California Addendum

State Specific Provider Requirements

# General Terms.

## *Relationship to Master Provider Agreement*.In the event that a provision of this Addendum conflicts with a provision of the Agreement, the provisions of this Addendum shall supersede, govern and control to the extent required by law and to the extent Contigo Health, Provider, Customers, Downstream Clients or Payors are subject to such law.

## *Applicability*. Provisions included herein which are not otherwise addressed by the Agreement shall be considered additional obligations upon the Parties for purposes of Covered Services provided in this State. Provisions included herein which specifically contradict an obligation under a provision of the Agreement shall replace that specific Agreement provision for purposes of Covered Services provided in this State, to the extent necessary to comply with applicable law. The provisions of this Addendum apply only to the entities covered by the referenced law and only for purposes of Covered Services provided in this State, unless otherwise required by the terms of the applicable law.

## *Definitions*. Capitalized terms used herein but not defined shall have the meaning assigned in the Agreement or assigned in the applicable law.

## *Citations*. The citations in this Addendum are current as of the date of this Addendum. Renumbering or recodification of statutes or regulations does not nullify the intent of the applicable provision provided herein.

## *Compliance with Law; Change of Law*. Any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with applicable law. To the extent a law cited herein is modified in a manner impacting this Addendum, any required revisions shall be automatically incorporated herein and any provisions which are no longer applicable shall be considered severed from this Addendum effective as of the date of the change in law. Contigo Health will update this Addendum after a change in law when reasonably practicable.

# Network Arranger Laws

## As required by Cal. Bus. & Prof. Code § 511.1(b), the list of contracted Providers may be sold, leased, transferred, or conveyed to other payors or Contracting Agents, which may include workers’ compensation or automobile insurers. Payors to which the list of contracted Providers may be sold, leased, transferred or conveyed may be permitted to pay a Provider’s contracted rate without actively encouraging the payor’s beneficiaries to use the list of contracted providers when obtaining medical care. Provider shall be provided with any other applicable disclosures under Cal. Bus. & Prof. Code § 511.1(b) at the time of entering into the Agreement.

# General Insurance Laws

## As required by Cal. Ins. Code § 10123.36(c), if the contracting Provider is a provider group and maintains economic profiles of individual providers who may be selected by insureds, Provider shall, upon request, provide a copy of individual economic profiling information to individual providers who are profiled. Provider shall provide this information upon request until 60 days after the date upon which the agreement between the insurer and individual provider or Provider terminates, or until 60 days after the date the contract between the Provider and individual provider terminates, whichever is applicable.

## As required by Cal. Ins. Code § 10123.855, the health insurer shall reimburse the Provider for the diagnosis, consultation, or treatment of an insured or policyholder appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

## As required by Cal. Ins. Code § 10126.5, to the extent the contract between the Provider and health insurer requires the Provider to accept the lowest payment rate charged by the Provider to any party as payment from the health insurer, such requirement shall not apply in relation to any cash payments made to the Provider by individual uninsured patients.

## As required by Cal. Ins. Code § 10133.15(j)(1), Provider shall inform the insurer within 5 business days of either of the following occurring: (a) the Provider is not accepting new patients or (b) if the Provider had previously not accepted new patients, the Provider is currently accepting new patients.

## As required by Cal. Ins. Code § 10133.15(n), to the extent Provider is a provider group, Provider shall provide information to the insurer in relation to each provider that contracts with the provider group necessary for the insurer to satisfy its provider directory obligations under Cal. Ins. Code § 10133.15.

## As required by Cal. Ins. Code § 10178.3(b), the list of contracted Providers may be sold, leased, assigned, transferred or conveyed to other payors or Contracting Agents, which may include workers compensation insurers or automobile insurers. Payors to which the list of contracted Providers may be sold, leased, transferred or conveyed may be permitted to pay a Provider’s contracted rate without actively encouraging the payor’s beneficiaries to use the list of contracted providers when obtaining medical care. Provider shall be provided with any other applicable disclosures under Cal. Ins. Code § 10178.3(b) at the time of contracting.

## As required by Cal. Code Regs. tit. 10, § 2240.4(b)(2), Provider will not make additional charges for rendering network services except as provided in the contract between the insurer and insured.

## As required by Cal. Code Regs. tit. 10, § 2240.4(b)(4), Provider’s primary consideration will be the quality of the services rendered.

## As required by Cal. Code Regs. tit. 10, § 2240.4(b)(5), Providers are prohibited from discrimination against any insured in the provision of contracted services on the basis of sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, health insurance coverage, utilization of medical or mental health or substance use disorder services or supplies, or other unlawful basis including without limitation, the filing by such insured of any complaint, grievance, or legal action against a Provider.

## As required by Cal. Code Regs. tit. 10, § 2240.4(e), to the extent the Agreement is in relation to Provider’s participation a particular network, insurer will obtain Provider’s written assent before including Provider as a participant in other networks of the insurer.

## As required by Cal. Code Regs. tit. 10, § 2538.3(d), Provider shall comply with the health insurer’s language assistance program developed pursuant to Cal. Code Regs. tit. 10, § 2538.3.

# Health Maintenance Organization (HMO)/Managed Care Organization (MCO) Specific Laws

## As required by Cal. Health & Safety Code § 1367(h), the health care service plan shall inform Provider of the dispute resolution provisions, including location and phone where disputes may be submitted, upon contracting and upon any changes.

## As required by Cal. Health & Safety Code § 1367.02(c), if the contracting Provider is a medical group or individual practice association and maintains economic profiles of individual providers, Provider shall, upon request, provide a copy of individual economic profiling information to individual providers who are profiled. Provider shall provide this information upon request until 60 days after the date upon which the agreement between the health care service plan and individual provider or Provider terminates, or until 60 days after the date the contract between the Provider and individual provider terminates, whichever is applicable.

## As required by Cal. Health & Safety Code § 1367.27(j)(1), Provider shall inform the health care service plan within 5 business days of either of the following occurring: (a) the Provider is not accepting new patients or (b) if the Provider had previously not accepted new patients, the Provider is currently accepting new patients.

## As required by Cal. Health & Safety Code § 1367.27(n), to the extent Provider is a provider group, Provider shall provide information to the health care service plan in relation to each individual provider in the group necessary for the insurer to satisfy its provider directory obligations California law.

## As required by Cal. Health & Safety Code § 1371.22, to the extent the contract between the Provider and health care service plan requires the Provider to accept the lowest payment rate charged by the Provider to any party as payment from the health care service plan, such requirement shall not apply in relation to any cash payments made to the Provider by individual uninsured patients.

## As required by Cal. Health & Safety Code § 1374.14(a), the health care service plan shall reimburse the Provider for the diagnosis, consultation, or treatment of an enrollee or subscriber appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

## As required by Cal. Health & Safety Code § 1374.66(e), to the extent the Agreement includes risk-sharing for out of network services:

### If payment is capitated or prepaid, the Agreement shall disclose the amount to be paid for in-network services;

### The Agreement shall disclose the mathematical method by which funding for the risk-sharing arrangement is established, the mathematical method by which and to the extent to which payments for out of network services are debited against the risk-sharing funds, and the method by which the risk-sharing arrangement is reconciled at least annually; and

### The Agreement shall be approved by the Director.

## As required by Cal. Health & Safety Code § 1375.4(a), to the extent the Agreement is between a health care service plan and a risk-bearing organization, the risk-bearing organization shall provide financial information to the health care service plan and meet any other financial requirements to assist the health care service plan in maintaining the financial viability of the arrangement. Additionally, the health care service plan shall disclose information to the risk-bearing organization that enables the organization to be informed regarding the financial risk assumed. The health care service plan shall provide payments of all risk arrangements, excluding capitation, within 180 days after the close of the fiscal year.

## As required by Cal. Health & Safety Code § 1375.5, to the extent the Agreement is between a health care service plan and a risk-bearing organization, the risk-bearing organization agrees to be at financial risk for the provision of services in accordance with the terms of the Agreement.

## As required by Cal. Health & Safety Code § 1375.6, to the extent the Agreement is between a health care service plan and a risk-bearing organization and the Agreement requires Provider to accept rates or other methods of payment specific in third party agreements, Provider acknowledges and agrees that such rates and methods of payment have been mutually agreed upon.

## As required by Cal. Health & Safety Code § 1375.7(b), the health care service plan shall provide Provider with 45 business days’ notice of changes to the Agreement through amendments to manuals, policies or procedures, and the Provider has the right to negotiate the change or terminate the Agreement if no agreement regarding the change can be made. In the event the Provider is a preferred provider arrangement, the health care service plan shall provide Provider with at least 45 business days’ notice of any material change, and the Provider shall have the ability to terminate the Agreement rather than accept the material change. In the event the Agreement is with a noninstitutional provider and the health care service plan provides benefits to enrollees or subscribers covered under Medi-Cal or Health Families Program and the Provider is compensated on a fee for service basis, the health care service plan may materially change the Agreement upon at least 90 business days’ notice. The Provider must have the ability to negotiate and agree to such change within 30 business days of the notice or terminate the Agreement. The health care service plan shall disclose the requirement to comply with quality improvement or utilization management programs to a Provider at least 15 business days prior to the execution of the Agreement.

## As required by Cal. Health & Safety Code § 1375.8(b), Provider expressly agrees to assume the financial risk for certain injectable medications specified under Cal. Health & Safety Code § 1375.8.

## As required by Cal. Health & Safety Code § 1379, if the health care service plan fails to pay as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the Provider for any sums owed by the health care service plan and Provider shall not bill, charge, collect remuneration from or otherwise have any recourse against the subscriber or enrollee, party acting on their behalf, California or a California agency, or any Medicaid plans.

## As required by Cal. Health & Safety Code § 1395.6(b), the list of contracted Providers may be sold, leased, assigned, transferred or conveyed to payors. Payors to which the list of contracted Providers may be sold, leased, transferred or conveyed may be permitted to pay a Provider’s contracted rate without encouraging members to use the list of contracted providers. Provider shall be provided with any other applicable disclosures under Cal. Health & Safety Code § 1395.6(b) at the time of contracting.

## As required by Cal. Code Regs. tit. 28, § 1300.67.04(e)(4), Provider shall comply with the health care service plan’s language assistance program developed pursuant to Cal. Health & Safety Code § 1367.04.

## As required by Cal. Code Regs. tit. 28, § 1300.67.8, Provider shall maintain records and information necessary for the health care service plan to maintain compliance with applicable requirements for at least two years. Such obligation shall not terminate upon a termination of the Agreement. The health care service plan shall, at reasonable times upon demand, have access to the books, records and papers of the Provider relating to the health care services provided to subscribers and enrollees, to the cost thereof, to payments received by the Provider from subscribers and enrollees of the health care service plan (or from others on their behalf), and, unless the Provider is compensated on a fee-for-service basis, to the financial condition of the Provider. Surcharges are prohibited for covered services; the health care service plan shall take appropriate action upon receipt of notice of any prohibited surcharge. Upon termination of the Agreement for any cause, Provider shall comply with the provisions of subdivision (a)(1) of Section 1300.67.4.

## As required by Cal. Code Regs. tit. 28, § 1300.71(g)(4), except for applicable co-payments and deductibles, a Provider shall not invoice or balance bill a health care service plan’s enrollee for the difference between the Provider’s billed charges and the reimbursement paid by the health care service plan or a capitated provider with which the health care service plan has contracted to process claims for any covered benefit.

## As required by Cal. Code Regs. tit. 28, § 1300.71(l), to the extent such information is not already included in the Agreement, the health care service plan (and any of its capitated providers processing claims) shall disclose to Provider the information required by Cal. Code Regs. tit. 28, § 1300.71(l) upon entering into the Agreement and upon request thereafter.

## As required by Cal. Code Regs. tit. 28, § 1300.71(m), the health care service plan shall provide at least 45 days prior written notice before making changes to the disclosures required under Cal. Code Regs. tit. 28, § 1300.71(l) and Cal. Code Regs. tit. 28, § 1300.71(o).

## As required by Cal. Code Regs. tit. 28, § 1300.71(o), the health care service plan (and any of its capitated providers processing claims) shall disclose to Provider the information required by Cal. Code Regs. tit. 28, § 1300.71(m) upon entering into the Agreement, annually on or before the anniversary date of the Agreement, and upon request.