, but only if the Plan member executed a written acknowledgement of patient responsibility prior to the provision of the service(s), in which the Plan member acknowledges that such services are not covered by the Plan and are the Plan member's own financial responsibility. Upon request, Contractor must provide County with a copy of any acknowledgment of patient responsibility form executed by the Plan member or a person responsible for his/her care. Notwithstanding the foregoing, Contractor may not bill a Medi-Cal member, Healthy Families member, or any other Government Program Member when prohibited by law.

c. **Surcharges.** Contractor must provide all covered services to Plan members under this Contract, as periodically amended, with no surcharge to any Plan member.

9. Contractor will notify DHCS and Director of the Department of Managed Health Care in the event this Contract is amended or terminated. Notice is considered given when deposited in the U.S. Mail, first class postage prepaid, addressed as follows:

Medi-Cal Managed Care Division
Department of Health Care Services
1501 Capitol Avenue, MS 4400
Sacramento, California 95899-7413

State Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, California 95814-2725

10. Turnover and Phase-out Period and Transfer of Care.

a. At the expiration or termination of this Contract, Contractor must assist County in the Turnover Period, as required by the State DHCS, in such a manner that the continuity of access and quality of care to Plan members is maintained. Upon termination of this Contract, Contractor must continue to provide Authorized Covered Services to Members who are receiving Covered Services from Contractor until all such Covered Services are completed and the Member is discharged, unless Plan makes reasonable and medically appropriate provision for the assumption of such Covered Services by another hospital or healthcare facility. The compensation and other terms and conditions, including the rates set forth in the Payment Provisions of this Contract, will continue to apply to Covered Services provided to each such Member. The Turnover period consists of the orderly transfer to the State DHCS or successor Contractor, of Plan member's medical care including, but not limited to, the transfer of medical records, patient files, and any other pertinent information necessary for efficient case management of Plan members.

b. At the completion of the Turnover Period, Contractor must assist County in the Phase-out Period, as required by the State DHCS, which will ensure that County has completed all remaining contractual obligations under this Contract. County will remain liable for covered services provided to Plan members by the Contractor until the services being rendered are completed or County makes reasonable and medically appropriate provisions for the transfer of such services.

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c. In the event of termination of this Contract for any reason, Contractor will assist the Plan in the transfer of care for Plan members. Plan will continue to provide payment to Contractor at the agreed upon capitation rates listed in the Payment Provisions, that are provided after termination and before transfer of care. In the event of termination of Contractor's subcontract for any reason, Contractor agrees to assist Plan in the transfer of care for Plan members.

d. In the event Contractor is suspended, terminated, or decertified from participation in the Medi-Cal Program, or otherwise ceases operations with limited or no prior notice, Contractor will not receive payment for services provided after the decertification, suspension, or termination date. Contractor must notify County immediately upon receiving a decertification notification from the California Department of Public Health or any other notice that Contractor has been suspended or excluded from the Medi-Cal program.

e. Contractor agrees to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Plan determine that the Contractor has not performed satisfactorily.

11. Payment of Claims. County will timely pay Contractor claims within forty-five (45) working days after receipt. Notice must be provided to Contractor in the case of contested claims within forty-five (45) working days after receipt. County will have sufficient claims processing/payment systems to timely process and pay Contractor and to reasonably determine the status of received claims and calculate provisions for incurred but not reported claims as required under Title 28, CCR, §§ 1300.77.1 and 1300.77.2.

12. Third Party Tort Liability. County and Contractor will not make any claim for recovery of the value of services rendered to a Plan member when such claim would be based on a recovery in an action involving the tort liability of a third party or casualty liability insurance, including Workers' Compensation awards and uninsured motorists coverage. County and Contractor will identify and notify State DHCS of cases in which an action by the Plan member involving the tort or Worker' Compensation liability of a third party could result in recovery by the Plan member of funds to which the State DHCS has lien rights under Article 3.5 (commencing with § 14124.70), Part 3, Division 9, Welfare and Institutions Code. Such cases will be referred to the State DHCS within 10 days of discovery.

13. Assumption of Risk. County assumes the total risk of providing covered services for each Plan member as specified in Title 22, § 53251 (a), (c), (d), and (e), except as otherwise allowed in Contract #29-772 with the State DHCS and any subsequent amendment thereto, and accordingly noted in this Contract.

14. Disputes. General Conditions Paragraph 9. (Disputes), is hereby deleted in its entirety, and replaced with a new Paragraph, to read as follows:

"9. Disputes/Grievances. Contractor is entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7. Contractor has the right to submit a grievance and Contractor hereby agrees to abide by the Plan's formal grievance process to resolve Provider grievances as described in the Provider Manual, as periodically amended, which is incorporated herein by reference, and which is on file in the Plan's Administrative offices, located

[redacted]

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at 595 Center Avenue, Suite 100, in Martinez, and a copy of which County has provided to Contractor. Disputes between County and Contractor concerning the meaning, requirements, or performance of this Contract are subject to the formal Provider grievance process. A grievance may be filed with the Contra Costa Health Plan, Director of Provider Relations, in written form via U.S. mail, private courier, or in person to:

Contra Costa Health Plan
c/o Director of Provider Relations
595 Center Avenue, Suite 100
Martinez, California 94553

15. **Health Care Language and Assistance.**

a. **Interpreter Services.** Contractor will provide all Plan members with all interpretive services required by the Provider Manual.

b. Contractor must communicate fully and clearly, without regard to benefit coverage limitations, with Plan members and/or their authorized representatives, in a culturally competent manner, about all treatment options, including the option of no treatment, deemed to be medically appropriate for a Plan member's particular condition. Contractor must provide Plan members with disabilities with necessary assistance to effectively communicate between Contractor and Plan member.

c. Contractor must comply with standards and requirements set forth in the Health and Safety Code § 1367.04 to provide members with access to language assistance in obtaining health care services. In addition, Contractor must cooperate with the County by providing any information necessary to assess compliance with health care language assistance.

d. County will provide Contractor cultural competency, sensitivity, and diversity training.

16. **Utilization Management/Quality Assurance Programs/Discharge Planning.** For those Contracts that County has determined Contractor is authorized to perform duties and activities associated with Plan operations, including, but not limited to quality assurance, member services, marketing, and credentialing, ("Delegated Contracts"), the following provisions apply:

a. No individuals responsible for utilization management decisions with respect to Plan members may receive financial incentives that reward the individual for issuing denials of coverage or service or that encourage decisions that result in underutilization.

b. To the extent applicable, Contractor must comply with the applicable requirements of 42 CFR 422.208 and 422.210, or successor regulations (the "PIP Rules"), including physician incentive plan disclosure and maintenance of stop-loss protection, and must comply with information requests and audits by Plan and CMS regarding compliance with the PIP Rules. Upon request, and as required for Plan to comply with its obligations under the PIP Rules, Contractor must obtain and disclose to Plan and CMS the terms of the payment arrangements between Contractor and [redacted]

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Contractor Physicians, and must provide evidence of compliance with applicable requirements of the PIP Rules.

c. Contractor agrees to allow County to use provider's performance data. Quality Improvement disease management, health education/promotion, and cultural and linguistic initiatives will be determined through collaborative processes that include CCHP/CCHS clinical and administrative staff. Contractors are expected to cooperate with Quality Improvement activities.

d. Contractor must provide discharge planning services for Plan members. Contractor must cooperate with Plan to assure timely and appropriate discharge of Plan members. Discharge planning services begin upon the Plan member's admission to a hospital and continue until completed by the medically-appropriate discharge date. Contractor must provide to Plan, upon request, documentation of the discharge planning process for any Plan member.

e. Contractor must notify the Plan of the hospital admission of any Plan member within the same or next business day.

f. Contractor must respond to any request by Plan for medical information within the same or next business day.

17. **Provider Updates.** Contractor shall update the County within five (5) business days if: (i) Contractor is not accepting new patients; or (ii) if Contractor had previously not accepted new patients, but Contractor is currently accepting new patients.

18. If Contractor is not accepting new patients, Contractor shall direct an enrollee or potential enrollee seeking to become a new member to both the Plan for additional assistance in finding a provider and to the Department of Managed Health Care to report any potential directory inaccuracy.

19. For those Network Providers at risk for non-contracted emergency services, Contractor is responsible for coverage and payment of emergency services and post stabilization care services and must cover and pay for emergency services regardless of whether the Provider that furnishes the services has a contract with the Plan. Contractor may not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR Section 438.114 (a) of the definition of emergency medical condition. Further, Contractor may not deny payment for treatment obtained when a representative of Contractor instructs the member to seek emergency services.

ATTACHMENT B
Number: 77-412

COMPENSATION

Subject to the provisions of this Contract, County shall pay Contractor at the rates set forth below, but shall not exceed $650,000 for the period January 1, 2022 through December 31, 2022; $650,000 for the period January 1, 2023 through December 31, 2023; and $650,000 for the period January 1, 2024 through December 31, 2024.

1. **For Hospice Services:**

   a. **For Commercial Members and Medi-Cal Members:** County shall pay Provider those rates set forth in the prevailing Medicare Schedule of Maximum Allowances in effect at time of service. Contractor will bill CCHP using the following codes:

Service	Revenue Code	Notes
Routine home care	0650 High rate 0659 Low rate	Routine home care rates include one per diem rate for days 1-60 (High rate), and one per diem rate for days 60+ (Low Rate).
Service Intensity Add-on	552 (billed in 15 minute increments)	Add-on payments for hospice social worker and nursing visits provided during the last 7 days of life when provided during routine home care; minimum of 15 minutes, maximum of 4 hours total per day. There are no Service Intensity Add-On payments during the first 2 days of admission.
Continuous home care	652	Hourly Rate
Inpatient respite care	655	Per Diem Rate
General inpatient care	0656**	Per Diem Rate

** Revenue Code 0656 must be billed in conjunction woth HCPCS Code T2045. A treatment authorization request (TAR) is required.

b. **Long-Term Care shall** include a variety of services designed to meet the Members' health or personal care needs during a long or short period of time. Members who elect the Medi-Cal hospice benefit are not disenrolled from CCHP.
Contractor will bill CCHP using the following codes:

i. 658: Hospice Care in a Skilled Nursing Facility (SNF) (Per diem), Medi-Cal custodial is 95% of the rate for the SNF; and
ii. 658: Hospice Long Term Care Room and Board (Per diem), Medi-Cal custodial is 95% of the rate for the SNF.

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c. **For Original Medicare (AKA Fee-for-Service Medicare Members):**
Covered services and supplies for Members who are Original Medicare recipients will be reimbursed at tthe Medicare rate of payment by Centers for Medicare and Medicaid Services (CMS) in effect at time of service. Provider will bill Medicare CMS as primary payor.

2. **For Palliative Care Services:**

a. **For Commercial Members and Medi-Cal Members:**

RATE	CPT CODE	REV CODE	MODIFIER ***	SPECIALTY	DESCRIPTION
$145.00	99343		P9	MD	Home visit, new patient initial 45 minute
$205.00	99344		P9	MD	Home visit, new patient initial 60 minute
$146.00	99349		P9	MD	Home visit, established patient(s) 45 minute
$200.00	99350		P9	MD	Home visit established patient 60 minute
$ 86.00	99497		P9	MD	Advanced Care Planning by M.D. first 30 minutes
$ 80.00	99498		P9	MD	Advanced Care Planning by M.D. >30 minutes
$165.00	G0299	551	P9	RN	Per Visit
$190.00	G0155	561	P9	SW	Per Visit

***All CPT codes above to be billed with modifier "P9" for record keeping purposes to separate existing services from Palliative Care services as DHCS has yet to define specific Palliative Care codes.

b. **For Original Medicare (AKA Fee-for-Service Medicare Members):**
Covered services and supplies for Members who are Original Medicare recipients will be reimbursed at the Medicare rate of payment by Centers for Medicare and Medicaid Services (CMS) in effect at time of servoce. Provider will bill Medicare CMS as primary payor.

Note: Payment will be made only for those services that are pre approved by CCHP.

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HIPAA BUSINESS ASSOCIATE ADDENDUM

To the extent, and as long as required by the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act, this HIPAA Business Associate Addendum ("Addendum") supplements and is made a part of the Contract identified as Number **77-412** (hereinafter referred to as "Agreement") by and between a Covered Entity (Contra Costa County for its Health Services Department, hereinafter referred to as "County") and Business Associate (the Contractor identified in the Agreement, hereinafter referred to as "Associate").

A. County wishes to disclose certain information to Associate pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("PHI") under Federal law, defined below.

B. County and Associate intend to protect the privacy and provide for the security of PHI disclosed to Associate pursuant to the Agreement as required by the Health Insurance Portability and Accountability Act of 1996. Public Law 104-191("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH Act"), and the regulations promulgated thereunder by the U.S. Department of Health and Human Services (collectively, the "HIPAA regulations"), and other applicable laws.

C. As part of the HIPAA regulations, the Privacy Rule and the Security Rule, defined below, require County to enter into a contract containing specific requirements with Associate prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(a) and (e), and 164.504(e) of the Code of Federal Regulations and contained in this Addendum.

In consideration of the mutual promises below and the exchange of information pursuant to this Addendum, the parties agree as follows:

1. **Definitions**. As used in this Addendum, the following terms have the following meanings:

   a. **Breach** has the meaning given to such term under the HITECH Act and HIPAA regulations set forth at 42 U.S.C. Section 17921 and 45 C.F.R. Section 164.402.

   b. **Breach Notification Rule** means the HIPAA regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and D.

   c. **Business Associate** ("Associate") has the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

   d. **Confidential Medical Information Act** means California Civil Code Sections 56 et seq.

   e. **Covered Entity** has the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

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f. **Data Aggregation** has the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

g. **Day** means calendar day unless otherwise indicated.

h. **Designated Record Set** has the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

i. **Electronic Media** means:

(1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media.

j. **Electronic Protected Health Information (ePHI)** means any Protected Health Information that is stored in or transmitted by electronic media.

k. **Electronic Health Record** has the meaning given to such term under the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921.

l. **Health Care Operations** has the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

m. **HIPAA Rules or Final Rule** means the Privacy Rule, Security Rule, Breach Notification Rule and Enforcement Rule set forth at 45 C.F.R. Part 160 and Part 164.

n. **Privacy Rule** means the Standards for Privacy of Individually Identifiable Health Information set forth in 45 C.F.R. Parts 160 and 164, Subparts A and E.

o. **Protected Health Information** ("PHI") means any information in any form or medium, including oral, paper, or electronic: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501. Protected Health Information includes electronic Protected Health Information.

p. **Protected Information** means PHI provided by County to Associate or created, maintained, received or transmitted by Associate on behalf of the County in connection with the Agreement.

q. **Secretary** means the Secretary of the U.S. Department of Health and Human Services.

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r. **Security Incident** has the meaning given to such term under the Security Rule, including, but not limited to, 45. C.F.R. Section 164.304.

s. **Security Rule** means the HIPAA regulation that is codified at 45. C.F.R Parts 160 and 164, Subparts A and C.

t. **Unsecured PHI** has the meaning given to such term under the HITECH Act and any guidance issued pursuant to said Act including, but not limited to, 42 U.S.C. Section 17932(h) and 45 C.F.R. Section 164.402.

Terms used in this Addendum but not defined have the meanings given to such terms under the HIPAA Rules.

2. **Obligations of Associate.** Associate acknowledges that it is directly required to comply with HIPAA, the HITECH Act, the HIPAA regulations and the Final Rule, and that Associate is directly liable under the HIPAA Rules, and subject to civil and criminal penalties for failure to comply with the Confidential Medical Information Act or for using and disclosing Protected Information when the use and disclosure is not authorized by the Agreement, the Addendum or as required by law. Associate acknowledges that it is directly liable and subject to civil penalties for failing to safeguard ePHI in accordance with the HIPAA Security Rule. Associate further acknowledges that Associate may be liable for the acts or omissions of its agents or subcontractors.

a. **Permitted Uses.** Associate shall not use Protected Information except for the purpose of performing Associate's obligations under the Agreement and as permitted or required under the Agreement and this Addendum or as required by law. Further, Associate shall not use Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if the County used it in the same manner.

b. **Permitted Disclosures.** Associate shall not disclose Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so disclosed by County. However, Associate may disclose Protected Information (i) in a manner permitted pursuant to the Agreement and this Addendum, (ii) for the proper management and administration of Associate, (iii) as required by law, or (iv) for Data Aggregation purposes for the Health Care Operations of County. To the extent that Associate discloses Protected Information to a third party, Associate must obtain, prior to making any such disclosure (i) reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this Addendum and used or disclosed only as required by law or for the purposes for which it was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify Associate of any breaches of confidentiality, suspected breaches, security incidents, or unauthorized uses or disclosures of the Protected Information, in accordance with Paragraphs 2.f. and 2.g. of this Addendum, to the extent such third party has obtained knowledge of such occurrences.

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c. **Prohibited Uses and Disclosures.** Associate shall not use or disclose PHI other than as permitted or required by the Agreement and this Addendum, or as Required by Law. Associate shall not use or disclose Protected Information for fundraising or marketing purposes. Associate shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out-of-pocket in full for the health care item or service to which the PHI solely relates. Associate shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of County and as permitted by the HITECH Act, 42 U.S.C. Section 17935(d)(2) and the HIPAA regulations, 45 C.F.R. Section 164.502(a)(5)(ii); however, this prohibition shall not affect payment by County to Associate for services provided pursuant to the Agreement.

d. **Appropriate Safeguards.** Associate shall implement appropriate safeguards to prevent the unpermitted use or disclosure of Protected Information, including but not limited to, the administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Information that it creates, receives, maintains, or transmits on behalf of County as required by the Agreement or this Addendum and in accordance with 42 C.F.R. Sections 164.308, 164.310, and 164.312. Associate shall comply with the policies, procedures, and documentation requirements of the Security Rule, including, but not limited to, 45 C.F.R. Section 164.316.

e. **Business Associate's Agents and Subcontractors.** Associate shall enter into written agreements with any agent or subcontractor, to whom it provides Protected Information received from the County or created, received, maintained or transmitted by Associate on behalf of the County to implement the safeguards required by paragraph 2.d. above with respect to Electronic PHI. Associate shall ensure that its agents and subcontractors agree in writing to the same restrictions, conditions and requirements that apply to Associate with respect to such information. This includes the requirement to immediately notify the Associate of any instances of any breach, security incident, intrusion, or unauthorized access to or use or disclosure of PI of which it becomes aware. Upon request, Associate shall provide copies of such agreements to the County. Associate shall implement and maintain sanctions against any agent, subcontractor or other representative that violates such restrictions, conditions or requirements and shall mitigate the effects of any such violation.

f. **Notification of Breach or Suspected Breach.**

Associate will notify County orally and in writing in the manner set forth in paragraph 2.g. within twenty-four (24) hours of its discovery of any suspected or actual breach of Protected Information; any use or disclosure of Protected Information not permitted by the Agreement or this Addendum; any Security Incident; and any actual or suspected use or disclosure of data in violation of applicable federal or state laws or regulations by Associate or its agents or subcontractors. Associate will take (i) prompt corrective action to cure any deficiencies and (ii) any action pertaining to such unauthorized uses or disclosures required by applicable federal and state laws and regulations.

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g. **Breach Notification Process.** (i) Written Notice. Associate shall notify County by writing to the County's Privacy Officer within twenty-four (24) hours of its discovery of any suspected or actual breach of Protected Information as described by paragraph 2.f. above. Associate's written notification shall be securely transmitted to:

Contra Costa County Privacy Officer
50 Douglas Drive, Suite 310-E
Martinez, CA 94553
Or Privacy.Officer@hsd.cccounty.us

(ii) Oral notice. In addition to the written notice required by 2.g.i., Associate shall notify County by calling the County's Privacy Officer within twenty-four (24) hours of its discovery of any suspected or actual breach of Protected Information as described by paragraph 2.f. above. Associate's oral notification shall be made by calling:

Contra Costa County Privacy Officer
(925) 957-5430

If the notification is made after business hours, on a weekend or a holiday, Associate will call the 24-hour Privacy Hotline at 1-800-659-4611 to submit the report.

Written and oral notifications shall include, to the extent possible, the identification of each individual whose unsecured Protected Information has been, or is reasonably believed by the Associate to have been accessed, acquired, used, or disclosed, as well as any other information the County is required to include in notification to the individual, the media, the Secretary, and any other entity under the Breach Notification Rule and any other applicable state or federal laws, including, but not limited to, 45 C.F.R. Section 164.404 through 45 C.F.R. Section 164.408. Associate shall take (i) prompt corrective action to cure any such deficiencies; and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

h. **Access to Protected Information.** Associate agrees to make Protected Information maintained by Associate or its agents or subcontractors in Designated Record Sets available to County for inspection and copying within five (5) days of a request by County to enable County to fulfill its obligations under state law and the Privacy Rule, including but not limited to, 45 C.F.R. Section 164.524. If Associate maintains Protected Information in electronic format, Associate shall provide such information in electronic format to enable County to fulfill its obligations under the HITECH Act and HIPAA regulations, including, but not limited to, 42 U.S.C. Section 17935(e) and 45 C.F.R. Section 164.524.

i. **Amendment of Protected Health Information.** Within ten (10) days of receipt of a request by County for an amendment of Protected Information or a record about an individual contained in a Designated

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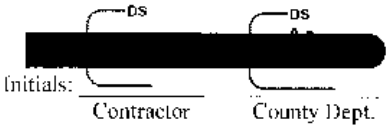
Record Set, Associate and its agents and subcontractors shall make such Protected Information available to County for amendment or other documentation and incorporate any such amendment to enable County to fulfill its obligations under the Privacy Rule including, but not limited to, 45 C.F.R. Section 164.526. If an individual requests an amendment of Protected Information directly from Associate, its agents or subcontractors, Associate must notify County within five (5) calendar days of the request. County, in its sole discretion, will determine whether to approve or deny a request for an amendment of Protected Information maintained by Associate, its agents or subcontractors.

j. **Availability of Protected Information and Accounting of Disclosures.** Within ten (10) days of a request by County for an accounting of disclosures of Protected Information, Associate and its agents or subcontractors shall make available to County the information required to provide an accounting of disclosures to enable County to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.528, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17935(c), as determined by County. As set forth in, and as limited by, 45 CFR Section 164.528, Associate need not provide an accounting to County of disclosures: (i) to carry out treatment, payment or health care operations, as set forth in 45 C.F.R. Section 164.506; (ii) to individuals of PHI about them as set forth in 45 CFR 164.502; (iii) incident to a use or disclosure otherwise permitted or required by this Subpart as provided in 45 C.F.R. 164.502; (iv) pursuant to an authorization as provided in 45 C.F.R. Section 164.508; (v) to persons involved in the individual's care or other notification purposes as set forth in 45 CFR Section 164.510; (vi) for national security or intelligence purposes as set forth in 45 C.F.R. Section 164.512(k)(2); (vii) to correctional institutions or law enforcement officials as set forth in 45 C.F.R. Section 164.512(k)(5); or (viii) as part of a limited data set in accordance with 45 C.F.R. 164.514(c). Associate agrees to implement a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years prior to the request, but not before the compliance date of the Privacy Rule. However, accounting of disclosures from an Electronic Health Record for treatment, payment or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that Associate maintains an electronic health record and is subject to this requirement. At a minimum, the accounting must include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or, in lieu of such statement, a copy of the individual's authorization or a copy of the written request for disclosure pursuant to 45 C.F.R. Section 164.502 (a)(2)(ii) or 45 C.F.R. Section 164.512, if any. In the event that the request for an accounting is delivered directly to Associate or its agents or subcontractors, Associate shall forward the request, in writing, to County within five (5) days of receipt. Associate shall not prepare, deliver or otherwise respond to the request for accounting without prior County approval.

k. **Governmental Access to Records.** Associate agrees to make its internal practices, books, and records relating to the use and disclosure of Protected Information available to County and to the Secretary for purposes of determining Associate's and County's compliance with HIPAA. Associate shall provide



County a copy of any Protected Information and other documents and records that Associate provides to the Secretary concurrently with providing such Protected Information to the Secretary.

l. **Minimum Necessary.** Associate and its agents and subcontractors will request, use, and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use, or disclosure. Associate understands and agrees that the definition of "minimum necessary" is in flux and shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary."

m. **Data Ownership.** Associate acknowledges that Associate has no ownership rights with respect to the Protected Information.

n. **Retention of Protected Information.** Except as provided in Section 3.c. of this Addendum, Associate and its subcontractors and agents must retain all Protected Information throughout the term of the Agreement and must continue to maintain the information required by Section 2.h. of this Addendum for a period of six (6) years after termination or expiration of the Agreement. However, accounting of disclosures from an Electronic Health Record for treatment, payment or health care operations purposes are required to be collected and maintained for three (3) years prior to the request, and only to the extent that Associate maintains an electronic health record and is subject to this requirement.

o. **Associate's Insurance.** In addition to any other insurance requirements specified in the Agreement, Associate will, at its sole cost and expense, insure its activities in connection with this Addendum. Associate will obtain, keep in force and maintain insurance or equivalent program(s) of self-insurance with appropriate limits, as determined by County, that will cover losses that may arise from any breach of this Addendum, violation of HIPAA, the HITECH Act, HIPAA regulations or applicable California law. It is expressly understood and agreed that the insurance required herein does not in any way limit the liability of Associate with respect to its activities in connection with this Addendum.

p. **Breach Pattern or Practice by Associate's Agents or Subcontractors.** Pursuant to 42 U.S.C. Section 17934(b) and 45 C.F.R. Section 164.504(e) (1) (ii), if the Associate knows of a pattern of activity or practice of an agent or subcontractor that constitutes a material breach or violation of the agent or subcontractor's obligations under the Agreement or Addendum, the Associate must take reasonable steps to cure the breach or end the violation. Associate shall meet with its agent or subcontractor to discuss and attempt to resolve the matter. Such meeting will be considered one of the reasonable steps to cure the breach or end the violation. If the steps taken are unsuccessful, the Associate must terminate its Agreement with the agent or subcontractor, if feasible. Associate shall provide written notice to County of any pattern of activity or practice of Associate's agents or subcontractors that Associate believes constitutes a material breach or violation of the agent or subcontractor's obligations under the Agreement or Addendum within five (5) days of discovery.

q. **Audits, Inspections and Enforcement.** At any time during the term of the Agreement, with or without notice, County and its authorized agents or contractors may inspect Associate's facilities, systems, books, records, agreements and written policies and procedures as may be necessary to determine the extent to which Associate's security safeguards comply with HIPAA, the HITECH Act, HIPAA

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regulations, and this Addendum. The fact that County has the right to conduct such inspection, that County conducts an inspection or fails to inspect, does not relieve Associate of its responsibility to comply with this Addendum. County's failure to detect, or County's detection but failure to notify Associate of, or to require Associate to remediate unsatisfactory practices, does not constitute acceptance of such practice or a waiver of County's rights under the Agreement or Addendum. Associate shall notify County within five (5) days of discovery that it is, or that any of its agents or subcontractors are, the subject of a non-County audit, compliance review or complaint investigation regarding HIPAA or other health privacy-related matter.

3. **Termination.**

a. **Material Breach.** A breach by Associate of any material provision of this Addendum, as determined by County, shall constitute a material breach of the Agreement and will be grounds for immediate termination of the Agreement pursuant to the Agreement's General Conditions, paragraph 5 (b), Failure to Perform.

b. **Reasonable Steps to Cure Breach.** Notwithstanding County's right to terminate the Agreement immediately, if County knows of an activity or practice of Associate that constitutes a material breach or violation of Associate's obligations under the provisions of this Addendum, County may elect to provide Associate an opportunity to cure such breach or end such violation. If Associate's efforts to cure such breach or end such violation are unsuccessful, County will either (i) terminate the Agreement, if feasible or (ii) if termination of the Agreement is not feasible, County will report Associate's breach or violation to the Secretary.

c. **Effect of Termination.** If the Agreement is terminated for any reason, Associate must, at the exclusive option of County, return or destroy all Protected Information that Associate, its agents and subcontractors, still maintain in any form. Associate may not retain any copies of such Protected Information. If County determines that return or destruction is not feasible, Associate may retain the Protected Information but must continue to extend the protections and satisfy its obligations under this Addendum. With regard to the retained Protected Information, Associate will limit further use of such Protected Information to those purposes that make the return or destruction of such Protected Information infeasible. If County directs Associate to destroy the Protected Information, Associate must act in accordance with the Secretary's guidance regarding the proper destruction of PHI and provide the County with written certification that the Protected Information has been destroyed. The obligations of Associate under this paragraph shall survive the Agreement.

d. **Indemnification.** In addition to any indemnification requirements of the Agreement, Associate agrees to save, hold harmless and indemnify County for the costs of any mitigation undertaken by Associate. Associate agrees to assume responsibility for any and all costs associated with the County's notification of individuals affected by a breach or unauthorized access, use or disclosure by Associate or its

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Initials: _____ _____

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employees, officers, subcontractors, agents or other representatives when such notification is required by any state or federal law or regulation, or under any applicable contract to which County is a party. Associate agrees to save, hold harmless, defend at its own expense if County so requests, and indemnify County, including County's employees, directors, officers, subcontractors, agents or other members of its workforce (each of the foregoing hereinafter referred to as "Indemnified Party"), against all actual and direct losses suffered by the Indemnified Party and against all liability to third parties arising from or in connection with any breach of this Agreement or from any acts or omissions related to this Agreement by Associate or its employees, directors, officers, subcontractors, agents or other members of its workforce. Accordingly, on demand, Associate shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results from the Associate's acts or omissions hereunder. The obligations of Associate under this provision shall survive the Agreement.

4. **Penalties/Fines.** Associate shall pay any penalty or fine assessed against County arising from Associate's failure to comply with the obligations imposed by the Addendum, HIPAA, the HITECH Act, the HIPAA regulations and other state and federal laws related to security and privacy. Associate shall pay any penalty or fine assessed against County arising from Associate's failure to comply with all applicable Federal or State Health Care Program Requirements, including, but not limited to any penalties or fines, which may be assessed under a Federal or State False Claims Act provision.

5. **Disclaimer.** County makes no warranty or representation that compliance by Associate with this Addendum, HIPAA, the HITECH Act, or the HIPAA regulations, will be adequate or satisfactory for Associate's own purposes. Associate is solely responsible for all decisions made by Associate regarding the safeguarding of PHI.

6. **Changes to Privacy Laws.**

   a. **Compliance with Law.** County and Associate acknowledge that state and federal laws relating to electronic data security and privacy are evolving and that this Addendum may require amendment to ensure compliance with such developments. County and Associate agree to take such action(s) as may be necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations, and other applicable state and federal laws relating to the security and confidentiality of PHI.

   b. **Amendment to Addendum.** In the event that a change to state or federal law, statute, or regulation materially affects the terms and conditions of this Addendum, the parties agree that County may

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unilaterally amend the Addendum, if an amendment is required to remain in compliance with state or federal law or regulation.

c. **Cybersecurity Risk.** In addition to the obligations Associate has in the Agreement and this Addendum, Associate will manage cybersecurity risk by staying current with, and integrating into its security program where appropriate, available federal and state agency guidance regarding cybersecurity of PHI. This includes, but is not limited to, the National Institute of Standards and Technology Cybersecurity Framework, the Cybersecurity Awareness Initiative of the Office for Civil Rights and the Office of the National Coordinator for Health Information Technology.

7. **Miscellaneous Provisions.**

a. **Assistance in Litigation or Administrative Proceedings.** Associate will make itself, and any subcontractors, employees or agent assisting Associate in the performance of its obligations under the Agreement, available to County, at no cost to County, to testify as witnesses or otherwise, in the event of litigation or administrative proceedings against County, its officers or employees, based upon a claimed violation of HIPAA, the HITECH Act, the HIPAA regulations, or any other laws relating to security and privacy and arising out of the Agreement or this Addendum.

b. **No Third Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than County, Associate, and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

c. **Interpretation.** The provisions of this Addendum prevail over any provisions in the Agreement that may conflict, or appear to be inconsistent with, any provision of this Addendum. This Addendum and the Agreement will be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations and other state and federal laws related to security and privacy. The parties agree that any ambiguity in this Addendum will be resolved in favor of a meaning that complies, and is consistent, with HIPAA, the HITECH Act, the HIPAA regulations and other state and federal laws related to security and privacy.

d. **Survival.** The obligations of Associate pursuant to Sections 2.j. and 3.c. of this Addendum survive the termination or expiration of the Agreement.

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11 Cal. Code Reg. Section 999.5(d)(5)(J)

Description of how each health facility will comply with the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 (H&S Section 129675-130070), including the certified Structural Performance Category of every building affected by the transaction and a copy of every final determination letter received from the Office of Statewide Health Planning and Development (now referred to as the Department of Health Care Access and Information) for every building affected by the transaction or agreement

N/A

11 Cal. Code Reg. Section 999.5(d)(5)(K)

Description of the measure proposed by the applicant to mitigate or eliminate any potential adverse effect on availability or accessibility of health care services to the affected community that may result from the agreement or transaction

Hospice East Bay and Chapters do not anticipate that the Transaction will result in any adverse effect on the availability or accessibility of health care services in Hospice East Bay's service area. Rather, as referenced in the responses to (d)(4)(B) and (d)(5)(H), once the Transaction has been completed Hospice East Bay and Chapters will evaluate opportunities to increase the health care services offered in Hospice East Bay's service area.

Hospice East Bay and Chapters have agreed in Section 7.3 of the Affiliation Agreement that after the Closing all assets of Hospice East Bay will continue to be used for qualifying healthcare and charitable purposes. All assets on Hospice East Bay's balance sheet as of the Closing and any proceeds from the sale of any real property or health facility owned by Hospice East Bay as of the Closing net of any gains or losses on invested assets, including, without limitation (i) that certain real property located at 3470 Buskirk Avenue, Pleasant Hill, California 94523 and (ii) the Bruns House inpatient hospice facility located at 2849 Miranda Avenue, Alamo, California 94507, will, unless otherwise decided by vote of the Hospice East Bay board (excluding board members who are also Chapters officers or employees), be irrevocably dedicated to use in Hospice East Bay's service area.

Hospice East Bay and Chapters have also agreed that for at least five (5) years after the Closing, Chapters shall not take any action to restrict, prohibit or limit Hospice East Bay's ability to maintain existing "specialty" programs that include the Bruns House, Veterans Program, Bridge Program (grief services for children and teens) and Music Therapy as long as any operating losses from those programs can be funded through a combination of Hospice East Bay's fundraising efforts and non-reserved investments.

11 Cal. Code Reg. Section 999.5(d)(5)(L)

A list of the primary languages spoken at the health facility or facility that provides similar health care and the threshold languages for Medi-Cal beneficiaries, as determined by the State Department of Health Care Services for the county where the health facility is located

The threshold languages for Contra Costa County are: English, Chinese and Spanish. English is the primary language spoken at the facility, with Language Line Solutions (formerly AT&T Language Line) available for audio or video interpretation for over 290 languages.

Title 11, California Code of Regulations, § 999.5(d)(6)

POSSIBLE EFFECT ON COMPETITION

11 Cal. Code Reg. Section 999.5(d)(6)(A)

For any agreement or transaction for which a Premerger Notification and Report Form is required to be submitted to the Federal Trade Commission under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, a brief analysis of the possible effect of any proposed merger or acquisition of each health care facility or facility that provides similar health care that is the subject of the agreement or transaction on competition and market share in any relevant product or geographic market.

N/A

11 Cal. Code Reg. Section 999.5(d)(6)(B)

The applicant shall provide the Premerger Notification and Report Form and any attachments thereto as filed with the Federal Trade Commission pursuant to the Hart-Scott-Rodino Antitrust Improvements Act of 1976 and 16 C.F.R. Parts 801-803. The procedure for designating information as confidential set forth in section 999.5(c)(3) of these regulations shall apply to any information submitted under this subsection.

N/A

Title 11, California Code of Regulations, § 999.5(d)(7)

OTHER PUBLIC INTEREST FACTORS

11 Cal. Code Reg. Section 999.5(d)(7)

The written notice of any proposed agreement or transaction set forth in section 999.5(a)(1) of these regulations shall include a section entitled "Other Public Interest Factors" that contains any other information the applicant believes the Attorney General should consider in deciding whether the proposed agreement or transaction is in the public interest

None beyond the information that is already contained in this notice

11 Cal. Code Reg. Section 999.5(d)(8)

The written notice of any proposed agreement or transaction set forth in section 999.5(a)(1) shall include a resolution of the board of directors of the applicant authorizing the filing of the written notice and a statement by the chair of the board that the contents of the written notice are true, accurate and complete.

Attached to this Section are the following:

- A copy of the Board Chair Attestation by Hospice East Bay
- A copy of the Board Resolution

ATTESTATION

November 13, 2024

This attestation (this "**Attestation**") is made consistent with California Code of Regulations tit. 11 § 999.5(d)(8) and relates to the proposed affiliation between Chapters Health System, Inc., a Florida not for profit corporation ("**Chapters**") and East Bay Integrated Care, Inc. d/b/a Hospice East Bay, a California nonprofit public benefit corporation ("**Hospice East Bay**"). As required under California Corporations Code § 5914, Hospice East Bay is providing written notice to the California Attorney General regarding the proposed affiliation with Chapters (the "**Written Notice**").

The undersigned, being the Chair of the Board of Directors of Hospice East Bay, hereby attests that the contents of the Written Notice are true, accurate and complete.

**

IN WITNESS WHEREOF, the undersigned has executed this Attestation on the date first written above.

EAST BAY INTEGRATED CARE, INC. D/B/A HOSPICE EAST BAY

Signed by:
By: [redacted]
Name: Michelle Lopes
Its: Chair of the Board of Directors

RESOLUTION NO. 2024-8-26

RESOLUTIONS OF THE BOARD OF DIRECTORS OF EAST BAY INTEGRATED CARE, INC. D/B/A HOSPICE EAST BAY REGARDING THE AFFILIATION WITH CHAPTERS HEALTH SYSTEM, INC.

WHEREAS, it is proposed that East Bay Integrated Care, Inc. d/b/a Hospice East Bay, a California nonprofit public benefit corporation (the "**Corporation**") affiliate with Chapters Health System, Inc., a Florida not for profit corporation ("**Chapters**"), pursuant to the terms of an Affiliation Agreement (the "**Affiliation Agreement**") that is summarized in **Exhibit A** and that is in substantially the form presented to the Board and attached to these Resolutions as **Exhibit B**:

WHEREAS, in order to effect the transactions contemplated by the Affiliation Agreement (collectively, the "**Affiliation**"), it is proposed that the Corporation should adopt the Amended and Restated Bylaws in substantially the form presented to the Board and attached to these Resolutions as **Exhibit C** (the "**Amended and Restated Bylaws**"), which would become effective only if the Affiliation is successfully completed and the closing conditions contained in the Affiliation Agreement are all satisfied or waived in accordance with the Affiliation Agreement's terms;

WHEREAS, as a result of the Affiliation Chapters will become the sole member of the Corporation and the Corporation will become a subsidiary of Chapters;

WHEREAS, the Corporation and Chapters desire to enter into the Affiliation Agreement and consummate the Affiliation to accomplish a number of mutual goals, including the preservation of the Corporation's legacy and the perpetuation of the nonprofit hospice model of comprehensive, community-based hospice care;

WHEREAS, the Board recognizes that the consummation of the Affiliation will require notice to, or the consent or approval of, various government agencies and private parties, including without limitation the Attorney General of the State of California (with respect to the change of control of the Corporation's inpatient hospice facility as contemplated by the Affiliation) and the California Department of Public Health (with respect to the licensing of the Corporation's facilities and operations) (collectively, the "**Required Consents**");

WHEREAS, the Board has had an opportunity to review the Affiliation Agreement and the Amended and Restated Bylaws; and

WHEREAS, the Board believes the Affiliation is in the best interest of the Corporation, in furtherance of its nonprofit and charitable purposes and for the benefit of the communities served by the Corporation, and desires to approve the Affiliation, the Affiliation Agreement, the Amended and Restated Bylaws, and the documents and transactions they contemplate.

NOW, THEREFORE, THE BOARD OF DIRECTORS OF THE CORPORATION RESOLVES AS FOLLOWS:

1. It is in the best interest of the Corporation, in furtherance of its nonprofit corporate and charitable purposes and for the benefit of the communities served by the Corporation, to enter into the Affiliation Agreement with Chapters, upon the material terms and conditions set forth in the Affiliation Agreement in substantially the form presented to this Board;

2. The Affiliation and the form, material terms, and provisions of the Affiliation Agreement in substantially the form presented to this Board are hereby adopted, approved and ratified in all respects;

3. The Amended and Restated Bylaws in substantially the form presented to this Board are hereby adopted, approved and ratified in all respects, to go into effect only upon the successful completion of the Affiliation and the satisfaction or waiver (in accordance with the Affiliation Agreement's terms) of all required closing conditions contained in the Affiliation Agreement;

4. The Corporation's officers are authorized and directed to negotiate, finalize, execute and deliver the Affiliation Agreement and the Amended and Restated Bylaws in substantially the form presented to this Board, and to approve on behalf of the Corporation any modifications or amendments to the form of the Affiliation Agreement or the Amended and Restated Bylaws presented to this Board that do not alter the material terms of the Affiliation Agreement or the Amended and Restated Bylaws; and

5. The Corporation's officers are authorized and directed to seek all Required Consents, and to provide all necessary notices and make all necessary applications in connection with the Affiliation.

OMNIBUS RESOLUTIONS

1. All officers, agents, attorneys and employees of the Corporation are authorized and directed to do and perform, or cause to be done and performed, all such acts, deeds, and things, and to make, execute, and deliver, or cause to be made, executed, and delivered, all such agreements, undertakings, documents, instruments, or certificates in the name of the Corporation and to retain such counsel, agents, and advisors and to incur and pay such expenses, fees, and taxes as shall, in the opinion of the Corporation's Interim President & CEO, be deemed necessary or advisable (such necessity or advisability to be conclusively evidenced by the execution of such actions) to effectuate or carry out fully the purpose and interest of all of the foregoing resolutions, including without limitation the Affiliation Agreement, the Amended and Restated Bylaws, the Affiliation and all of the actions contemplated thereby, which at or after the closing of the Affiliation Agreement may include the filing of an Amendment to the Articles of Incorporation of the Corporation reflecting that Chapters is the sole member of the Corporation; and

2. All actions taken prior to these Resolutions by the directors, officers, agents, attorneys and employees of the Corporation in connection with the Affiliation Agreement, the Amended

and Restated Bylaws, or the Affiliation are hereby adopted, affirmed, approved, and ratified in all respects as the acts and deeds of the Corporation.

[End of Text: Certificate of the Secretary Follows.]

Certificate of the Secretary

The undersigned, Susan Burroughs, Secretary of the Board of Directors of East Bay Integrated Care, Inc. d/b/a Hospice East Bay does hereby certify that the foregoing Resolution No. 2024-8-26 was passed, approved, and adopted by the Board of Directors of East Bay Integrated Care, Inc. d/b/a Hospice East Bay at a duly called and noticed meeting held on August 26, 2024, at which a quorum was present and voting.

Date: August 26, 2024

By: [redacted]
Susan Burroughs, Secretary

Exhibit A
Summary of Affiliation Agreement and Amended & Restated Bylaws

See attached.

Exhibit B
Form of Affiliation Agreement

See attached.

Exhibit C
Form of Amended and Restated Bylaws

See attached.

Title 11, California Code of Regulations, § 999.5(d)(9)

TRANSFEREE INFORMATION

11 Cal. Code Reg. Section 999.5(d)(9)

The written notice of any proposed agreement or transaction set forth in section 999.5(a)(1) shall include a list of the officers and directors of the transferee, the most recent audited financial statements for the transferee, the transferee's governance documents, such as the articles of incorporation and bylaws, and a description of the transferee's policies, procedures, and eligibility requirements for the provision of charity care

Attached to this Section are the following:

- A copy of the Chapters Health System, Inc. Policy and Procedure Manual for Financial Assistance (Charity Care, Expanded Charity Care, & Uninsured Discount) dated August 27, 2024
- A copy of the list of Directors and Officers of Chapters
- A copy of the Chapters Health System, Inc. Consolidated Financial Statements for December 31, 2023 and 2022
- A copy of the Chapters Health System, Inc. Second Articles of Amendment to Third Restated Articles of Incorporation
- A copy of the Chapters Health System, Inc. Third Restated Articles of Incorporation
- A copy of the Chapters Health System, Inc. Twelfth Amended Bylaws