PROVIDER INFORMATION

PRACTICE NAME: _ County of Ventura, owner and operator of Ventura County Medical Center

SPECIALTY: Multi-Specialty
D/B/A, IF APPLICABLE: N/A

NPI: See attached facility roster

TAX ID: 95-6000944

LOCATION/S: IF MORE THAN ONE LOCATION, PLEASE LIST ON ADDITIONAL SHEET OR BACK OF THIS

STREET: See attached facility roster

CITY:_____ **STATE:**_____

COUNTY: _____

ZIP:_____ **OFFICE PHONE:** _____

REMITTANCE ADDRESS (BUSINESS OFFICE):

STREET: 800 S. Victoria Avenue, L#4640

CITY: Ventura **STATE:** CA

ZIP: 93009-4640 **OFFICE PHONE:** 805-648-9561

BUSINESS CONTACT/NOTIFICATIONS:

NAME/TITLE: HCA Director

ADDRESS: 5851 Thille Street, L#4625, Ventura, CA 93003

PHONE/EMAIL: barry.zimmerman@ventura.org

ARE YOUR PROVIDERS TAKING NEW PATIENTS? YES____X_____NO_____

PROVIDERS: (LIST OR ATTACH ROSTER) Rosterattached

NAME	SPECIALTY	NPI	CAQH, IF APPLICABLE
ROSTER ATTACHED			

PLEASE ATTACH LIST OF SERVICES PROVIDED BY ORGANIZATION AND INDICATE IF ANY OF YOUR MID-LEVELS (E.G. NP, PA) DIRECT BILL.

PHYSICIAN PARTICIPATION AGREEMENT

This Provider Services Agreement ("Agreement") effective as of August 1, 2023 (the "Effective Date"), is made and entered into by and between ***Align Senior Care California, Inc.,*** ("Payor") and the County of Ventura, owner and operator of Ventura County Medical Center and Santa Paula Hospital ("Provider").

RECITALS

WHEREAS, Payor is a Medicare Advantage organization that offers one or more Medicare Advantage benefit plans, including special needs plans (a "Plan", as further defined below); and

WHEREAS, Payor desires that Provider and, as applicable, its Provider Practitioners Covered Services to Covered Persons enrolled in the Plan under the terms and conditions of this Agreement; and

WHEREAS, Payor and Provider, among other things, in order to comply with all applicable regulatory requirements, agree to be bound by the provisions of this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Payor and Provider agree as follows:

ARTICLE I
DEFINITIONS

When the following terms appear herein as capitalized words they shall have the meanings set forth in this section.

I.1 "Applicable Law" means all state and Federal statutes, rules, and applicable regulations including the requirements set forth in Schedule 2.

I.2 "Covered Person" means an individual who is covered under the Plan at the time Provider's service is furnished.

I.3 "Covered Services" means all authorized services and supplies provided by Provider to a Covered Person and for which a benefit is payable under the Plan, but subject to the exclusions and limitations described in the Plan.

I.4 "Emergency Services" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; (c) serious dysfunction of any bodily organ or part; (d) serious disfigurement; or (e) in the case of a pregnant woman, serious jeopardy to the health of the fetus. In no event shall the definition of Emergency Services under this Agreement be interpreted so as to conflict with Provider's emergency service obligations under Federal or state law.

I.5 "Medically Necessary" means that the service satisfies all of the following conditions:

(a) it is required for the diagnosis, treatment, or prevention of an illness or injury, or a medical condition such as pregnancy;

(b) it could not be omitted without adversely affecting the Covered Person's condition;

(c) it is generally accepted as safe and effective treatment under standard medical practice in the community where the service is rendered; and

(d) it is provided in a cost-effective manner that is consistent with an appropriate level of care.

I.6 "Participating Provider" means a Physician, Hospital, and any other licensed health care facility or professional who or which has entered into a written agreement to provide services to Covered Persons, is duly licensed under applicable state law, and who or which is currently so credentialed and designated as such by Payor.

I.7 "Provider Practitioner" means a physician, physician extender, or other licensed healthcare professional employed by or otherwise contracting with Provider or for whom Provider takes reassignment of and bills and collects claims under this Agreement, and by virtue of which such Provider Practitioner shall be a Participating Provider for purposes of this Agreement.

I.8 "Physician" means doctor of medicine (M.D.), osteopath (D.O.), or podiatrist (D.P.M.) licensed and credentialed to practice under the terms of the State of California and acting within the scope of his or her license, who contracts with Payor to provide Covered Services to Covered Persons.

I.9 "Plan" means a Medicare Advantage benefit plan approved by the Centers for Medicare and Medicaid Services (CMS) and set forth on Schedule 1.

ARTICLE II
PAYOR'S OBLIGATIONS

II.1 Obligations. Payor shall be solely responsible for all payment and administrative activities necessary or required for the commercially reasonable operation of the Plan.

II.2 Claims Payment. Payor shall pay all claims submitted by Provider or Provider Practitioners in a timely fashion in accordance with Attachment A and Payor's Policies and Procedures as required by law or regulation

II.3 Provider Manual Payor shall provide access to Provider Manual which may be periodically updated with current policies and procedures of Payor and any updates to the said policies and procedures of which are incorporated herein by reference. For any updates to the Provider manual that the Provider deems to result in a material financial impact, the Provider's right to exercise their rights in section VI. 11 (Dispute Resolution) and all sections of Article V (Term, Termination and Modification) are acknowledged to be invoked at any time at the Provider's discretion and provisions regarding the access of Payor to Provider's records.

II.4 Procedures. Payor shall develop and implement complaint, utilization review, drug utilization, quality assurance, and other procedures required by law or regulation.

II.5 Provider Listing. Payor shall have the right to use Provider's and Provider Practitioners' names, addresses, and phone numbers, for purposes of informing Covered Persons of the identity of

Provider and Provider Practitioners, advertising and promoting to Covered Persons on behalf of Payor, and otherwise to carry out the terms of this Agreement.

II.6 Credentialing. Payor shall be responsible for credentialing all Participating Providers pursuant to the criteria established by Payor. As a condition of participation, the credentials of Provider, and every Provider Practitioner must be verified and approved by Payor prior to this Agreement becoming effective and before any services are rendered by Provider or the Provider Practitioners to Members. Provider shall cooperate and promptly provide all information required or requested by Payor related to credentials. The parties acknowledge and agree that Payor, in their sole and absolute discretion, may elect not to approve Provider, or any Provider Practitioner for any reason, including, without limitation, if it is determined that the services of a Physician are not needed.

II.7 Utilization Review. Payor agrees to arrange for or conduct utilization review as described in Payor's Policies and Procedures and to furnish Provider with copies of the utilization review findings.

ARTICLE III
PROVIDER'S OBLIGATIONS

III.1 Provision of Services. Provider and Provider Practitioners agree to provide to Covered Persons those Covered Services which are within the scope of their licensure, expertise, and usual and customary. Provider agrees to provide or cause Provider Practitioners to provide Covered Services with the same care and attention and in the same physical settings as customarily provided for patients who are not Covered Persons. Provider shall offer services to Covered Persons who request such services and shall not discriminate against any Covered Person because of race, disability, color, religion, sex, or national origin, provided, however, that the Provider shall not be required to continue providing medical care if the Covered Person refuses to follow the medical advice and treatment prescribed or if there is otherwise determined to be good cause for refusing to provide medical services.

III.2 Delivery of Medical Treatment. Provider shall ensure that the health care services performed and provided by Provider and Provider Practitioners under this Agreement are rendered in a competent and efficient manner according to laws and regulations provided by the State of California and in accordance with generally accepted medical standards prevailing in the medical community served by Provider.

III.3 Coverage Verification. Except in a situation involving the delivery of emergency services, prior to providing Covered Services to any individual who presents himself or herself as a Covered Person, Provider or Provider Practitioners shall verify such patient's coverage with Payor as required by Payor. Failure to verify such patient's coverage may result in no payment due to Provider or Provider Practitioners.

III.4 Representations of Eligibility. Any information about coverage furnished to Provider or Provider Practitioners by Payor shall not be considered to be a guarantee of eligibility or coverage under the Plan. The presentation of an identification card by a Covered Person shall not be considered to be a guarantee of eligibility under the Plan or that coverage under the Plan will be provided. Payor may retroactively, with good cause, deny payment to Provider for any services provided to a Covered Person or for any services unless prior authorization has been provided by Payor to Provider and Provider has rendered services in good faith. Such services authorized by Payor and rendered in good faith by Provider will not be denied by Payor. In the event Payor confirms eligibility for a Covered Person at the time services are rendered by Provider, and it is later determined that the individual was in

fact not a Covered Person, Provider shall seek reimbursement from such ineligible individual (or from the party that has assumed financial responsibility, including but not limited to individual's legal guardian or representative, Medicare, Medicaid or another health plan/payor, hereafter "Responsible Party"), to the extent permitted by applicable Law. In the event Provider does not receive payment from the ineligible individual or from the Responsible Party, Payor shall compensate Provider at the reimbursement rates specified in this Agreement, if the following conditions are met: 1) Provider submits evidence that Payor confirmed eligibility for the dates of service; 2) services were authorized by Payor or Payor's designee; 3) Provider exercised good faith efforts to bill such ineligible individual or Responsible Party for at least two (2) billing cycles; 4) Provider submits documentation which supports Provider's attempts to bill the ineligible individual or Responsible Party; and 5) Provider has not received payment for such services within thirty (30) days following delivery of the second billing. If subsequent to receiving payment from Payor, Provider receives reimbursement from the ineligible individual or from the Responsible Party, Provider shall reimburse Payor the payment previously paid by Payor.

III.5 Provider's Responsibilities. Payor shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider or Provider Practitioners provides Covered Services under this Agreement. Provider will be solely responsible for the provision of Provider Services to a Covered Person. Provider understands that Payor may deny payment for services rendered to a Covered Person which it determines are not Medically Necessary, are not Covered Services, or are not otherwise provided in accordance with the policies and procedures set forth in this Agreement or the Plan, unless such services have been priorly authorized by Payor and documentation provided matches the services rendered and pre-authorized, and Provider has provided clinical criteria that supports such services are medical necessary. Such a denial does not absolve Provider or Provider Practitioners of its responsibility to provide appropriate services to Covered Persons.

III.6 Compensation for Covered Services. Provider and Provider Practitioners shall accept as payment in full for Covered Services to Covered Persons the amounts as stated in the Fee Schedule I attached hereto and incorporated herein as Attachment A. Provider hereby agrees that in no event, including, but not limited to nonpayment by Payor or its health carrier, the insolvency of Payor, or breach of this agreement, shall Provider bill, charge, collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against Covered Persons or persons other than Payor for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of the agreement between Payor and Covered Persons. Provider further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Covered Persons and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the Covered Person or persons acting on the Covered Person's behalf.

III.7 Provision of Non-Covered Services. In the event that Provider provides any services other than Covered Services to any Covered Persons, prior to the provision of such services, Provider shall advise the Covered Person, in writing (i) of the nature of the service; (ii) that the service is not a Covered Service for which Payor will pay; and (iii) that the Covered Person will be solely responsible for paying for the service.

III.8 Participating Providers and Approvals. Except in an Emergency, or as otherwise described under Applicable Requirements, Provider and the Provider Practitioners shall refer Members for Covered Services only to Participating Providers.

III.9 Coordinated and Managed Care. Provider shall participate in the policy and procedures established by Payor designated to facilitate the coordination of Covered Services received by Covered Persons. Subject to medical judgment, patient care interests, the Covered Person's express instructions, and recognizing that a level of a Covered Person's Covered Services may be affected by Provider rendering services, Provider shall abide by the rules and regulations of Payor governing referrals of Covered Persons and reporting of clinical encounter data.

III.10 Coordination of Benefits. Provider shall make all reasonable efforts to assist Payor in coordinating the subrogation of benefits with other health care plans and third parties, including Medicaid and/or other governmental programs. Provider understands that Provider's compensation from Payor will be on the basis specified in the fee schedule attached hereto as Attachment A, less any recovery from third- party or other payors.

III.11 Compliance with Rules, Regulations, Policies, and Procedures. Provider shall comply and cooperate with the requirements of Payor set forth in this Agreement, as amended to date and from time to time thereafter, governing credentialing, utilization management, quality assurance program, complaints, rules and regulations, and policies and procedures of Payor or governing state and Federal laws and regulations, including but not limited to policies and procedures concerning coordination of benefits and third-party liability.

II1.12 Insurance Coverage. Provider, at its expense, shall purchase and maintain professional liability insurance, including such tail or prior acts coverage as may be necessary to avoid a gap in coverage for claims arising from incidents occurring during the term of this Agreement. Such insurance shall: (i) provide minimum policy limits of $1,000,000 per occurrence/$3,000,000 aggregate or such other limits as may be required by Payor and or any local, state or federal regulations.

Provider will furnish Payor with certificates reflecting the coverage of such insurance and agrees that Payor may confirm that such insurance coverage is adequate and in force through the term of this Agreement. Upon written request Provider will allow Payor reasonable access to insurance carrier data and information on Provider's medical malpractice history, including the number, type, nature, and disposition of claims filed against Provider and its Participating Providers.

Provider shall provide Payor with at least thirty (30) days notification prior to any reduction in the amount of coverage, any adverse changes in policy terms, or cancellation or non-renewal of any required coverage. Provider warrants that any Participating Provider that Provider employs or with whom Provider contracts shall purchase and maintain whatever type and amount of professional liability insurance as may be customary in the industry for that class of provider.

III.13 Representations and Warranties. Provider hereby represents that all of the information and documentation provided by Provider to Payor prior to and during the term of this Agreement is true, correct, and complete and Provider hereby agrees to use best efforts to update any such information and documentation within three (3) business days if any change should occur regarding any such information or documentation previously provided to Payor. Provider further represents and warrants to Payor that: (i) this Agreement constitutes the legal, valid and binding obligation of Provider and each Provider Practitioner, enforceable against Provider and each Provider Practitioner, in accordance with its terms, and the individual signing this Agreement on behalf of Provider has been duly authorized and empowered to execute the Agreement; (ii) that if it is a corporation or other entity, it is duly organized under applicable law; (iii) the execution, delivery and performance of this Agreement has been duly authorized by all required

action of Provider, and (iv) such execution, delivery and performance does not violate any provisions of the organizational documents of Provider, any agreement to which Provider is a party (including any agreement with any other payor or managed care provider), or any laws or regulations applicable to Provider.

III.14 No Exclusion/Debarment. Provider represents and warrants that Provider and all Provider Practitioners are not:

(a) Currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the Federal health care programs).

(b) Convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs.

(c) Under investigation or otherwise aware of any circumstances which may result in exclusion from participation in Federal health care programs.

(d) In violation of any requirement of DEA narcotic registration or any other state law requirement.

III.15 Notice of Adverse Action. Provider will use best efforts to notify Payor in writing, within forty-eight (48) hours or as required by the applicable law, of receiving any written or oral notice of the commencement of any legal, equitable, or regulatory proceeding naming or otherwise involving Provider that could reasonably be expected to interfere materially and adversely with Provider's performance of any of its duties or obligations under this Agreement. Provider shall forward to Payor any written complaint or grievance of a Covered Person against Provider or Payor within twenty-four (24) hours of receipt thereof or as soon as reasonably possible. Provider shall maintain a written record of any Covered Person's complaint and provide such record to Payor promptly upon request. Provider also shall notify Payor promptly of any action against any license or certification of Provider, and of any material change in the ownership or business operations of Provider which may affect licensure or certifications of Provider.

III.16 Provider Representations and Warranties. Provider represents and warrants, for Provider or for each Provider Practitioner, as applicable, that Provider or each Provider Practitioner:

(e) has an unrestricted license issued by the State to provide Covered Services;

(f) will provide Covered Services in compliance with all Applicable Laws and professional standards of care;

(g) certified to participate in Medicare under Title XVIII of the Social Security Act, and in Medicaid under Title XIX of the Social Security Act or other applicable State law pertaining to title XIX of the Social Security Act, has not been debarred, suspended or otherwise excluded from participation in the Medicare or Medicaid programs;

(h) holds a current DEA narcotic registration certificate, where applicable;

(i) shall maintain such licensure, compliance, certification and registration, throughout the term of this Agreement and shall immediately notify Payor in the event any such licensure, compliance, certification and registration is not maintained;

(j) shall maintain all required professional credentials and meet all continuing education requirements necessary to retain Board certification or eligibility in Provider's or Provider Practitioner's area(s) of practice and shall immediately notify Payor in the event any such professional credentials are not maintained;

(k) shall provide written notice to Payor if Provider is, or becomes, under an employment agreement or other agreement that restricts, limits or prohibits participation in other agreements or arrangement like and/or including Payor;

(l) shall not maintain any action at law against a Covered Person to collect sums owed by Payor or any agent acting on its behalf. In the event Payor fails to pay for Covered Services to Covered Persons, Covered persons shall not be liable to Provider or Provider practitioner for any sums owned by Payor or any agent acting on its behalf;

III.17 Utilization Review. Provider agrees to cooperate and comply with the Utilization Review program, as described in Payor's Policies and Procedures in effect with regard to Covered Persons treated by Provider.

III.18 Indemnification. Each party shall indemnify and hold harmless the other party and its boards, agencies, departments, officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its boards, agencies, departments, officers, directors, shareholders, employees, agents, and representatives under this Agreement. The terms of this Section shall survive the termination of this Agreement.

ARTICLE IV
RECORDS

IV.1 Records and Confidentiality. Provider shall maintain the medical, financial, and administrative records concerning all hospital services provided to Covered Persons that Provider would maintain in the ordinary course of business. Such records shall be retained by Provider for the period of time required by all applicable laws or regulations, but in no event less than ten (10) years from the date the service was rendered or termination of this Agreement, whichever first occurs. During the term of this Agreement and for ten (10) years thereafter, Provider agrees that Payor, as well as state and Federal agencies, have the right to review records directly related to services rendered to Covered Persons, upon reasonable notice, during regular business hours. Provider further agrees to obtain any necessary releases from Covered Persons with respect to their records and the information contained therein to permit Payor, or state and Federal agencies, access to such records. Payor and Provider agree that each Covered Person's medical records shall be treated as confidential so as to comply with all state and Federal laws and regulations regarding the confidentiality of patient records. Subject to the foregoing, Provider shall supply Payor and the state and Federal agencies at the agreed upon fee schedule with copies of Covered Persons' medical records upon reasonable request. Provider shall participate in any system established by Payor to facilitate the sharing of records, subject to applicable confidentiality requirements. In accordance with State and federal regulations regarding Medicare Enrollees, Provider will maintain complete and accurate fiscal, medical, and social records in such format as necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Agreement. These records will be retained for a period of at least ten (10) years after the starting date of the applicable retention period or until the resolution of any ongoing audit occurs, unless a longer period of time is required under state or federal law or regulations.

IV.2 Transfer and Confidentiality. Provider agrees to cooperate in the transfer of Covered Person's medical records to Participating Providers that Payor has contracted with under the Plan, including paper medical records when electronic means are not available and to transfer any medical records in Provider's custody within ten (10) business days of a Covered Person's request. Provider further agrees to cooperate with Payor and any state or Federal agency in making available, and in arranging or

allowing inspection of, such records as may be required under state or Federal law or regulation or as may be appropriate to disclose to such authorities in connection with their assessment of quality of care or investigation of a Covered Person's grievances or complaints.

IV.3 Other Records. During the term of this Agreement, Provider shall, upon request of Payor, furnish any other record related to Covered Services furnished pursuant to this Agreement, or a copy thereof. Upon termination or expiration of this Agreement, Provider shall provide copies of all such records to Payor prior to final settlement of all claims and outstanding contract issues.

IV.4 Production of Records Notwithstanding Termination. Notwithstanding termination of this Agreement or termination of Provider's participation in the Plan for any reason, the access to records granted hereunder in this Article V shall survive the termination of this Agreement.

ARTICLE V
TERM, TERMINATION AND MODIFICATION

V.1 Initial Term and Renewal. This Agreement shall have an initial term of two (2) years, commencing as of the Effective Date, and shall renew automatically from year to year thereafter, unless either party gives the other party at least sixty (60) days prior written notice to renegotiate or terminate this Agreement.

V.2 Termination Without Cause. In addition to and notwithstanding the other termination provisions hereof, either party shall each have the right to terminate this Agreement at any time, without cause, upon sixty (60) days prior written notice to the other party.

V.3 Termination for Substantial Default. In the event of a substantial default of a party's responsibilities hereunder, either party shall provide the other party with thirty (30) days prior written notice, which notice shall set forth the grounds for termination. If the grounds for termination continue for the thirty (30) day period after written notice, the nonbreaching party shall have the right to immediately terminate this Agreement upon the expiration of the thirty (30) day period.

V.4 Automatic Termination; Provider Conduct. This Agreement may be automatically terminated by Payor upon a determination made in good faith and with reasonable belief by Payor that (i) Provider poses a threat of imminent harm to Covered Persons, (ii) action has been taken by a state agency, licensing board, or accreditation organization which limits, restricts, suspends, or terminates Provider's ability to provide services in accordance with such license, (iii) Provider has perpetuated a fraud; (iv) Provider's liability coverage as required under Section III.13 of this Agreement is no longer in effect; (v) Provider commences a proceeding in Bankruptcy Court for dissolution or reorganization; (vi) Provider fails to comply with applicable law; (vii) one of Provider's representations under Section III.16 becomes untrue; or (viii) a determination of continued non-compliance with the Utilization Review program is made.

V.5 Effects of Termination. Upon termination of this Agreement, neither party shall have any further obligation hereunder except for (i) obligations accruing prior to the date of termination, including but not limited to, any obligation by Provider to provide covered health care services to Covered Persons and Payor obligations for claims payment, and (ii) obligations, promises, or covenants contained herein which are expressly made to extend beyond the term of this Agreement, including confidentiality, indemnification, and provisions regarding the access of Payor to Provider's records.

Provider understands and agrees that notice of termination of this Agreement shall not relieve Provider's obligation to provide or arrange for Covered Services through the effective date of termination

or expiration of this Agreement. With notice to Payor, Provider shall continue to provide Covered Services to any Covered Persons hospitalized on the effective date of termination until the earlier of (i) the conclusion of the course of treatment or the date of discharge; (ii) the transfer to another Participating Provider who participates in the Plan; or (iii) sixty (60) days from the effective date of termination. In such event, Provider will continue to be paid for these services at the rates stated in Attachment A.

V.6 Termination; Disclosure; Claims. In the event this Agreement expires or terminates for any reason or cause, each party consents to the other party's disclosure thereof. In the event this Agreement terminates or expires, Provider agrees to promptly supply to Payor all information necessary for the payment of any outstanding claims.

ARTICLE VI
MISCELLANEOUS

VI.1 Amendment. Notwithstanding any other provision to the contrary, this Agreement may only be amended in any respect by mutual written agreement of both Parties or by sixty (60) day advanced written notice from Payor to Provider at which time Provider can decline amendment in writing or propose alternative language for any amendment from Payor, or notify Payor of pending County Board of Supervisors review with a proposed date of answer Provider's right to exercise their rights in section VI.11 (Dispute Resolution) and all sections of Article V. (Term, Termination and Modification) are acknowledged to be invoked before and after the initial sixty (60) day notice at the Providers discretion.

VI.2 Assignment. Except as otherwise provided, neither this Agreement nor any of the rights or obligations hereof may be assigned or transferred by either party without the prior written notification of the other party. Provider agrees to participate, on the same terms and conditions set forth herein, with any affiliated entity, parent, or subsidiary of Payor, unless otherwise declined by Provider or Payor.

VI.3 Non-Exclusivity. This Agreement shall not be an exclusive agreement between Payor and Provider. Nothing contained herein shall be construed to restrict the rights of Payor or Provider to participate in other managed care systems or contract with other Participating Providers or similar plans.

VI.4 Waivers. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach of this Agreement.

VI.5 Severability. In the event any provision of this Agreement is held to be unenforceable for any reason, the unenforceability thereof shall not affect the remainder of this Agreement, which shall remain in full force and effect and enforceable in accordance with its terms.

VI.6 Gender and Number. Whenever the context hereof requires, the gender of all words shall include the masculine, feminine, and neuter, and the number of all words shall include the singular and plural.

VI.7 Article and Other Headings. The articles and other headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

VI.8 Independent Contractor Status. This Agreement is not intended to create nor shall it be deemed or construed to create any relationship between the parties other than that of independent contractors. Neither of the parties to this Agreement, nor any of their respective employees, shall be construed to be the agent, employer, or representative of the other party. Nothing in this Agreement shall

interfere with or in any way alter the physician-patient relationship. Provider and its Participating Providers shall have the sole responsibility for the care and treatment of Covered Persons under their care and exercise their own medical judgment.

VI.9 Agreement Governs. To the extent of any conflict between the terms of this Agreement and any ancillary obligation created or documentation including the Provider Manual, the terms of this Agreement shall govern.

VI.10 Conformance with Law. Each party shall perform this Agreement in conformance with all applicable Federal, state, and local laws, rules and regulations. The relationships and transactions contemplated by this Agreement shall be subject to regulation by state or Federal government authorities.

VI.11 Dispute Resolution. The Parties shall in good faith first attempt to resolve any controversy, dispute, alleged breach or disagreement arising out of or related to this Agreement (a "Dispute"). Authorized representatives of Payor and Provider shall make a good faith attempt to resolve the Dispute within a reasonable time frame mutually agreed by the Parties in writing after submission of the dispute notice, and if such efforts are unsuccessful, the Dispute shall be submitted to arbitration shall be arbitrated in accordance with the procedures set forth in the American Health Lawyers Association Dispute Resolution Service.

VI.12 Beneficiaries of Agreement. Notwithstanding that benefits may inure to Payor and to Covered Persons under this Agreement, it is not the intention of this Agreement that Covered Persons shall be third party beneficiaries of the obligations assumed by either party to this Agreement, and no such Covered Person shall have the right to enforce any such obligation.

VI.13 Impossibility of Performance. Neither party shall be liable or deemed to be in default for any delay or failure in performance under this Agreement or other interruption of service or employment deemed resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, or any similar or dissimilar cause beyond the reasonable control of such party.

VI.14 Governing Law. This Agreement has been executed and delivered in, and shall be interpreted, construed, and enforced pursuant to and in accordance with the laws of California to the extent any provision of this Agreement conflicts with Applicable Law, Applicable Law shall apply.

VI.15 Notice. Any notice, demand, or communication required, permitted, or desired to be given hereunder shall be deemed effectively given when personally delivered or mailed by prepaid certified mail, return receipt requested, addressed as follows:

Provider:	Payor:
County of Ventura	Align Senior Care of California, Inc.
5851 Thille Street, L#4625	c/o AllyAlign Health
Ventura, Nuckols Road	Suite 110
Attn: HCA Director	Glenn Allen VA 23060

VI.16 Entire Agreement. This Agreement, including the Provider Manual and any amendments, riders, attachments, or appendices, constitutes the entire understanding between the parties and

supersedes any prior understandings and agreements between the parties, or between Provider and any covered Person or other person on behalf of any Covered Person, whether written or oral, respecting the subject matter of this Agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the Effective Date first written above.

PAYOR	**PROVIDER**
Align Senior Care of California, Inc	_____
	(
BY:_____	BY:_____
SIGNATURE:_____	SIGNATURE:_____
TITLE:_____	TITLE:_____
DATE:_____	DATE: _____
	TAX ID: _____

ATTACHMENT A
FEE SCHEDULE I

Payor agrees to reimburse Provider the following for Covered Services which are covered under this Agreement which shall include but not limited to Professional, Technical Outpatient Services and Drugs provided to a Covered Person. This attachment applies to all such Covered Services and is effective for all claims paid on or after Effective Date.

Payor will pay Provider at [redacted] percent ([redacted]%) of the prevailing Medicare Fee Schedule, as administered by the appropriate Medicare Carrier for provider's location less applicable copayments, deductibles, and coinsurances. Payments will be made at the lessor of the Medicare fee schedule or billed charges if Medicare includes fees for similar services or charges.

Payor will make adjustments to fee schedule no later than 60 days after the publication of CMS fee schedule updates.

In the event there is no Medicare to include but not limited to local carrier pricing, allowable rates for services or drugs provided by Provider, Payor agrees to reimburse Provider at [redacted] [redacted] of Provider's billed charges for authorized Covered Services.

SCHEDULE 1

PLAN PARTICIPATION ADDENDUM

Provider shall participate in the Medicare Advantage Plans below as indicated by Payor.

To be completed by Payor:

X	ISNP (institutional special needs plans)
X	CSNP (chronic special needs plans)
X	DSNP (dual special needs plans)
	HMO (health maintenance organization plans)
	PPO (preferred provider organization plans)
	POS (point of service plans)

SCHEDULE 2
MEDICARE ADVANTAGE ADDENDUM

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

The terms and conditions of this Addendum shall supersede and replace any inconsistent provisions of the Agreement, to ensure compliance with MMA and CMS requirements. All other provisions of the Agreement not inconsistent with the provisions of this Addendum shall remain in full force and effect.

DEFINITIONS:

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

Completion of Audit: completion of any audit by the Department of Health and Human Services, the Government Accountability Office, or their designees, of Medicare Advantage Organization, its contractor(s) or a related entity.

Downstream Entity: any party involved with the Medicare Advantage Organization benefit that directly or indirectly enters into a written arrangement, acceptable to CMS, with First Tier Entity.

Final Contract Period: the final term of the contract between CMS and Medicare Advantage Organization.

First Tier Entity: a Provider that has entered into a written arrangement (the Agreement), acceptable to CMS, with Medicare Advantage Organization to provide administrative services or health care services for Enrollees.

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

Medicare Advantage Organization: Align Senior Care, a public or private entity organized and licensed by a state as a risk-bearing entity that is certified by CMS as meeting the Medicare Advantage contract requirements.

Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through Medicare Advantage Organization.

REQUIRED PROVISIONS:

1. HHS, the Comptroller General, or their designees have the right to directly audit, evaluate, collect and inspect any books, contracts, computer or other electronic systems (including medical records and documentation) of First Tier Entity and its Downstream Entities through ten (10) years from the final date of the Final Contract Period or from the date of Completion of Audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

2. First Tier Entity will comply with the confidentiality and Enrollee record accuracy requirements set forth in 42 C.F.R. § 422.118, including: (1) abiding by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by Enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3. Enrollees will not be held liable for payment of any fees that are the legal obligation of Medicare Advantage Organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4. Enrollees eligible for both Medicare and Medicaid will not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. Medicare Advantage Organization will inform First Tier Entity, and First Tier Entity will inform Downstream Entity(ies), of Medicare and Medicaid benefits and rules for Enrollees eligible for Medicare and Medicaid. First Tier Entity and Downstream Entities may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. First Tier Entity will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. Any services or other activity performed in accordance with the Agreement between Medicare Advantage Organization and First Tier Entity, or any agreement between First Tier Entity and a Downstream Entity or between any Downstream Entities, are consistent and comply with Medicare Advantage Organization's contractual obligations to CMS. [42 C.F.R. § 422.504(i)(3)(iii)]

6. Contracts or other written agreements between the First Tier Entity and a Downstream Entity, or between Downstream Entities, for the provision of health care services must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties.[42 C.F.R. §§ 422.520(b)(1) and (2)]

7. First Tier Entity and any Downstream Entity will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

8. If any of Medicare Advantage Organization's activities or responsibilities under its contract with CMS are delegated by First Tier Entity to any Downstream Entity:

   (i) The delegated activities and reporting responsibilities will be specified in a written agreement.

(ii) CMS and Medicare Advantage Organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or Medicare Advantage Organization determine that such parties have not performed satisfactorily.

(iii) Medicare Advantage Organization will monitor the performance of the parties on an ongoing basis.

(iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by Medicare Advantage Organization or the credentialing process will be reviewed and approved by Medicare Advantage Organization and Medicare Advantage Organization must audit the credentialing process on an ongoing basis.

(v) If Medicare Advantage Organization delegates the selection of providers, contractors, or subcontractor, Medicare Advantage Organization retains the right to approve, suspend, or terminate any such arrangement. [42 C.F.R. §§ 422.504(i)(4) and (5)]

9. In performing services under the Agreement, First Tier Entity will not perform any functions, activities or services (or directly contract with any person or entity that performs any functions, activities or services on First Tier Entity's behalf under this Agreement), where such functions, activities or services require access to or storage of Enrollee information outside of the United States of America or its territories.

ATTACHMENT B
STATE LAW REQUIRED PROVISIONS

CALIFORNIA: To the extent that services are provided by Align Senior Care California, Inc., California law requires that specific provisions be included in each contract between a health maintenance organization and a provider of health care services. Except as provided herein, all other provisions of the Agreement between Payor and Provider not inconsistent herein shall remain in full force and effect. This Exhibit shall supersede and replace any inconsistent provisions to such Agreement and shall continue concurrently with the term of such Agreement.

Required Provisions:

1. 1. Availability of Covered Services. Provider shall make available Covered Services at least Monday through Friday during business hours with reasonable after-hours access in accordance with accessibility standards described in the Provider Manual. Provider shall provide Emergency Services when Medically Necessary twenty-four (24) hours a day / seven (7) days a week, three hundred sixty-five (365) days a year, and shall not be required to obtain prior authorization for Emergency Services from Payor. [§1300.67.2, Knox-Keene Health Care Service Plan Act of 1975.]

2. Compensation for Covered Services. Provider agrees that, whether or not there is any unresolved dispute for payment and in the event Payor or the Plan fail to pay for Covered Services, under no circumstances shall Provider, directly or indirectly, make any charge or claim or maintain any action at law against any Covered Person for any sums owed by Payor and/or the Plan, and that this provision shall survive termination of this Agreement whether by rescission or otherwise. No surcharge to any Covered Person shall be permitted. A surcharge shall mean any additional fee not provided for in the Covered Person's contract with the Plan and Evidence of Coverage. Provider may bill and collect co-payments and deductible specifically permitted in the Covered Person's contracts with the Plan. Provider may further bill and collect from Covered Persons all charges for non-Covered Services provided to Covered Persons. Provider shall report to Payor in writing all surcharge and copayment moneys paid by Covered Persons directly to Provider. However, should any conclusive overpayment by Payor be made against any claim submitted by Provider, Payor shall notify Provider for reimbursement and may offset any overpayment to amounts payable processed against current claims until such overpayment is offset in full. [§1300.67.8, Knox-Keene Health Care Service Plan Act of 1975.]

3. Provider shall comply with the requirements of (i) the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations set forth in 45 CFR Parts 160-164, and any applicable state privacy and security law ("HIPAA"), (ii) the requirements of the Health Information Technology for Economic and Clinical Health Act and regulations adopted or to be adopted pursuant thereto ("HITECH") that relate to the obligations of Provider required to protect the privacy and provide for the security of patient records, and (iii) the California Confidentiality of Medical Information Act. [§1385.10, Knox-Keene Health Care Service Plan Act of 1975.]