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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

JENNIFFER ROIZ, et al.,

Plaintiffs,

v.

CALIFORNIA PHYSICIANS' SERVICE DBA BLUE SHIELD OF CALIFORNIA, MAGELLAN HEALTH, INC., MAGELLAN HEALTHCARE, INC., and HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA,

Defendants.

Case No. 3:25-cv-09978-WHO

MAGELLAN'S REPLY MEMORANDUM IN SUPPORT OF MOTION TO DISMISS THE FIRST AMENDED COMPLAINT AGAINST MAGELLAN

Date: August 5, 2026
Time: 2:00 p.m.
Location: Courtroom 2; 17th Floor
Judge: William H. Orrick

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REPLY MEMORANDUM

I. Introduction

Plaintiffs' Opposition confirms that the FAC is an amalgamation of faulty claims. Is this a breach of contract case? Consumer fraud? An action to recover ERISA benefits? None of the above as to Magellan, because Plaintiffs cannot plead sufficient facts to establish the many claims (not to mention the subsidiary legal violations underlying those claims) they seek to pin on Magellan. On their second attempt to do so, Plaintiffs have still not met this basic requirement. At bottom, Plaintiffs plead a host of generalized, non-specific issues relating to their individual care needs and using a provider directory, and they throw every claim at the wall of those vague allegations to see what sticks. That does not cut it.

First, Plaintiffs' contract claims fail because they are not third-party beneficiaries of the Blue Shield-Magellan contract. The contract's plain language forecloses third-party enforcement, and Plaintiffs' arguments to the contrary ignore binding Ninth Circuit and California law. Even if Plaintiffs could enforce the contract, they have not identified any specific breach by Magellan that caused them harm—instead pleading only generalized grievances about directory quality without tying them to a specific contractual obligation.

Second, Plaintiffs' UCL claim fails because it sounds in fraud and does not satisfy Rule 9(b). Plaintiffs cannot identify which defendant made which statement or what specific fraudulent representation Magellan made to them before they enrolled in their plans, and they rely on superseded Ninth Circuit authority in defense of their impermissible collective pleading. And Plaintiffs' attempt to recast their fraud allegations as "unlawful" conduct does not rescue the claim—their shotgun pleading of dozens of statutes without specifying how Magellan violated any of them fails to satisfy even Rule 8.

Third, Plaintiffs' intentional and negligent misrepresentation claims fail for the same reasons. Both claims sound in fraud and must satisfy Rule 9(b), which they do not. Plaintiffs' transparent effort to evade Rule 9(b) by summarily asserting "negligent" misrepresentation in the alternative should be rejected—Plaintiffs plainly plead a case about fraud, not negligence.

Fourth, Plaintiffs' unjust enrichment claim fails because Magellan did not retain any

benefit at Plaintiffs' expense. Plaintiffs paid premiums to Blue Shield, not Magellan, and the capitated payments Blue Shield made to Magellan are not derived from any fund to which Plaintiffs have a legal or equitable claim. The claim also fails Rule 9(b) because it rests entirely on Plaintiffs' deficient fraud allegations.

Fifth, Roiz's ERISA denial-of-benefits claim fails because she has not identified a specific plan term entitling her to the benefit she was denied. Her vague allegations about an inadequate network and directory are not actionable plan benefits subject to an adverse benefit determination.

Sixth, Roiz's ERISA fiduciary-duty claim fails because Magellan was not acting as a fiduciary when taking the actions about which she complains. The only arguably fiduciary act—denying her request for out-of-network coverage—is duplicative of her denial-of-benefits claim, and the mere mishandling of an individual benefit claim does not give rise to a fiduciary-duty claim as a matter of law.

II. Statement of the Issues to Be Decided

1. Whether to dismiss Plaintiffs' contract-based claims against Magellan because Plaintiffs are not third-party beneficiaries of the contract between Magellan and Blue Shield and because Plaintiffs fail to plead a specific material breach by Magellan that caused them harm. *See infra* Part III.A.
2. Whether to dismiss Plaintiffs' claim under the California UCL against Magellan because the FAC (i) fails to plead fraud by Magellan with particularity as required by Rule 9(b), (ii) fails to provide notice of how Magellan allegedly violated any predicate statute or regulation; and (iii) fails to plead inadequacy of legal remedies. *See infra* Part III.B.
3. Whether to dismiss Plaintiffs' claims for intentional and negligent misrepresentation against Magellan because Plaintiffs fail to plead fraud by Magellan with particularity. *See infra* Part III.C.
4. Whether to dismiss Plaintiffs' claim for restitution for unjust enrichment against Magellan because Magellan did not receive any benefit at Plaintiffs' expense and because Plaintiffs fail to plead fraud by Magellan with particularity. *See infra* Part III.D.
5. Whether to dismiss Roiz's claim for denial of benefits under ERISA against Magellan

because the FAC does not plausibly allege that Magellan denied benefits in violation of any plan term. *See infra* Part IV.A.

6. Whether to dismiss Roiz's claim for breach of fiduciary duty under ERISA against Magellan because the FAC does not adequately allege plan-wide injury and the claim is duplicative of the denial-of-benefits claim. *See infra* Part IV.B.

III. Plaintiffs' State-Law Claims Against Magellan Must Be Dismissed.

A. Plaintiffs' contract claims against Magellan fail (Counts Three and Six).

Plaintiffs' Opposition asserts that they are third-party beneficiaries of the Blue Shield-Magellan contract and that they have adequately alleged a breach of that contract by Magellan that caused them harm. Opp. at 13–16. Plaintiffs are incorrect on both points.

1. Plaintiffs are not third-party beneficiaries of the Blue Shield-Magellan contract.

The Court should reject Plaintiffs' attempt to subvert the plain language of the Blue Shield-Magellan contract. Under California law, whether a third party may enforce a contract turns not on whether that party might incidentally benefit from performance in the abstract, but on the motivating purpose of the contracting parties as discerned from the express terms of the agreement. *Goonewardene v. ADP, LLC*, 434 P.3d 124, 132–33 (Cal. 2019); Cal. Civ. Code § 1638. The Blue Shield-Magellan contract both unambiguously states the parties' intent and supplies a rule of construction: "The parties do not intend to confer and this Agreement shall not be construed to confer any rights or benefits to any person, firm, group, corporation or entity other than the parties." Ex. 1 at 53.[1] Both the Ninth Circuit and the Northern District have held such clear expressions of the contracting parties' intent enforceable under California law. *Balsam v. Tucows Inc.*, 627 F.3d 1158, 1163 (9th Cir. 2010); *In re Accellion, Inc. Data Breach Litig.*, 713 F. Supp.

[1] Magellan initially filed an excerpt of the Blue Shield-Magellan contract to avoid burdening the Court with additional unnecessary pages not relevant to the issues. Plaintiffs complain that Magellan "did not submit the complete contract," Opp. at 14 n.5, so for avoidance of doubt as to its contents, Magellan now files a complete version of the contract and its Addendum 2 with very limited redactions of sensitive, wholly irrelevant business information that avoids the need for the parties to seal it. *See* LR 79-5(a) ("A party must explore all reasonable alternatives to filing documents under seal.").

3d 623, 647 (N.D. Cal. 2024). Plaintiffs do not cite these authorities, let alone distinguish them.

Instead, Plaintiffs contend that because the Blue Shield-Magellan contract refers to "Members" and "Enrollees," it is "self-evident" that they are intended beneficiaries notwithstanding the agreement's express disclaimer to the contrary. Opp. at 14–15. But as *Goonewardene* teaches, that the parties to a contract contemplate the administration of a subcontractor's services to third parties does not manifest a "motivating purpose" to benefit them under the contract; "the relevant motivating purpose of the contracting parties is simply to assist the employer in the performance of its required tasks, not to provide a benefit to its employees with regard to the amount of wages they receive." 434 P.3d at 137. So too here. The motivating purpose of Blue Shield and Magellan in entering their contract is to assist Blue Shield in the performance of its obligations to its customers, not to enhance the benefits due to those customers. In other words, while Plaintiffs may be incidental beneficiaries, they are not *intended* beneficiaries. *Jones v. Aetna Cas. & Surety Co.*, 26 Cal. App. 4th 1717, 1724–25 (1994). Plaintiffs' reliance on *Oakland Bulk & Oversized Terminal, LLC v. City of Oakland*, 112 Cal. App. 5th 519 (2025), is therefore misplaced. The plaintiff there overcame a disclaimer only because a known third party was named and defined in the contract, granted a unique assignment right, and "was specifically formed to build" the contemplated project. *Id.* at 563–64. Those are objective indicia of particularized intent to benefit a specific entity, not generic references to a class of service recipients.[2]

Plaintiffs next argue that third-party enforcement is "necessary to effectuate the objectives of the contract," since "Blue Shield cannot be solely entrusted to enforce" it because its "costs decrease when Members cannot access in-network care." Opp. at 14. But if Magellan's breach of the agreement in turn causes Blue Shield to breach its own obligations—as the FAC in fact

2 Plaintiffs also cite *Inland Nw. Renal Care Grp., LLC v. WebTPA Emp. Servs., LLC*, 2020 WL 1866436 (W.D. Wash. Mar. 26, 2020). That unpublished case applied Washington law and is in any event distinguishable on its facts, because the relevant contract provided the plaintiff "the benefit of pursuing the judicial remedy set forth in the [contract] against [the Defendant]." *Id.* at *7. No such provision exists here.

expressly alleges—members can recover from Blue Shield, as Plaintiffs seek to do here, and Blue Shield can recover from Magellan if Magellan's breaches of the agreement are to blame. The Blue Shield-Magellan contract's own language reinforces this structure: Section 4.1(a) states that "[t]he Benefit Plan is the exclusive agreement between BSC and Members regarding the benefits, exclusions and other conditions relating to coverage" and that the Blue Shield-Magellan contract "is not intended nor shall it be deemed or construed to modify the contractual obligations of BSC to Members." Ex. 1 at 13–14. Blue Shield thus faces direct liability for any shortfall in Magellan's performance, which is precisely the mechanism *Goonewardene* found sufficient to alleviate the need to confer third-party beneficiary status on the plaintiff employees. 434 P.3d at 137 ("[The employer] is available and fully capable of pursuing a breach of contract action against ADP if, by failing to comply with its contractual responsibilities, ADP renders [the employer] liable for any violation of the applicable wage orders and labor laws."). This case is thus on all fours with *Goonewardene*, and Plaintiffs do not even attempt to distinguish it. Counts Three and Six should be dismissed with prejudice on this basis alone.

2. Plaintiffs have not adequately pleaded any material breach of contract that caused them harm.

Even assuming *arguendo* that Plaintiffs could enforce the Blue Shield-Magellan contract, their breach-of-contract claim still fails on breach and causation. Plaintiffs plead generalized poor performance and a kitchen sink of statutory violations without identifying which specific obligation Magellan breached and how each such breach caused Plaintiffs' injuries.

On breach, Plaintiffs' Opposition points to specific contractual provisions—Magellan's obligation to verify directories every 90 days, to "investigate and undertake corrective action" upon notice of inaccuracies, and to comply with a dozen-plus federal and state statutes. Opp. at 15–16. But pointing to obligations is not the same as alleging facts showing a breach. The FAC does not allege that Magellan failed to perform a specific quarterly verification cycle, or that it received new information from a provider and failed to update the directory within two days, or that it was unable to verify a specific provider and failed to remove that provider. FAC ¶¶ 287–91. Instead, it incorporates by reference an undifferentiated list of statutes—the No Surprises Act,

the ACA, ERISA § 720, the IRC § 9820, the Knox-Keene Act, and California Insurance Code § 10133.15—and alleges in conclusory fashion that Magellan "violated" them all. FAC ¶¶ 286–91. Each statute imposes distinct, operationalized requirements with specific triggering conditions and timeframes, yet Plaintiffs do not allege which requirement was triggered and not followed. Plaintiffs' Opposition does not address this shotgun pleading deficiency of their own making.

As to Castillo's report that certain providers lacked "availability," FAC ¶ 88, the Opposition asserts that Magellan's continued listing of those providers necessarily means it breached the contract, Opp. at 15. But the FAC does not identify what was actually inaccurate about those listings—it alleges only that providers "did not have availability." FAC ¶ 88. A provider who is in-network and under contract but temporarily has a full schedule is not erroneously listed. Without identifying which contractual or statutory provision would have been triggered by Castillo's report and what Magellan was required to do in response, Plaintiffs cannot establish a breach (and even if they could, it would be as to Castillo alone).

On causation, Plaintiffs allege three categories of harm: inflated premiums, out-of-network costs, and foregone care, Opp. at 15, but connect none of them to a specific breach of the Blue Shield-Magellan contract. Premiums are paid to Blue Shield under Plaintiffs' own plans; Plaintiffs do not allege that any specific breach by Magellan of its contract with Blue Shield caused Blue Shield to turn around and charge Plaintiffs higher premiums. As for out-of-network costs, the only Plaintiff who alleges paying out-of-pocket is Roiz, FAC ¶ 63, and her out-of-network expenses resulted from a denial of out-of-network coverage, *see infra* Section IV.A—not from any inaccurate directory entry that remained because Magellan breached a specific contractual procedure. And as to foregone care, Plaintiffs point to a litany of contract terms and legal requirements without specifying which one actually prevented Castillo from finding care for her son. It is therefore impossible to identify the causal link between a specific contractual failure and that harm. Plaintiffs must allege what particular damages flowed from Magellan's specific breach of *its contract with Blue Shield*, not Plaintiffs' contract with Blue Shield. *See King v. Facebook, Inc.*, 572 F. Supp. 3d 776, 790 (N.D. Cal. 2021) (dismissing breach-of-contract claim where plaintiff failed to allege cognizable damages caused by the alleged breach); *see also X Corp. v.*

Ctr. for Countering Digital Hate, Inc., 724 F. Supp. 3d 948, 969 (N.D. Cal. 2024) (general contract damages must flow "directly and necessarily from" the defendant's breach). Generalized allegations that the directory was inaccurate and Plaintiffs did not get the care to which they were entitled do not suffice.

B. Plaintiffs' claim under the California Unfair Competition Law fails (Count Seven).[3]

1. Plaintiffs fail to plead fraud with the particularity required by Rule 9(b).

Magellan agrees with Plaintiffs that "Rule 9(b)'s heightened pleading requirement is inapplicable to UCL claims that do not sound in fraud." Opp. at 19. Sensibly, Plaintiffs stop just short of arguing that *their* UCL claim does not sound in fraud,[4] instead vaguely asserting—without citation—that Rule 9(b) should not apply because they allege conduct that was "unlawful *per se* without fraud or deceit." *Id.* But courts routinely apply Rule 9(b) to "unlawful" UCL claims when they sound in fraud, particularly where, as here, many of the specific predicate legal violations are consumer fraud statutes. *Hadley v. Kellogg Sales Co.*, 243 F. Supp. 3d 1074, 1094 (N.D. Cal. 2017) (noting that when the "basis" for a UCL claim sounds in fraud, such as plaintiff's unlawful prong UCL cause of action based on violations of the California False Advertising Law and the California Consumers Legal Remedies Act, plaintiff must "satisfy Rule 9(b) as to the UCL's unlawful prong" (citation omitted)). Short of this half-hearted argument, Plaintiffs do not

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[3] As Magellan argued in its motion, Mag. Mot. at 12, the Blue Shield-Magellan contract is over, and Magellan could thus not possibly harm Plaintiffs in the future since it is no longer Blue Shield's mental health service administrator. Should the Court agree with Plaintiffs' argument that this "raises issues of proof, not pleading," Opp. at 21, it should nonetheless make clear that to obtain equitable relief against Magellan, Plaintiffs will need to prove they are under threat of an imminent injury traceable to Magellan. *Summers v. Earth Island Inst.*, 555 U.S. 488, 493 (2009).

[4] The FAC plainly sounds in fraud, and any implication by Plaintiffs to the contrary is farcical. The FAC accuses Magellan and Blue Shield of "lies," "fraudulent misrepresentations," and "deception" literally dozens of times. *See, e.g.*, FAC ¶¶ 7, 193, 219, 233, 359, 374, 381 ("lies"); 230, 361, 362, 363 ("fraudulent misrepresentations"); 198, 362 ("deception"); *see also* FAC ¶¶ 183 ("Defendants' directory is intentionally and grossly inaccurate."); 216 ("Defendants' misrepresentations about their mental health provider network and coverage are materially misleading to consumers."); 340 ("Defendants intentionally lie about the provider network in order to induce people to enroll in Blue Shield's plans based on misinformation."). Rule 9(b) clearly applies to Plaintiffs' allegations of "a unified course of fraudulent conduct" on which their claims rely. *Kearns v. Ford Motor Co.*, 567 F.3d 1120, 1125 (9th Cir. 2009).

meaningfully dispute Magellan's argument that their entire UCL claim, including the "unfair"[5] and "unlawful" prongs, sounds in fraud and is thus subject to Rule 9(b). *See* Mag. Mot. at 11, 13, 14 n.6; *Kearns*, 567 F.3d at 1125–26; *Hadley*, 243 F. Supp. 3d at 1094, 1104–05.

Applying Rule 9(b) to Plaintiffs' entire UCL claim against Magellan, the Court should dismiss it. Reading the FAC simply does not allow one to "determine precisely what statements [by Magellan] were allegedly false, misleading, or unfair." *Colgate v. JUUL Labs, Inc.*, 345 F. Supp. 3d 1178, 1190–91 (N.D. Cal. 2018) (Orrick, J.). That is because the FAC does not "set out which of the defendants made which of the fraudulent statements," instead alleging "everyone did everything." *Destfino v. Reiswig*, 630 F.3d 952, 958 (9th Cir. 2011) (internal quotation marks omitted). Rule 9(b) does not permit such collective pleading, instead requiring Plaintiffs to "at a minimum identify the role of each defendant in the alleged fraudulent scheme." *United States v. Corinthian Colls.*, 655 F.3d 984, 997–98 (9th Cir. 2011) (internal quotation marks omitted). The FAC does no such thing; to the contrary, "Defendants" are alleged to have collectively made practically every false statement, and played every conceivable role, in the so-called fraudulent scheme. *See, e.g.*, FAC ¶¶ 4, 9, 145, 173, 174, 206, 209, 211.

Plaintiffs' sole authority to the contrary is not even good law. They invoke *United States v. United Healthcare Insurance Co.*, 832 F.3d 1084 (9th Cir. 2016), for the proposition that "there is no flaw in a pleading [where] collective allegations are used to describe the actions of multiple defendants who are alleged to have engaged in precisely the same conduct." *Id.* at 1102 (internal quotation marks omitted); Opp. at 19. But Plaintiffs fail to mention that the cited opinion was amended and superseded on denial of rehearing *en banc* by *United States v. United Healthcare Insurance Co.*, 848 F.3d 1161 (9th Cir. 2016). The controlling decision is worse for Plaintiffs, not

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[5] Plaintiffs briefly assert that they allege conduct that could make out a claim under the "unfair" prong of the UCL statute. But "where the unfair business practices … overlap entirely with the business practices addressed in the fraudulent and unlawful prongs of the UCL," it rises and falls with them. *Hadley v. Kellogg Sales Co.*, 243 F. Supp. 3d 1074, 1104–05 (N.D. Cal. 2017). Such is the case here, where Plaintiffs don't claim to allege any practice that was "unfair" but not "fraudulent" or "unlawful." *See* Opp. at 18 ("Defendants acted unfairly by creating the illusion of a robust mental health provider network and charging inflated premiums for plans that did not include such a network.").

better: whereas the superseded opinion held that a qui tam relator's False Claims Act complaint satisfied Rule 9(b) as to all defendants, the amended (and controlling) opinion held that generalized, group-pleaded allegations ***failed*** Rule 9(b) as to the defendants against whom the complaint offered "only broad allegations lacking particularized supporting details" and "no details linking these defendants to the scheme." 848 F.3d at 1181–82. In any event, the proposition Plaintiffs lean on is inapposite. In addition to the finding that the pleading at issue tied particularized detail to each defendant (a finding which was later rescinded), the *United Healthcare* panel initially excused collective allegations because the relator alleged that each defendant *separately* engaged in "precisely the same conduct," namely each submitting false certifications. 832 F.3d at 1102. Here, by contrast, the FAC does not allege that Magellan and Blue Shield each independently committed identical, particularized misconduct. Nor could it. Blue Shield, as the operator of the healthcare plans that contract with Plaintiffs, and Magellan, as a subcontractor of Blue Shield that serves as a mental health service administrator (MHSA), play fundamentally different roles in Plaintiffs' allegations. Ignoring this, Plaintiffs lump undifferentiated misrepresentation allegations onto "Defendants" without identifying which defendant made which statement. "Rule 9(b) undoubtedly requires more." *Corinthian Colls.*, 655 F.3d at 998.

Critically, Plaintiffs make no allegation that any one of them ever saw a misrepresentation by Magellan *prior to enrolling in their Blue Shield plans*, but the entire premise of their fraud claims is that Magellan supposedly lied to them to induce their enrollment in the plan. *See, e.g.*, FAC ¶¶ 53, 73, 99, 111, 175, 221, 359, 362. So, even assuming Plaintiffs could survive a Rule 9(b) challenge to Magellan's conduct *during* their enrollment (and they cannot), that couldn't possibly support their claim that Magellan induced their enrollment in Blue Shield's health insurance plans by fraud. *See Roland v. Hubenka*, 12 Cal. App. 3d 215, 223 (1970) (finding no reliance where misrepresentations "occurred after the parties had entered into a written agreement for the purchase and sale of the property"). The FAC nowhere answers the question that controls these claims: what specific fraudulent statement is Magellan alleged to have made to Plaintiffs *before* they enrolled in the relevant Blue Shield health insurance plans that induced their

participation in the plans? It simply does not allege one.

2. Plaintiffs fail to plausibly allege that Magellan committed any non-fraud predicate legal violation.

Plaintiffs do not meaningfully respond to Magellan's argument that, even generously applying Rule 8 to certain of their "unlawful" UCL allegations, they fail to state a claim because all the FAC does is enumerate dozens of statutes and regulations and offer the conclusory allegation that Magellan violated these statutes without explaining how. *See* Mag. Mot. at 14-16. As Magellan explained, this kitchen-sink approach is not a new trick: it is called "shotgun pleading," and it does not comply with Rule 8 because it fails to put Magellan on notice of how exactly it is alleged to have violated the law. *Gibson v. City of Portland*, 165 F.4th 1265, 1291 (9th Cir. 2026). This principle applies with equal force to "unlawful" UCL claims. *See Monreal v. GMAC Mortg., LLC*, 948 F. Supp. 2d 1069, 1076 (S.D. Cal. 2013) ("[M]erely listing statutes [as UCL predicates] without articulating specific facts to satisfy each element of the identified statute is insufficient."). Plaintiffs' Opposition repeats the mistakes of the FAC, by baldly asserting that Magellan is subject to their laundry list of statutes and didn't comply with them—without pointing to the factual matter in the FAC that supplies the factual basis for each legal wrong (because there is none). Opp. at 20–21.

At bottom, Plaintiffs' argument appears to be that they can proceed against Magellan on a broad UCL theory predicated on any one—or some unspecified combination—of their enumerated statutes simply because those statutes speak generally to maintaining provider directories and networks and Magellan generally maintained shoddy provider directories and networks. But these statutes impose specific and detailed compliance obligations and procedures, not strict liability for inaccuracies. *See, e.g.*, 42 U.S.C. § 300gg-115(a)(2)–(4) (requiring plans to verify and update directory information at least every 90 days, establish a procedure for removing providers whose information cannot be verified, update directory information within two business days of receiving new provider information, and maintain a public provider database); Cal. Code Regs. tit. 10, §§ 2240.1, 2240.6 (imposing specified network access standards and directory-maintenance procedures, including online posting, weekly online updates, quarterly paper-copy updates, and

accuracy-maintenance requirements). Plaintiffs fail to "state with reasonable particularity the facts supporting the statutory elements of [each] alleged violation." *Stearns v. Select Comfort Retail Corp.*, 763 F. Supp. 2d 1128, 1150 (N.D. Cal. 2010) (internal quotation marks omitted). Thus, even applying Rule 8, Plaintiffs have not stated an unlawful UCL claim.[6] Count Seven against Magellan should be dismissed.[7]

C. Plaintiffs' intentional and negligent misrepresentation claims against Magellan fail (Counts Eight and Nine).

Plaintiffs do not dispute that Rule 9(b) applies to their intentional misrepresentation claim, which should be dismissed for failure to comply with the heightened pleading requirements for fraud as argued above. *See supra* Section III.B.1. In an undeveloped footnote, Opp. at 22 n.12, Plaintiffs urge the Court to join a "growing trend of authority" applying Rule 8 to California negligent misrepresentation claims. *Id.* (citing *Levit v. Nature's Bakery, LLC*, 767 F. Supp. 3d 955, 970 (N.D. Cal. 2025)). As Magellan argued in its motion, the Court need not decide whether Rule 9(b) *always* applies to negligent misrepresentation claims to apply it here because Plaintiffs are clearly alleging intentional fraud rather than negligence. *See* Mag. Mot. at 16; *supra* n.4. By seeking to avoid Rule 9(b), Plaintiffs ask the Court for permission to smuggle their intentional fraud allegations through the much more lenient Rule 8 standard merely because they conclusorily plead "negligent" misrepresentation in the alternative. But nothing in the complaint can be fairly

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[6] Plaintiffs also suggest in a footnote that Magellan is liable under the UCL as an "aider and abettor" of Blue Shield's unlawful conduct. Opp. at 21 n.10 (citing *Plascencia v. Lending 1st Mortg.*, 583 F. Supp. 2d 1090, 1098 (N.D. Cal. 2008)). This argument does not rescue their UCL claim because they do not plead that Magellan had actual knowledge of the specific primary violation and gave "substantial assistance" to Blue Shield. *Plascencia*, 583 F. Supp. 2d at 1098 (internal quotation marks omitted). The FAC does not identify any specific primary violation by Blue Shield that Magellan knowingly assisted; instead, it relies on the same undifferentiated, group-pleaded allegations of fraud that independently fail Rule 9(b). *See supra* Section III.B.1.

[7] Magellan maintains that Plaintiffs cannot pursue the UCL's equitable remedies if they have adequate remedies at law. *See* Mag. Mot. at 12. Should the Court allow any of Plaintiffs' legal claims for damages against Magellan to proceed, this principle would separately foreclose their UCL claim. *See Sonner v. Premier Nutrition Corp.*, 971 F.3d 834, 844 (9th Cir. 2020) (holding federal courts applying the UCL must require the plaintiff to plead that she lacks a remedy at law).

read to allege negligence. The Court should not permit this end-run around Rule 9.

D. Plaintiffs' claim for "restitution for unjust enrichment" fails (Count Ten).

Plaintiffs' Opposition fails to save their restitution/unjust enrichment claim against Magellan. To start, Plaintiffs have misconstrued Magellan's argument. Mag. Mot. at 16–17. Magellan does not argue that the claim fails because Plaintiffs did not confer a benefit directly on Magellan, *contra* Opp. at 23, but rather that any benefit incurred by Magellan did not come at the expense of Plaintiffs at all, directly or indirectly. In more doctrinal terms, the problem with Plaintiffs' restitution claim is that they lack a legal or equitable right to the "benefit" Magellan received—capitated payments from Blue Shield pursuant to its contract with Magellan.[8] *City of Oakland v. Oakland Raiders*, 83 Cal. App. 5th 458, 479 (2022) ("[W]here someone other than the plaintiff provided the benefit the defendants allegedly unjustly retained … the plaintiff is entitled to restitution from the defendant where the plaintiff 'has a better legal or equitable right.'" (quoting Rest. 3d Restitution and Unjust Enrichment § 48)); *see also Korea Supply Co. v. Lockheed Martin Corp.*, 63 P.3d 937, 947 (Cal. 2003) ("The object of restitution is to restore the status quo by returning to the plaintiff funds in which he or she has an ownership interest."). These payments are not derived from Plaintiffs' premiums, which they would owe to Blue Shield regardless whether it contracted with a mental health service administrator like Magellan to administer the mental and behavioral health portion of the benefit for which Plaintiffs contract with Blue Shield. *See Tindell v. Murphy*, 22 Cal. App. 5th 1239, 1254 (2018) (benefit not received at plaintiffs' expense where a third-party paid for the defendant's services). Thus, no benefit has inured to Magellan of which Plaintiffs are legally entitled to restitution.

Regardless, Plaintiffs' allegations in support of their restitution claim fail to satisfy Rule 9(b), which separately forecloses the claim. Plaintiffs do not dispute that Rule 9(b) applies to their restitution claim, *see* Opp. at 23, and their Opposition in fact confirms that they base their restitution claim entirely on their allegations of fraud. *Id.* ("By lying about its inadequate provider

[8] Blue Shield does not pay Magellan in the form of shared profits, as Plaintiffs suggest, Opp. at 23, but rather a capitated, per-member rate. Ex. 1 at 2.

network, Magellan induced Plaintiffs to enroll in Blue Shield plans."). But nowhere does the FAC tell Magellan or the Court exactly who "lied" to them about an "inadequate provider network," what specific statements they contend were misleading or fraudulent, when Plaintiffs encountered the statements, or where the statements were made or located—and the FAC is particularly lacking in any specific allegations of fraud by Magellan before Plaintiffs enrolled in their plans, which is the entirety of their basis for restitution. *See supra* Section III.B.1. Count Ten fails too.[9]

IV. Plaintiff Roiz's ERISA Claims Against Magellan Must Be Dismissed.

A. Roiz's claim for improper denial of benefits against Magellan fails (Count Eleven).

Roiz does not meaningfully dispute Magellan's and Blue Shield's argument that the denial of her request to extend coverage for her out-of-network provider cannot support her claim for denial of benefits because she has not pleaded a specific plan term entitling her to the denied benefit. *See* Opp. at 26–27. Instead, Plaintiffs focus on more nebulous "benefits" Roiz was allegedly denied such as "a robust network of providers," "an accurate directory," and "assistance locating a provider." Opp. at 27. But those are not actionable plan benefits because they are not subject to an "adverse benefit determination," which is the event that triggers an ERISA denial of benefits claim. *See Star Dialysis, LLC v. WinCo Foods Employee Benefit Plan*, 401 F. Supp. 3d 1113, 1138 (D. Idaho 2019) (denial of benefits claim "necessarily requires an adverse benefit determination"). Relatedly, a claim based on denial of high-level benefits such as terms requiring the plan to "provide benefits for covered health services and pay all reasonable and medically necessary expenses incurred by a covered members … is too general to demonstrate that defendants breached the plan terms." *Kisting-Leung v. Cigna Corp.*, 780 F. Supp. 3d 985, 1003 (E.D. Cal. 2025) (internal quotation marks omitted). The only specific adverse benefit determination by Magellan that Roiz pleads is the denial of coverage for her out-of-network

[9] Magellan maintains that Plaintiff Roiz's state-law claims are pre-empted by ERISA because they reference and have a connection with Roiz's ERISA plan; her state-law claims separately fail for this reason. *See* Mag. Mot. at 5-6. But the Court need not address this issue assuming it agrees with Magellan that *all* of the Plaintiffs' state law claims against Magellan fail on the merits. Should any of the state-law claims against Magellan survive the instant motion, however, the Court should clarify that such claims can be brought only by the Plaintiffs enrolled in non-ERISA plans.

therapist, which is why Magellan and Blue Shield focused on it in their Motions. *See* 29 C.F.R. § 2560.503-1(m)(4)(1) (defining "adverse benefit determination"). For the reasons Magellan has already argued, to which Plaintiffs do not meaningfully respond in their Opposition, Roiz has not pleaded a specific plan term entitling her to the only benefit she was denied. Mag. Mot. at 17–19.

To the extent Roiz alleges a denial of benefits based on her difficulty finding a provider, Magellan's argument is not that Roiz was "being too picky," Opp. at 27, but that she has not pleaded that her difficulty finding a provider resulted from a breach of a specific plan term. Moreover, even if difficulty finding a provider somehow counted as a "denial of benefits," it is entirely unclear what remedy would allow Roiz to "recover benefits due to [her] under the terms of [the] plan." § 1132(a)(1)(B). Plaintiffs' damages are supposedly inflated premiums, out-of-network payments, and the costs of foregone care, but these damages are unrecognizable as "recovery of benefits" wrongfully denied under ERISA. Count Eleven should be dismissed.

B. Roiz's claim for breach of fiduciary duty against Magellan fails (Count Twelve).

Plaintiffs' Opposition confirms that (1) Magellan was not acting as a plan fiduciary when taking any of the actions about which Roiz complains, and (2) Roiz does not allege a distinct injury sufficient to sustain a claim under § 1132(a)(3).[10]

First, Magellan does not dispute that it could be a functional fiduciary with respect to the exercise of discretionary authority over benefits, such as the denial of Roiz's request to cover her out-of-network therapist. That is precisely the reason for the "narrow view" of her fiduciary duty claim against Magellan, Opp. at 27, because it is the only action Magellan is alleged to have taken during which it could have had fiduciary duties. The case law is abundantly clear that fiduciary duties are action-specific, and that the defendant must have been performing a fiduciary function when taking the specific action at issue. *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000). But denying Roiz's request for out-of-network coverage does not give rise to a fiduciary duty claim. *Amalgamated Clothing & Textiles Workers Union, AFL-CIO v. Murdock*, 861 F.2d 1406, 1414 (9th Cir. 1988). The remaining actions Plaintiffs point to—"interpreting plan terms, developing

[10] Roiz has abandoned her claim for breach of fiduciary duty under § 1132(a)(2). Opp. at 30 n.14.

plan policies, and maintaining the directory and other plan documents"—are plainly not enough to support Roiz's fiduciary duty claim. *See* Opp. at 28. Even assuming that these are discretionary activities giving rise to a fiduciary duty, Roiz does not point to a single plan term, policy, or other document that Magellan "interpreted" or "developed" in a way that breached a fiduciary duty. And Plaintiffs do not dispute the principle that "communicating with beneficiaries about their rights and options under the plan" is a ministerial, non-fiduciary function, rendering their generalized directory and call center issues non-actionable. *Chaganti v. Ceridian Benefits Servs., Inc.*, 208 Fed. App'x 541, 547 (9th Cir. 2006) (internal quotation marks omitted).

Second, because the only arguably fiduciary act taken by Magellan was the denial of Roiz's out-of-network extension, that claim is entirely duplicative of her denial-of-benefits claim. She cannot proceed under § 1132(a)(3) for this reason. *Castillo v. Metropolitan Life Ins. Co.*, 970 F.3d 1224, 1229 (9th Cir. 2020). And in any event, as a matter of law the mere "mishandling of an individual benefit claim does not violate any of the fiduciary duties defined in ERISA." *Murdock*, 861 F.2d at 1414.

V. The Court Should Not Grant Leave to Amend.

The Court should deny Plaintiffs' request for leave to amend. Opp. at 32. Where, as here, Plaintiffs have already amended the complaint once, the Court's discretion to deny leave to amend is "particularly broad." *Zucco Partners, LLC v. Digimarc Corp.*, 552 F.3d 981, 1007 (9th Cir. 2009) (internal quotation marks omitted). Denial of leave to amend is particularly appropriate when the plaintiff has had prior notice of her pleading deficiencies and failed to correct them. *Id.* (failure to correct known deficiencies is a "strong indication that the plaintiffs have no additional facts to plead" (internal quotation marks omitted)). Such is the case here—Plaintiffs amended the complaint only after Magellan and Blue Shield moved to dismiss their first complaint on essentially the same grounds as they seek to dismiss the FAC. *See* ECF Nos. 41, 43. The Court should therefore dismiss the FAC against Magellan with prejudice.

VI. Conclusion

For the foregoing reasons, the Magellan Defendants respectfully request that the Court dismiss Plaintiffs' complaint against Magellan with prejudice.

Dated: July 7, 2026

Respectfully submitted,

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Attorneys for Magellan Defendants

CERTIFICATE OF SERVICE

I certify that on July 7, 2026, I electronically filed the foregoing Reply in Support of Magellan's Motion to Dismiss with the Clerk of Court using the ECF system, which sent notification of such filing to all counsel of record.

By: */s/ Steven M. Cady*
Steven M. Cady

EXHIBIT 1

BEHAVIORAL HEALTH SERVICES AGREEMENT
BETWEEN
HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA
AND
BLUE SHIELD OF CALIFORNIA

This BEHAVIORAL HEALTH SERVICES AGREEMENT (this **"Agreement"**), is entered into effective June 15, 2011 (the **"Effective Date"**), by and between Human Affairs International of California, a California corporation (**"HAI-CA"**), and California Physicians' Service, a California nonprofit mutual benefit corporation dba Blue Shield of California (**"BSC"**).

RECITALS

A. BSC is licensed as a prepaid health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 and the regulations promulgated thereunder, each as amended (the **"Knox-Keene Act"**). BSC contracts with individuals, associations, employer groups, and governmental entities to provide or to arrange for the provision of covered health care services and/or related administrative services to individuals enrolled in Benefit Plans (as defined herein) underwritten or administered by BSC.

B. HAI-CA is licensed as a specialized health care service plan under the Knox-Keene Act, and through its contracted network of professional and facility providers, is able to provide or arrange for the delivery of professional mental health and substance abuse services and related administrative services.

C. HAI-CA and BSC desire that HAI-CA provide or arrange for the delivery of mental health and substance abuse services, to Members (as defined herein) and provide related administrative services, in accordance with the terms of this Agreement.

ARTICLE 1
DEFINITIONS

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

1.1 Administrative Manual: The manuals developed by BSC which set forth the operational rules and procedures applicable to the provision of services by HAI-CA pursuant to this Agreement, comprised of the applicable portions of the HMO IPA/Medical Group Procedures Manual, the HMO Benefit Guidelines, the Blue Shield Medical Interface Manual, the BSC Provider Manual, BSC Delegation Standards and criteria, BSC credentialing policies and procedures, BSC Medicare Advantage contractual obligations, outpatient drug formulary and drug prior authorization requirements, and the Blue Shield Medical Policy Manual.

1.2 Affiliate: means, in respect of any Person, any other Person that is directly or indirectly controlling, controlled by, or under common control with such Person or any of its subsidiaries, and the term "control" (including the terms "controlled by" and "under common control with") means having, directly or indirectly, the power to direct or cause the direction of the management and policies of a Person, whether through ownership of voting securities or by contract or otherwise.

1.3 Association: The Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

1.4 Benefit Plan: A plan of benefits which includes health care coverage, is issued or administered in whole or in part by BSC and contains the terms and conditions of a Member's coverage. For purposes of this Agreement, "Benefit Plan" shall include the benefit plans of all other independent licensees of the Association which entitle its enrollees to obtain health care services within the Service Area through the Association's Blue Card Program (**"Blue Card Plans"**).

1.5 Blue Card Member: An enrollee in a Blue Card Plan.

1.6 BSC Behavioral Health Provider: A BSC Provider who provides mental health and/or substance abuse services to Non-Risk Members.

1.7 BSC Provider: A duly licensed health care professional or facility that has an executed written agreement in effect with BSC to provide Covered Services to Members.

1.8 Capitation Payment: An amount equal to a single Capitation Rate multiplied by the number of Members who are enrolled in the Benefit Plan(s) (other than Blue Card Plans) to which the Capitation Rate applies.

1.9 Capitation Rate: The amount to be paid to HAI-CA for each Member per month, as specified in Exhibit C hereto, including the MHSA Capitation Rates, the Self-Funded Administrative Rates and the FEP Administrative Rates.

1.10 CMS: the Centers for Medicare and Medicaid Services.

1.11 Commencement Date: January 1, 2012.

1.12 Copayment: Any copayments, deductibles, or coinsurance specifically described as the financial responsibility of the Member for a Covered Service in the applicable Benefit Plan in effect as of the date of service.

1.13 Covered Services: The Medically Necessary health care services and supplies covered by a Member's Benefit Plan, including, without limitation, Covered MHSA Services.

1.14 Covered MHSA Services: Those mental health and substance abuse services and supplies that are: (a) Covered Services under a Full-Risk Member's Full-Risk Benefit Plan; (b) included in the list of Covered MHSA Services attached hereto as Exhibit D; and (c) not listed in the list of Exclusions from Covered MHSA Services attached hereto as Exhibit E. Such mental health and substance abuse services and supplies shall be Covered Services only when determined to be Medically Necessary.

1.15 Eligible Employees: Persons who are employees of BSC and not enrolled for coverage under a Benefit Plan, but by virtue of such employment are eligible to receive Work/Life Services (as defined in Section 6.1), and such persons' dependents.

1.16 Emergency Services: Covered MHSA Services required to address an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the Member's health or that of another person or unborn child in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. Emergency Services shall also include any other services as regulated by applicable federal or state regulations, laws or statutes, including without limitation, for Members enrolled in a BSC Medicare Advantage Benefit Plan, any other services defined as emergency services in 42 C.F.R. § 422.113.

1.17 Enrolling Unit: The employer or other defined or otherwise legally constituted group with whom a Benefit Plan is in effect.

1.18 Full-Risk Benefit Plans: Those Benefit Plans that are underwritten by BSC and identified in Section 1 of Exhibit A hereto.

1.19 Full-Risk Member: An individual who is eligible for and enrolled in a Full-Risk Benefit Plan.

1.20 Governmental Entity: any federal, state, or municipal court or other governmental department, commission, board, bureau, agency, or instrumentality, governmental or quasi-governmental, domestic or foreign.

1.21 HAI-CA Provider: A health care professional or facility that is qualified and duly licensed and/or certified and has an executed written agreement in effect with HAI-CA to provide mental health and/or substance abuse services to Full-Risk Members.

1.22 Medicare Advantage Member: An individual who is eligible for and enrolled in a BSC Medicare Advantage Full-Risk Benefit Plan.

1.23 Medically Necessary: Mental health or substance abuse services and supplies which are provided in accordance with recognized professional practices and standards, and which are determined by BSC or HAI-CA (to the extent such determination is delegated to HAI-CA pursuant to this Agreement) to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such medical condition; (c)not furnished primarily for the convenience of the Member, the Member's family, or the treating provider or other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) with respect to inpatient services, could not have been provided in a health care provider's office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. The fact that a provider has performed or prescribed a procedure or treatment or the fact that such procedure or treatment may be the only procedure or treatment for a particular condition, injury, sickness or mental illness does not mean that such procedure or treatment is Medically Necessary. The definition of Medically Necessary used in this Agreement relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define medically necessary.

1.24 Member: An individual who: (a) has applied for and is enrolled in an individual Benefit Plan; or (b) meets the eligibility requirements specified by the Enrolling Unit and is enrolled in such Enrolling Unit's group Benefit Plan.

1.25 Non-Risk Benefit Plans: Those Benefit Plans that are not Full-Risk Benefit Plans and are identified in Section 2 of Exhibit A hereto, in support of which HAI-CA may provide administrative services and bears no financial risk or financial responsibility.

1.26 Non-Risk Member: A Member enrolled in a Non-Risk Benefit Plan.

1.27 PCP: A BSC Provider who is a family practitioner, general practitioner, internist, or pediatrician who provides primary care services to Full-Risk Members and is responsible for coordinating, referring, and managing the delivery of health care services to Full-Risk Members. A PCP may include an obstetrician-gynecologist who has agreed to serve as a PCP.

1.28 Person: any individual, partnership, limited partnership, corporation, limited liability company, association, joint stock company, trust, joint venture, unincorporated organization, or Governmental Entity.

1.29 Proposal: The proposal to provide mental health and substance abuse services submitted on behalf of HAI-CA to BSC, dated July 27, 2009, and as amended thereafter.

1.30 Self-Funded Member: An individual who is eligible for and enrolled in a self-funded Benefit Plan that is administered in whole or in part by BSC and that includes a managed behavioral health services rider.

1.31 Service Area: The geographic area in which BSC is licensed as a health care service plan, as set forth in Exhibit B hereto.

1.32 Urgent Care Services: Covered MHSA Services (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness or injury with respect to which treatment can not reasonably be delayed. For Medicare Advantage Members, Urgent Care Services, at a minimum, include all services which are defined by CMS as "Urgently Needed Services".

1.33 UM Services: A system of reviewing a Member's Covered Services to facilitate the continuity, cost effectiveness and appropriateness of care, including clinical triage, referral, prior authorization, concurrent review, retrospective review, discharge planning and case management to ensure appropriate use of resources.

ARTICLE 2
MHSA SERVICES

2.1 Mental Health and Substance Abuse Services. Commencing on the Commencement Date, HAI-CA shall provide or arrange for the provision of Covered MHSA Services to Full-Risk Members and shall perform certain related administrative services supporting the Full-Risk Benefit Plans and the Non-Risk Benefit Plans for and on behalf of BSC, as set forth in this Agreement (collectively, **"MHSA Services"**):

2.2 Transition of Care. HAI-CA's responsibility for outpatient Covered MHSA Services shall commence on the Commencement Date. HAI-CA's responsibility for inpatient and residential care Covered MHSA Services shall commence on: (a) the Commencement Date, for inpatient and residential care admissions occurring on or after the Commencement Date, or (b) the twenty-third (23rd) day following the Commencement Date for inpatient and residential care admissions occurring prior to the Commencement Date. Any Member in outpatient treatment with a provider who/that is not contracted with HAI-CA to furnish Covered MHSA Services to BSC Members as of the Commencement Date or such other time following the Commencement Date that such person becomes a Member may continue in treatment with such provider at the in-network benefit level for a period of at least sixty (60) days following the Commencement Date depending on the Member's clinical needs and specific benefit plan coverage. After such sixty (60) day period (or more), treatment through a provider that is not an HAI-CA Provider shall be treated as out-of-network, subject to the terms of Section 9.1 of this Agreement.

2.3 Development and Management of HAI-CA Network.

(a) HAI-CA shall establish and maintain a network of professional and facility health

care providers contracted with HAI-CA to furnish Covered MHSA Services to Full-Risk Members (the **"HAI-CA Provider Network"**). The HAI-CA Provider Network shall satisfy at all times and in all markets within the Service Area the access standards established by applicable state and federal law (including, without limitation, the Knox-Keene Act) and BSC, as well as the Minimum Network Access Standards from time to time promulgated by the Association and communicated to HAI-CA by BSC with no fewer than ninety (90) days advance notice; provided, however, that HAI-CA shall be excused from satisfying the Association's Minimum Network Access Standards in a given rural area, if a sufficient number of providers are not available in such rural area and provided that the Association has granted BSC a waiver of compliance for such rural area. Upon written request by BSC, HAI-CA shall provide BSC a copy of HAI-CA's then current provider agreements, all of which shall comply with the applicable requirements of the Knox-Keene Act and the Social Security Act.

(b) HAI-CA shall establish and maintain a credentialing and re-credentialing process that is compliant with the applicable requirements of the Knox-Keene Act, the National Committee for Quality Assurance (**"NCQA"**), the Utilization Review Accreditation Commission (**"URAC"**) and CMS, to which all HAI-CA Providers shall be subject. HAI-CA shall provide a copy of HAI-CA's credentialing process to BSC for approval, which approval shall not be unreasonably withheld. Prior to implementing any change to its credentialing process, HAI-CA shall provide a copy of the proposed change to BSC for review and approval, which approval shall not be unreasonably withheld.

(c) On or before the fifteenth (15^{th}) day of each month, HAI-CA shall provide BSC with a current listing of HAI-CA Providers, including such related data and in such format as from time to time agreed upon by the parties. HAI-CA shall promptly notify BSC, in writing, if at any time HAI-CA determines that the HAI-CA network of licensed HAI-CA Providers no longer satisfies the requirements of the Knox-Keene Act or otherwise becomes out of compliance with the Minimum Network Access Standards. In the event BSC reasonably determines that there are not sufficient HAI-CA Providers to provide Covered MHSA Services to Full-Risk Members, BSC shall notify HAI-CA of the alleged deficiency. Within thirty (30) days of such notice, BSC and HAI-CA shall meet to assess the alleged deficiency, and, if appropriate, develop a mutually satisfactory plan of correction.

2.4 Customer and Intake Services.

(a) HAI-CA shall operate a telephone service center to support customer service operations with respect to the provision of Covered MHSA Services to Full-Risk Members and Medical Management (as defined in Section 2.9(b)) services with respect to Self-Funded Members. Such telephone service center shall be staffed with customer service representatives who are familiar with the Full-Risk Benefit Plans to which this Agreement applies and who are trained and qualified to receive comments (including expressions of customer dissatisfaction) and to respond to questions from Full-Risk Members and HAI-CA Providers regarding such Full-Risk Benefit Plans, including (without limitation) questions relating to Covered MHSA Services, questions relating to the identity and location of HAI-CA Providers, and questions relating to the payment of claims for the provision of Covered MHSA Services to Full-Risk Members.

(b) A twenty-four (24)-hour, toll-free telephone line shall be staffed by HAI-CA for Full-Risk Members. Services provided by HAI-CA through such phone line shall include referral of Full-Risk Members for required Covered MHSA Services, crisis intervention, and responding to Full-Risk Member inquiries and questions regarding Covered MHSA Services. The services of an appropriately qualified health care professional shall also be made available by HAI-CA through such telephone line. Services after normal business hours shall be limited to crisis services.

2.5 Mixed Services. When a Full-Risk Member has a condition or illness which requires Covered MHSA Services and non-Covered MHSA Services, HAI-CA shall be responsible for

providing or arranging and paying for only the Covered MHSA Services. BSC or the Full-Risk Member shall be responsible for payment of any non-Covered MHSA Services. In determining whether certain services shall be considered Covered MHSA Services or non-Covered MHSA Services, HAI-CA and BSC shall refer to the list of Covered MHSA Services attached hereto as Exhibit D, the Exclusions contained in Exhibit E and the Mixed Services Protocol set forth in the Blue Shield Medical Interface Manual.

2.6 Provisions for Emergency Services.

(a) Notice to HAI-CA. Full-Risk Members requiring Emergency Services may receive such services without the need to obtain prior approval from HAI-CA. However, such Full-Risk Members may notify HAI-CA's toll-free telephone line prior to obtaining such service. The toll-free telephone line clinician will refer the call to an appropriate HAI-CA Provider, who will conduct a preliminary mental health needs assessment for the Full-Risk Member and, as medically appropriate, either provide such services or refer the Full-Risk Member to another HAI-CA Provider. Providers of care may contact HAI-CA's toll-free telephone line prior to rendering Emergency Services to a Full-Risk Member. The toll-free telephone line clinician will authorize such services as are necessary to evaluate, treat and stabilize the Full-Risk Member's emergency condition.

(b) Follow-up Care. All treatment and services provided following the provision of Emergency Services and stabilization of a Full-Risk Member's condition, which are not themselves Emergency Services, shall be covered hereunder only if provided by HAI-CA Providers and in accordance with HAI-CA's care authorization requirements. HAI-CA will arrange for Full-Risk Members who have received Emergency Services from a non-HAI-CA Provider to be referred to an HAI-CA Provider for follow-up care.

(c) Denial of Coverage. Any treatment or services provided to a Full-Risk Member that have not been authorized in advance by HAI-CA as described in Section 2.6(a) (where such prior authorization is required under the applicable Benefit Plan), and that are later determined by HAI-CA not to have been Emergency Services, shall not be Covered MHSA Services and shall not be covered hereunder, unless otherwise authorized by HAI-CA.

(d) Transfer of Inpatient. If, incident to the provision of Emergency Services, a Full-Risk Member becomes an inpatient or resident of a hospital or other facility, HAI-CA may, as medically appropriate, transfer the Full-Risk Member to a hospital or other facility that is an HAI-CA Provider. If HAI-CA makes such a transfer, HAI-CA shall pay all necessary and reasonable costs of transportation to the HAI-CA Provider.

(e) Reimbursement Provision. If a Full-Risk Member receives Emergency Services or Urgent Care Services in accordance with the requirements of this Section from a provider that is not an HAI-CA Provider, HAI-CA shall, as applicable, compensate the Provider for such services or reimburse the Full-Risk Member for charges paid by the Full-Risk Member for such services, less any applicable Copayments, in accordance with the applicable Benefit Plan. To be eligible to receive reimbursement, a Full-Risk Member must submit to HAI-CA, in person or by mail, a written claim explaining the charges incurred and including a copy of any statement, receipt or bill obtained from the provider for those charges. A claim for reimbursement must state the Full-Risk Member's name, address and social security number, as well as the providers name and address, the description and charges for the services rendered, and a mental health diagnosis. Claims shall be allowed only if submitted to HAI-CA within one (1) year after the date on which the first services described by the claim were provided.

2.7 Claims Administration.

(a) HAI-CA shall be financially responsible for payment of all claims for Covered MHSA Services (other than injectable psychotropic prescription medications as described in Exhibit D) provided by HAI-CA Providers to Full-Risk Members, all claims for emergency screening exams provided to Full-Risk Members, and all claims for Covered MHSA Services furnished by providers outside of the HAI-CA Provider Network pursuant to an authorization from HAI-CA. HAI-CA's contracts with HAI-CA Providers shall require that the HAI-CA Providers look solely to HAI-CA for payment for Covered MHSA Services, except for authorized copayments, coinsurance or deductible amounts. HAI-CA shall process claims from and pay providers for Covered MHSA Services in a timely, accurate fashion and shall comply with the claims payment requirements of state and federal law, including, without limitation the Knox-Keene Act and any applicable CMS rules and regulations. HAI-CA will pay all behavioral health claims according to its Medical Necessity criteria, authorized care, and mixed services protocol subject to Federal and State regulatory requirements.

(b) If HAI-CA delegates to a subcontractor (*e.g.*, a management company, claims administrator, subcontracted capitated provider, etc.) the obligation to process claims on HAI-CA's behalf, then HAI-CA shall: (a) immediately notify BSC of such delegation, including any change in the delegated entity; and (b) require that the subcontractor comply with the claims payment procedure requirements set forth in this Agreement.

2.8 Benefit and Claims Co-Accumulation. Each party shall be financially responsible for reimbursing Members and/or payments made to providers for copayment, coinsurance, deductible or claim amounts paid or denied on account of such party's failure to correctly calculate accumulators. For purposes of this Section, a party shall be deemed to have failed to correctly calculate accumulators if such party charged the copayment, coinsurance, deductible or paid the claim amounts on the date after which the Member reached his/her maximum out-of-pocket benefit limit.

2.9 UM and Medical Management Services.

(a) HAI-CA shall provide UM Services in support of the administration of the Full-Risk Benefit Plans, in accordance with the applicable requirements of the Knox-Keene Act, NCQA, URAC and CMS. HAI-CA will apply standards of Medical Necessity, appropriateness and efficiency in accordance with HAI-CA's Utilization Management Guidelines and policies and procedures, as described in the provisions of the Proposal attached hereto as Appendix 2.9, and consistent with BSC Medical Policy as amended from time to time. Any changes to HAI-CA's utilization management guidelines and policies and procedures shall be subject to review and approval by BSC, which approval shall not unreasonably be withheld or delayed. BSC shall provide HAI-CA with prior written notice of any changes to BSC Medical Policy that may relate to the provision of UM Services hereunder. HAI-CA shall involve an appropriately licensed physician whenever rendering a recommendation that mental health and/or substance abuse services that have been requested, or for which payment has been requested, are not Medically Necessary. HAI-CA's protocols for the provision of UM Services shall be made available to providers and to Full-Risk Members upon reasonable request.

(b) In addition, HAI-CA shall provide Medical Management services (as defined below) in support of the administration of those self-funded Non-Risk Benefit Plans identified in Section 2(a) of Exhibit A hereto and that are administered by BSC and that include a managed behavioral health services rider (**"Self-Funded Buy-Up Plans"**), unless otherwise requested by BSC pursuant to Section 2.9(c) of this Agreement, in accordance with the same standards and protocols described in Section 2.9(a) of this Agreement. For purposes of this Section 2.9(b), **"Medical Management**" includes only the prior authorization, concurrent review, discharge planning, and case management

components of UM Services, as described in the provisions of the Proposal attached hereto as Appendix 2.9. HAI-CA's protocols for the provision of Medical Management Services shall be made available to providers and to Members enrolled in Self-Funded Buy-Up Plans upon reasonable request.

(c) As part of the UM Services and Medical Management services, HAI-CA shall provide Care Coordination services to Members. Care Coordination services includes an intake process to initiate HAI-CA Provider Network follow-up for members. The intake process must be offered by phone and, at HAI-CA's discretion, may be supplemented by other methods such as fax, email, and online. Members may call in directly, be "warm transferred" from BSC or BSC's designated third party staff (e.g. care manager from a contracted case or disease management program vendor), or referred by their primary care physician, BSC staff, or BSC's designated third party staff. Upon receipt of a Member call, HAI-CA will coordinate contact between the Full-Risk Member and the appropriate HAI-CA Provider(s). Upon receipt of a call on behalf of a Full-Risk Member from BSC's designated third party staff or Member's primary care physician, HAI-CA will initiate contact directly with the Member, assess the Member's needs, and arrange appropriate follow-up with the appropriate HAI-CA Provider(s). HAI-CA will track and report on Care Coordination services including, but not limited to, the number of intake referrals by method (phone, fax, email, online, etc.), source for the referral (Member, primary care physician, BSC, BSC's third party, etc.), time between receipt of referral and successful closure, and reasons for closure for those referrals that are unsuccessfully concluded.

(d) HAI-CA shall, upon request by BSC, and with sixty (60) days prior written notice, provide outpatient medical management services in support of the FEP PPO product line, at the rates set forth in Section 4 of Exhibit C to this Agreement.

(e) Upon request by BSC, HAI-CA shall provide the following UM Services to Full-Risk Members receiving Covered MHSA Services outside the State of California (**"OOS Medical Management Services"**), in accordance with the same standards and protocols described in Section 2.9(a) of this Agreement and in exchange for the case rate set forth in Section 5 of Exhibit C hereto:

(1) concurrent review and the submission of written reports to BSC (on a weekly or more frequent basis) for the following levels of care – inpatient acute care including mental health and substance abuse, residential treatment including mental health and chemical dependency rehabilitation, and partial hospitalization;

(2) discharge planning initiated by HAI-CA in collaboration with BSC case management staff;

(3) coordination of Full-Risk Member transfers to HAI-CA Provider when medically appropriate;

(4) collaboration and consultation with out-of-state facility, HAI-CA medical directors and BSC medical directors as necessary;

(5) telephonic and written notification of discharge date to BSC as soon as discharge date is determined by HAI-CA;

(6) coordination of benefits with BSC case manager in preparation of discharge or in complex cases requiring special circumstances; and

(7) coordination of follow-up appointment post discharge.

The OOS Medical Management Services described in this Section shall not apply to Members receiving Covered MHSA Services outside of the State of California through a Blue Card provider. In addition, notwithstanding any provision of this Agreement to the contrary, HAI-CA shall not be financially responsible for the cost of Covered MHSA Services provided to Full-Risk Members outside of the State of California and shall not be responsible for paying or processing claims for such services.

(f) Subject to Sections 2.14, HAI-CA shall have the right to determine the level and extent of Covered MHSA Services which are appropriate for the treatment of Full-Risk Members and Self-Funded Members. Except in the case of Emergency Services or Urgent Care Services, Covered MHSA Services will be provided to Full-Risk Members hereunder only if provided by an HAI-CA Provider in accordance with HAI-CA's utilization management or certification procedures. Full-Risk Members may request authorization/certification for Covered MHSA Services from HAI-CA's toll-free telephone line. For each Full-Risk Member or Self-Funded Member who makes such a request, HAI-CA's telephone representative will conduct a preliminary mental health needs assessment and will refer the Full-Risk Member to an HAI-CA Provider or the Self-Funded Member to a BSC Provider. The HAI-CA Provider will meet with the Full-Risk Member, evaluate the Member's condition, and either provide Covered MHSA Services, or refer the Member to another participating HAI-CA Provider who is authorized to provide Covered MHSA Services.

(g) Subject to Section 4.1(b), HAI-CA may authorize and provide to Full-Risk Members services that are not Covered MHSA Services but are clinically appropriate, cost effective alternatives to Covered MHSA Services.

2.10 Outpatient Drug Formulary and Pharmacy Information.

(a) HAI-CA will implement its core pharmacy program for Full-Risk Members as described in the provisions of the Proposal attached hereto as Appendix 2.10 and shall require that its participating providers comply with HAI-CA's utilization management and quality management processes (as approved by BSC in accordance with this Agreement) and BSC's outpatient drug formulary and drug prior authorization requirements. The features of HAI-CA's core pharmacy program shall include:

(1) Trend Analysis and Other Analytics – Case finding analytics shall be performed twice a year using pharmacy claims data. Areas of focus for intervention shall be identified on the basis of such analysis. Individual cases shall be targeted for intervention within HAI-CA's targeted care management (**"TCM"**) and other clinical programs.

(2) Education and Communications – HAI-CA will provide BSC with electronic educational materials on prescribing best practices to distribute to their providers via email, posting on website or mail. An electronic results file with provider addresses will also be provided so that BSC customers can send targeted educational mailings to providers identified as outliers. These materials will target the areas of opportunity identified from the pharmacy claims analysis.

(3) Web-Based Resources – Clinical guidelines will be available for providers via HAI-CA's website. BSC may also provide a link on its website to such information. HAI-CA shall provide content on a quarterly basis for inclusion in provider communication such as a newsletter that includes interviews, local and national quality initiatives, and tips on medication management.

(4) Physician Help Line – A physician help line will offer primary care physicians access to a telephone consultation with an adult psychiatrist via a toll-free number for questions about behavioral health prescribing.

(5) Best Practices Consultation – HAI-CA's Care Management Center medical director, based in California, will provide feedback on the patterns of usage of psychotropic medications and suggest intervention strategies. If requested by BSC, HAI-CA's medical director will serve on the BS Pharmacy & Therapeutics committee and offer input into formulary determinations as newer psychotropic medications come to the market and are reviewed by BSC.

(6) Health Plan Case Manager Trainings – HAI-CA will provide onsite training for BSC's care manager staff and medical directors on topics such as effective use of antidepressants, hazards associated with atypical antipsychotics, and lithium management.

(7) PBM and PCP Education and Coordination – HAI-CA's pharmacy services shall span a wide range of PCP education, outreach and education programs as well as direct involvement, as preferred by BSC, on PBM boards of review, formulary committees and more.

(b) In the event that BSC provides to HAI-CA computerized or electronic data regarding prescriptions obtained by Full-Risk Members and drugs supplied, HAI-CA agrees that such information is provided for the limited and restricted purpose of utilization management and quality improvement. Under no circumstances may HAI-CA 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.

(c) HAI-CA acknowledges that BSC and its designees retain sole authority to perform, in relationship to outpatient pharmacy, claims processing, formulary development, a prior authorization program, selection and contracting of a pharmacy network, and determination of pharmacy benefit design.

2.11 IPA/Medical Group. HAI-CA will in good faith collaborate with BSC on specific initiatives designed to support the delegated IPA/Medical Group model, including, without limitation, initiatives designed to align behavioral health reporting with BSC's regional network utilization management strategies.

2.12 Credentialing of BSC Behavioral Health Providers. As of the Commencement Date, HAI-CA will assume responsibility for credentialing and re-credentialing of professional providers participating in BSC's directly contracted behavioral health professional network in accordance with the same credentialing process and standards identified in Section 2.3(b) of this Agreement, and to the extent that such providers are also HAI-CA Providers. Upon written request not less than ninety (90) days in advance, HAI-CA shall assume responsibility for credentialing and re-credentialing of facility providers participating in BSC's directly contracted behavioral health network in accordance with the same credentialing process and standards identified in Section 2.3(b) of this Agreement, and to the extent that such providers are also HAI-CA Providers, at no additional cost to BSC.

2.13 Administrative Manual. HAI-CA and each HAI-CA Provider shall, as applicable, comply with the Administrative Manual, the terms of which are incorporated herein by reference. BSC may, in its sole discretion, periodically modify the Administrative Manual. BSC shall notify HAI-CA no fewer than sixty (60) days prior to the effective date of any change to the Administrative Manual. If HAI-CA reasonably concludes that a change in the Administrative Manual would result in a material change (as defined in Section 10.4 or 10.5, as applicable), then HAI-CA and BSC shall confer in good faith regarding the change.

2.14 Delegation.

(a) BSC delegates to HAI-CA the responsibilities set forth in this Agreement, and HAI-CA agrees to accept and perform such delegated responsibilities in full compliance with BSC's delegation criteria and standards for performance of delegated activities set forth in Exhibit H hereto. Subject to Section 4.6, HAI-CA acknowledges that BSC shall retain the right to overturn or reverse any utilization management determination made by HAI-CA in the performance of the delegated services hereunder, including without limitation, the determination of the Medical Necessity of covered services, the determination as to which services are covered services, and the determination as to who is or is not a Member.

(b) HAI-CA acknowledges BSC's responsibility to monitor HAI-CA's compliance with the delegation criteria and standards and agrees to cooperate with BSC's monitoring of such compliance, as set forth in Exhibit H hereto.

ARTICLE 3
HAI-CA PROVIDERS; ACCESS AND AVAILABILITY

3.1 HAI-CA Provider Standards.

(a) In arranging Covered MHSA Services hereunder to Full-Risk Members, HAI-CA shall utilize only HAI-CA Providers who are credentialed and recredentialed in accordance with HAI-CA's credentialing standards, unless the Covered MHSA Service is not reasonably available from an HAI-CA Provider.

(b) HAI-CA will require that all HAI-CA Providers maintain facilities and equipment which meet all applicable legal requirements, including accessibility, and which otherwise comply with the provider credentialing requirements developed by HAI-CA for such providers. Accessibility shall include compliance with the requirements of the Americans With Disabilities Act.

3.2 Availability of Covered MHSA Services.

(a) HAI-CA shall ensure that routine Covered MHSA Services are available to Full-Risk Members during normal business hours (generally, Monday through Friday, 8:00 a.m. to 5:00 p.m.) and that In-Network and Emergency Services and referrals are available, as Medically Necessary, twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. Appointment, scheduling, and office waiting times shall satisfy the following standards:

(1) Emergency Services shall be made available to Full-Risk Members immediately.

(2) In-Network Urgent Care Services shall be made available to Full-Risk Members within forty-eight (48) hours of the time the Covered MHSA Services are requested.

(3) Covered MHSA Services other than Emergency Services and Urgent Care Services shall be made available to Full-Risk Members within ten (10) working days of the time the Covered MHSA Services are requested.

(b) HAI-CA shall be deemed to be in compliance with the above requirements if an appointment at a geographically appropriate HAI-CA Provider is offered as available to a Full-Risk Member within the time period specified, notwithstanding the Full-Risk Member's preference or availability for appointment times.

(c) HAI-CA shall require that each HAI-CA Provider maintains adequate on-call coverage arrangements with another HAI-CA Provider to provide coverage for Full-Risk Members when such HAI-CA Provider is temporarily unavailable. The provision of services to Full-Risk Members by the on-call HAI-CA Provider shall be governed by the terms of this Agreement.

(d) Unless an HAI-CA Provider elects to close his/her practice to new Full-Risk Members or ceases to be an HAI-CA Provider, each HAI-CA Provider shall provide Covered Services to each Full-Risk Member who is or at any time during the previous two (2) year period had been a patient of the HAI-CA Provider. HAI-CA shall ensure that at anytime that an HAI-CA Provider is accepting new patients of other health care service plans, such HAI-CA Provider accepts Full-Risk Members hereunder.

3.3 Provider Closures and Terminations.

(a) HAI-CA shall require an HAI-CA Provider to give HAI-CA at least ninety (90) days prior written notice if during the term of this Agreement the HAI-CA Provider elects to close his/her/its practice to new health care service plan enrollees. HAI-CA shall notify BSC in writing within five (5) business days of receiving any such notice.

(b) In the event that a contract with an HAI-CA Provider is suspended or terminated, of in the event HAI-CA declines to contract with a provider seeking to become an HAI-CA Provider, HAI-CA shall provide the provider with written notice of the reason for the action as required by state and federal law, including any standards and profiling data HAI-CA used to evaluate the provider, the number and mix of similar health care providers that HAI-CA needs (if applicable), and notice of the provider's right to appeal the action, including notice of the process and timing to request a hearing. In the event HAI-CA terminates a contract with an HAI-CA Provider for deficiencies in the quality of care provider, HAI-CA shall give notice of the action to the appropriate licensing and disciplinary bodies.

3.4 Termination of Provider/Patient Relationship.

(a) An HAI-CA Provider may terminate his/her professional relationship with a Full-Risk Member only in accordance with the procedures established by HAI-CA and approved by BSC. In the event an HAI-CA Provider terminates his/her relationship with a Full-Risk Member, HAI-CA shall assist the Full-Risk Member in selecting another HAI-CA Provider for the provision of Covered MHSA Services.

(b) In no event may an HAI-CA Provider terminate the professional relationship with a Full-Risk Member because of such Full-Risk Member's medical condition, or the amount, variety, or cost of Covered MHSA Services that are required by the Full-Risk Member.

(c) Notwithstanding the foregoing, when the consent of CMS or any other governmental agency to the termination of a physician-patient relationship is required pursuant to the rules and regulations governing the Medicare Program or any other governmental program, neither HAI-CA nor an HAI-CA Provider may terminate the physician-patient relationship with a BSC Medicare Advantage Full-Risk Member or such other Full-Risk Member without first obtaining the consent of BSC, CMS, or as applicable, the other governmental agency.

3.5 Communication Between Providers of Care. Subject to all applicable laws relating to confidentiality, HAI-CA shall use its best efforts to have each HAI-CA Provider to communicate with

a Full-Risk Member's selected PCP (or other treating/referring physician), in accordance with the appropriate standards of care, including the following guidelines:

(a) Upon completion of an assessment, if a current medical condition is reported or if the Full-Risk Member is on medication for a medical condition, and the Full-Risk Member states that his/her PCP is aware of the condition, a written report of the results of the assessment and plans for treatment will be sent to the Full-Risk Member's PCP.

(b) Upon discovery of any condition or disorder, other than a mental disorder/substance abuse condition covered by this Agreement, which the HAI-CA Provider reasonably believes may not be known to and/or treated by the Full-Risk Member's PCP, the HAI-CA Provider will call the Full-Risk Member's PCP to discuss the case for appropriate medical intervention. The HAI-CA Provider will also have follow up discussion with the PCP and recommend that the Full-Risk Member consult with the PCP regarding the condition.

(c) The Full-Risk Member's PCP will be notified in writing, in accordance with procedures approved by HAI-CA and BSC, if a psychiatrist or other HAI-CA Provider prescribes any medication for the Full-Risk Member.

(d) The Full-Risk Member's PCP will be notified and/or consulted if an HAI-CA Provider is considering electroconvulsive therapy, or any other treatment that requires a medical evaluation, for the Full-Risk Member.

(e) Upon completion of a course of treatment for the Full-Risk Member meeting any of the requirements of Sections (a) through (d) of this Section, the HAI-CA Provider will communicate the results of the treatment, in writing, to the Full-Risk Member's PCP.

(f) All communications required by this Section shall be provided within thirty (30) days for every episode of care; provided that such communication takes place in accordance with applicable state and federal law and that the Full-Risk Member does not request that there be no communication between the HAI-CA Provider and the PCP. Documentation of all such communications shall be maintained in the medical records of the HAI-CA Provider.

3.6 Continuity of Care. HAI-CA shall comply and shall require all HAI-CA Providers to comply with all obligations of state and federal law relating to continuity of care and continued access to terminated providers, including, but not limited to, Sections 1367(d), 1373.95 and 1373.96 of the Knox-Keene Act and 42 C.F.R. § 422.112.

3.7 Training; Provider Manuals. HAI-CA, at its sole cost and expense, shall be responsible for training HAI-CA Providers, maintaining and distributing training manuals and reference guides, and ensuring that HAI-CA Providers are notified of and understand their obligation to provide Covered MHSA Services pursuant to the terms of this Agreement, the Full-Risk Benefit Plans and the administrative rules related to such Benefit Plans. BSC will not communicate directly with HAI-CA Providers without the prior approval of HAI-CA.

ARTICLE 4
IDENTIFICATION OF COVERED MHSA SERVICES; COVERAGE DISPUTES

4.1 Covered MHSA Services under Benefit Plans.

(a) The Benefit Plan is the exclusive agreement between BSC and Members regarding the benefits, exclusions and other conditions relating to coverage of Covered Services, including

Covered MHSA Services. This Agreement is not intended nor shall it be deemed or construed to modify the contractual obligations of BSC to Members.

(b) BSC may request and HAI-CA shall provide HAI-CA's advice regarding the mental health and substance abuse services which HAI-CA believes should be covered or excluded under the Full-Risk Benefit Plans and as to how the Covered MHSA Services and exclusions to Covered Services should be described, but the final determination regarding the identification and description of the Covered MHSA Services shall be solely that of BSC, subject to Section 4.6 hereof. With respect to Full-Risk Benefit Plans issued to Full-Risk Members, HAI-CA shall have the right to review any new description or revision of the description of Covered MHSA Services.

(c) BSC shall provide Benefit Plan information to HAI-CA as it becomes available, as required by HAI-CA to administer Covered MHSA Services hereunder.

4.2 Benefit Administration and Member Servicing. HAI-CA will determine whether services or supplies requested by or on behalf of a Full-Risk Member, or for which such a Full-Risk Member has requested reimbursement, are Covered MHSA Services. BSC delegates to HAI-CA the discretion and authority to construe and interpret the terms of the Full-Risk Benefit Plans and make benefit determinations with regard to the payment of any claim for which HAI-CA has financial responsibility, except as otherwise provided in Sections 2.2 and 2.14 of this Agreement. If a determination is made that the requested services and/or supplies are not Covered MHSA Services, the Full-Risk Member shall be advised of the determination regarding the lack of MHSA coverage for the requested service and the Full-Risk Member's rights under the Full-Risk Benefit Plan to appeal a denial of coverage. Such appeals shall be handled in accordance with Section 4.5 hereof.

4.3 New Benefit Plans and Changes to Covered MHSA Services Under Benefit Plans.

(a) BSC shall use reasonable efforts to notify HAI-CA in writing no fewer than thirty (30) days prior to implementation of any modification to an existing Benefit Plan or development of a new Benefit Plan.

(b) In the event BSC modifies the terms of any Full-Risk Benefit Plan or develops a new Full-Risk Benefit Plan, the provision of services by HAI-CA related to such modification or new Full-Risk Benefit Plan shall be subject to Sections 10.4 and 16.1(b) of this Agreement, respectively.

(c) No later than the effective date of the Benefit Plan (or any change thereto), HAI-CA shall load into its systems all Benefit Plan data furnished by BSC and provide BSC with written confirmation that such systems load has been completed.

4.4 BSC Provider and Full-Risk Member Communications. Subject to BSC's review and prior approval and the terms of Section 8.1, HAI-CA shall develop the content of materials regarding HAI-CA and Covered MHSA Services to be included in material that will be periodically sent to BSC Providers and Full-Risk Members by BSC. BSC shall be responsible for distributing such materials, including postage. If BSC produces its own communication materials regarding HAI-CA or Covered MHSA Services, BSC shall submit the materials to HAI-CA for review and prior approval. In neither case will such approval be unreasonably withheld.

4.5 Coverage Disputes With Members.

(a) In the event of a dispute regarding coverage of Covered MHSA Services under a commercial Full-Risk Benefit Plan, HAI-CA will conduct the appeal; provided that HAI-CA shall have no obligation hereunder to conduct Member appeals related to BSC's Medicare Advantage

Benefit Plans. HAI-CA will provide a review of the initial denial and make a determination as to whether coverage is available under the Full-Risk Benefit Plan. If HAI-CA determines that the denial of coverage should be upheld, HAI-CA shall forward the appeal to BSC for review and response within fourteen (14) days of receipt of appeal. Should Medical Necessity be an issue during the review, BSC shall consider HAI-CA's Medical Necessity criteria when reviewing and rendering a decision, provided, however, that if such criteria conflict with BSC Medical Policy, BSC Medical Policy shall govern. All final decisions regarding coverage are reserved to BSC, subject to Section 4.6 of this Agreement. HAI-CA's medical director has the right to contact BSC's medical director to ensure that BSC has all pertinent information.

(b) In the event of a dispute regarding coverage of Covered MHSA Services under a Medicare Advantage Full-Risk Benefit Plan, or regarding coverage of covered services under a Non-Risk Benefit Plan, HAI-CA will refer Members to BSC for response and resolution. Should Medical Necessity be an issue during the review, BSC shall consider HAI-CA's Medical Necessity criteria when reviewing and rendering a decision, provided, however, that if such criteria conflict with BSC Medical Policy, BSC Medial Policy shall govern. All final decisions regarding coverage are reserved to BSC, subject to Section 4.6 of this Agreement. HAI-CA's medical director, or his or her designee, has the right to contact BSC's medical director to ensure that BSC has all pertinent information.

(c) If any coverage disputes with a Member result in actual or threatened litigation against HAI-CA and/or BSC, each shall promptly inform the other of the dispute and each shall fully cooperate with the other in resolving the dispute. In the event BSC and HAI-CA agree regarding the terms and conditions of a settlement of the dispute, each shall perform their respective obligations under the terms of the settlement. In the event either HAI-CA or BSC, at any time, elects to settle the dispute and the other does not agree with the terms of the settlement, the settling party shall pay for the provision of the services and/or supplies in dispute, and HAI-CA and BSC shall proceed with the dispute resolution procedure described in Section 4.6 of this Agreement.

4.6 Coverage Disputes Between HAI-CA and BSC Regarding Full-Risk Members. In the event of a dispute between BSC and HAI-CA regarding whether particular services and/or supplies for a Full-Risk Member are Covered MHSA Services for which HAI-CA has financial responsibility, or if BSC enters into a settlement agreement with a Full-Risk Member as a result of actual or threatened grievance, arbitration or litigation and BSC and HAI-CA do not agree on financial liability for such services (**"Coverage Dispute"**), the parties shall comply with the following Coverage Dispute Resolution Procedure.

(a) The Coverage Dispute shall be submitted to BSC's and HAI-CA's Medical Directors for review.

(b) The Medical Directors shall issue their determination within seven (7) business days after submission and receipt of appropriate and necessary information. In the event there continues to be a Coverage Dispute after review by the Medical Directors, the parties shall submit the Coverage Dispute to a Dispute Resolution Committee comprised of six (6) individuals, three (3) of whom shall be designated by BSC and three (3) of whom shall be designated by HAI-CA.

(c) The Dispute Resolution Committee shall review the Coverage Dispute. In the event a majority of each party's representatives on the Committee agree on a resolution of the Coverage Dispute, such resolution shall be binding on the parties. Otherwise, the parties may submit the Coverage Dispute to review by an independent third party as described in Section 4.6(d) below.

(d) In the event that the Dispute Resolution Committee is unable to resolve the Coverage Dispute, the matter shall be submitted to a qualified, independent third party mutually agreeable to

BSC and HAI-CA. The decision of the third party reviewer shall be binding on both parties. The cost of the third party reviewer shall be born equally by the parties.

(e) HAI-CA and BSC may elect to accumulate several Coverage Disputes and resolve them together, in the interest of efficiency, under this procedure without waiving any right that they may have.

ARTICLE 5
MEMBER ELIGIBILITY
AND COMPLIANCE WITH UNDERWRITING GUIDELINES

5.1 Eligibility of Members and Eligible Employees.

(a) Verification of Eligibility. BSC shall provide HAI-CA eligibility information regarding Full-Risk Members and Self-Funded Members by way of either: (a) a direct computer linkage; and/or (b) file transfer via FTP provided to HAI-CA at least monthly. The eligibility information shall be prepared and provided to HAI-CA at BSC's expense. The eligibility information shall be provided to HAI-CA by BSC on or before the 20th day of each month. The format and content of the eligibility information shall be developed by mutual agreement of the parties. Within twenty-four (24) hours of receipt, HAI-CA shall load into its systems all such eligibility information provided by BSC and provide BSC with written confirmation that such systems load has been completed. BSC and HAI-CA shall cooperate to resolve any issues that may prevent HAI-CA from loading an eligibility file. HAI-CA shall verify the eligibility of Members in accordance with the Administrative Manual and HAI-CA Providers shall verify the eligibility of Members in accordance with HAI-CA policies and procedures; provided that verification of eligibility shall not limit BSC's right to retroactively adjust eligibility in accordance with Section 5.1(c) of this Agreement. HAI-CA and HAI-CA Provider shall have no obligation to provide Covered MHSA Services (other than Emergency Services) to individuals whose eligibility, after reasonable efforts by HAI-CA or such HAI-CA Provider, cannot be confirmed. HAI-CA and HAI-CA Providers shall provide Emergency Services to individuals claiming eligibility but whose names do not appear on BSC's Member eligibility report.

(b) Identification Cards. BSC shall issue identification cards to Members, as set forth in the Administrative Manual. Production of such identification cards shall be indicative of, but not conclusive of, a person's status as a Member. Identification Cards furnished to Full-Risk Members, other than Full-Risk Members enrolled in a Medicare Advantage Benefit Plan, shall include the toll-free telephone number to contact HAI-CA.

(c) Retroactive Adjustments of Eligibility. BSC shall use reasonable efforts to discourage the retroactive addition and deletion of Members. However, the parties acknowledge that BSC may make exceptions, as necessary, for administrative or business reasons. Subject to the foregoing: (i) retroactive additions or deletions of Members, other than Medicare Advantage Members or Members enrolled in the Federal Employee Health Benefit Program, shall not exceed ninety (90) days; and (ii) retroactive additions or deletions of Medicare Advantage Members or Members enrolled in the Federal Employee Health Benefit Program shall not exceed thirty-six (36) months or three hundred sixty-five (365) days, respectively. No overpayment to HAI-CA resulting from any retroactive deletions shall be recouped by BSC more than thirty (30) days after the time limitations indicated in this paragraph. If a retroactive deletion spans multiple months (whether consecutive or not), any months that fall within the time limitations set forth herein are eligible for recoupment by BSC. Any underpayment to HAI-CA resulting from retroactive additions within the time limits indicated in this Section 5.1(c) shall be paid to HAI-CA within thirty (30) days of discovery. If retroactive additions occur beyond the time limitations but span multiple months

(whether consecutive or not), BSC shall pay HAI-CA for any months that fall within the time limitations set forth herein.

5.2 Compliance with Underwriting Guidelines. All Enrolling Units and Members to which or whom BSC issues a Benefit Plan that is underwritten by BSC shall meet BSC's underwriting guidelines, unless renewal of the Enrolling Unit's or individual's Benefit Plan is required pursuant to state or federal law. BSC shall have sole and exclusive authority to determine whether an Enrolling Unit or individual Member meets BSC's underwriting guidelines or whether BSC is otherwise legally obligated to issue a Benefit Plan to an Enrolling Unit or individual Member. Such authority shall also include the right to determine whether: (a) a Benefit Plan must be issued on a guaranteed issue basis to an individual Member or an Enrolling Unit under state or federal law; and (b) coverage of a Member must be continued on a Benefit Plan under any extension or continuation of coverage requirements in the Benefit Plan or in state or federal law.

ARTICLE 6
WORK/LIFE SERVICES

6.1 Work/Life Services.

(a) Work/Life Services. As of the Commencement Date, HAI-CA will provide or arrange for the provision of personal consults and work/life services to Members and Eligible Employees, as generally described in this Article 6, consistent with those provisions of the Proposal, attached hereto as Appendix 6.1, and as further agreed upon by the parties (collectively the **"Work/Life Services"**). The parties intend that the Work/Life Services qualify for exemption from regulation under the Knox-Keene Act. The parties acknowledge and agree that NCQA and URAC standards are not applicable to Work/Life Services.

(b) Assessment and Referral EAP. HAI-CA shall provide access to referrals, as appropriate, to Members and Eligible Employees requesting assessment and referral EAP services. Assessment and referral EAP services shall include: (1) unlimited twenty-four (24) hour toll-free telephone access; (2) assessment of Member's/Eligible Employee's needs during the Member's/Eligible Employee's initial phone call; (3) up to three (3) sessions per six (6) month period (which may include any combination of face-to-face (for California Members and Eligible Employees) and/or telephonic sessions with a counselor as requested by the Member or Eligible Employee) per Member or Eligible Employee, as deemed appropriate; (4) referral to community resources; and (5) follow-up and support services. If the services required by a Member or Eligible Employee are such that they are most appropriately provided by a psychiatrist, or if the individual's issue is not appropriate for assessment and referral, HAI-CA shall refer the Member or Eligible Employee to his/her plan for MHSA Services, including referral of Members to HAI-CA's intake line to access his/her Covered MHSA Services.

(c) Legal Referrals. HAI-CA shall refer Members and Eligible Employees requesting legal referral services to a network of attorneys. HAI-CA shall verify eligibility for the legal referral services and warm transfer the Member/Eligible Employee requesting a legal referral to the legal vendor for intake and a referral to a credentialed network attorney in the California county in which the Member or Eligible Employee resides or works or, if there is no such attorney in network in the county, in the major city (with a population exceeding one hundred thousand (100,000)) in the State of California closest to the Member's/Eligible Employee's residence or place of work. The selected attorney will be matched to the Member or Eligible Employee based on the issue presented and the attorney's expertise in that issue. During the intake process, the Member or Eligible Employee will receive a summary of the legal consultation benefit, including the option to meet with an attorney for a face-to-face consult or via a telephonic consult and the limit of one initial consult for up to sixty

(60) minutes per separate legal issue per year. The initial consult will be at no cost to the Member or Eligible Employee. The Member or Eligible Employee may retain the attorney following the initial consult at seventy-five percent (75%) of the referral attorney's standard charges for subsequent services. Legal referral services exclude third party consultation, or assistance with employment law related questions.

(d) Financial Counseling Referrals. HAI-CA shall refer Members and Eligible Employees requesting financial counseling services to financial counselors to discuss financial planning, debts, investments, or other financial matters, including one free face-to-face consultation with an expert financial representative for high-level financial or retirement planning per separate financial issue per year. Additional face-to-face services shall be made available to Members and Eligible Employees, at their expense, on a fee-per-transaction basis.

(e) Mediation Referrals. HAI-CA shall refer Members and Eligible Employees requesting mediation services to a mediator to help resolve disputes regarding such issues as family (divorce, custody, support, elder care issues), civil, landlord/tenant, collections, consumer dispute and non-legal matters when it is determined by HAI-CA that mediation would be a good alternative to litigation. The referral mediator will consult with the Member or Eligible Employee at no charge to the Member or Eligible Employee for the initial sixty (60) minute consultation per issue per year and seventy-five percent (75%) of the referral mediator's standard charges for subsequent services.

(f) Child/Family Care Referrals. HAI-CA shall refer Members and Eligible Employees requesting child/family care services to child care providers, community assistance resources or other child/family care services. Child/family care services may include HAI-CA's consultation with the Member or Eligible Employee about his/her concerns or questions regarding child development or parenting.

(g) Adult/Elder Care Referrals. HAI-CA shall refer Members and Eligible Employees requesting adult/elder care services to adult/elder care providers, community assistance resources or other adult/elder care services. Adult/elder care services may include consultation with the Member or Eligible Employee about his/her concerns or questions regarding the care and nurture of an adult/elder dependent.

(h) Chronic Condition Support Resources. HAI-CA shall refer Members and Eligible Employees requesting Chronic Condition support services to resources and support services for daily living with, or support for someone with, a chronic illness. Chronic Condition support services may include consultation with the Member or Eligible Employee about his/her concerns or questions with regard to support for daily living with illness, social services, support groups, housing, special travel needs, or assistive technology and advocacy.

(i) Income Tax Preparation. HAI-CA shall make available to Members or Eligible Employees personal income tax document preparation by a Financial Counselor who is a CPA, Enrolled Agent, or Certified Tax Preparer, at a preferred rate of seventy-five percent (75%) of the standard charges. Calls or local office visits by Members or Eligible Employees to such Financial Counselors shall be completed within sixty (60) minutes. HAI-CA shall maintain and provide Members and Eligible Employees access to the dedicated website described in Section 6.1(l) of this Agreement.

(j) Identity Theft. HAI-CA shall provide Members and Eligible Employees who have experienced an identity theft or fraud related event access to HAI-CA's confidential Fraud Resolution Program, which shall include the following services: (1) unlimited free consultation with a highly trained Fraud Resolution Specialist™ (FRS), including seven (7) emergency response activities; (2) identity and good credit restoration assistance; (3) an "ID Theft Emergency Response

Kit™" in conjunction with a telephonic consultation regarding use of the kit; (4) assistance disputing fraudulent debts resulting from identity theft; and (5) fraud and identity theft counseling, during which HAI-CA shall provide a document describing the "Preventative Steps" necessary to avoid future ID theft losses and damages to Members' and Eligible Employees' credit scores and reputations.

(k) Follow-Up. HAI-CA will conduct follow-up associated with the Member's or Eligible Employee's services (with respect to services other than legal and financial services), as follows:

(1) 24-Hour Urgent EAP Touch Point Call. In cases where an HAI-CA Work/Life specialist identifies that a Member or Eligible Employee is at risk of harm to self or others, the HAI-CA specialist shall initiate a twenty-four (24) hour "touch point" call. This contact shall provide additional support, refine search parameters, and confirm the safety of the Member or Eligible Employee.

(2) The Follow-Up Call. Notwithstanding the time frame specified in the Proposal, within ten (10) days after the Member or Eligible Employee requests urgent Work/Life Services or any child/family/elder care services, the HAI-CA Work/Life specialist managing the case shall call the Member or Eligible Employee to confirm receipt of the information and referral pack, answer any questions, assess satisfaction, and provide additional support. During this call, the specialist will remind the Member or Eligible Employee to complete the confidential quality assurance questionnaire.

(3) Alternate Electronic Follow-Up. In instances where the Member or Eligible Employee is not reached by phone on the first attempt, or if the Member or Eligible Employee declines the telephonic survey, HAI-CA shall offer the opportunity to complete an online satisfaction survey. If the Member or Eligible Employee wishes to participate in the electronic survey, the HAI-CA Work/Life specialist forwards the Web link and associated information to assist the Member or Eligible Employee in completing the survey.

(4) Routine Face-to-Face Cases. In face-to-face cases, the HAI-CA Provider shall follow up with the Member or Eligible Employee approximately thirty (30) days following the last session. The provider shall contact the Member or Eligible Employee to determine (i) the degree of improvement or change in the problem, and whether there are any additional needs or issues to address, (ii) the impact of the sessions on an employee's job performance, (iii) satisfaction with the services, and (4) the effectiveness of referral to community or benefits resources. The HAI-CA Provider shall call to invite the Member or Eligible Employee to reschedule a missed appointment. If the Member or Eligible Employee does not wish to reschedule, the provider shall assure him or her that assistance is available at any time. After a referral of a Member to the MHSA plan for treatment, the network provider shall contact the treating provider within thirty (30) days (or sooner if clinically indicated) to determine whether the Member is engaged in treatment.

(5) Critical Cases. An HAI-CA Work/Life specialist shall follow up within twenty-four (24) hours on urgent or emergency calls to the toll-free line that culminate in an emergency admission to a facility. Follow-up shall continue until the condition is stabilized. An HAI-CA Work/Life specialist shall follow-up on high-risk cases, such as persons calling about domestic violence who are referred to a shelter, or teenagers calling about sexual abuse.

(6) Legal and Financial. HAI-CA shall perform telephonic follow-up for each and every referral made, whether telephonic or face-to-face (unless the Member or Eligible Employee objects at the time of the referral). Such follow-up process shall begin forty-eight (48) hours after the initial referral and is performed by the same intake staff member who made the referral. The process

shall continue until the Member's or Eligible Employee's case is closed or the Member or Eligible Employee requests that the process be discontinued.

(l) Web-based Work/Life Resources. Subject to Section 8.1 of this Agreement, HAI-CA shall provide Members and Eligible Employees with access to a website through a link on blueshieldca.com and through a link on Blue Shield of California's intranet site myworkpath.com, respectively. The site shall offer self-referral to network providers, self-assessments, interactive seminars, a library covering hundreds of wellness topics, a drug interaction database, and include information regarding various topics, including, but not limited to:

- Adoption
- Aging
- Alzheimer's and Dementia
- Care Giving and Family Support
- Coping with Change
- Divorce
- Financial Fitness
- Grief and Loss
- Infertility
- Legal Documents
- Legal Issues
- Marriage and Committed Relationships
- Military Life and Deployment
- Natural Disasters
- Postpartum Depression
- Pregnancy and Birth
- Relocation
- Time Management

In addition, the site shall provide Members and Eligible Employees with access to (1) HAI-CA's Legal Resource Center, which includes an online (state-specific) will program, legal library, more than five thousand (5,000) state-specific legal forms, answers to frequently asked questions, and a vehicle for emailing requests for referral services, and (2) HAI-CA's Financial Resource Center, which includes a financial library, state-specific financial forms, income tax preparation materials, answers to frequently answered questions, financial calculators, and a vehicle for emailing requests for referral services, and (3) a member satisfaction survey. Within ninety (90) days of BSC's request, HAI-CA shall provide Members and Eligible Employees with access to the website through a "single sign-on link on both blueshieldca.com and myworkpath.com.

(m) Member Satisfaction Survey. HAI-CA will conduct a member satisfaction survey via phone, online and US Mail as described in Section 6.1(k) of this Agreement. HAI-CA will include in such survey at least three (3) questions to be determined by BSC, one of which will be the question to be used for the Work/Life Performance Guarantees described in Section 9.3 of this Agreement. All questions contained in the survey shall be subject to the prior approval of BSC.

6.2 Call Center, Intake and Referrals.

(a) Dedicated Toll-Free Telephone Access. HAI-CA shall allow Members and Eligible Employees to access Work/Life Services via a dedicated toll-free number with a customized greeting. The toll-free line shall be staffed by a dedicated unit of counselors located at HAI-CA's California Care Management Center in San Diego, California. The toll-free line shall be staffed twenty-four (24)

hours per day, three hundred sixty-five (365) days a year. After-hours calls (calls taking place outside of 8:00am to 6:00pm Pacific time, Monday through Friday, and on holidays) may be handled from sites outside of California. HAI-CA personnel shall answer the dedicated toll-free number with the customized greeting of BSC's program name, "LifeReferrals 24/7." All calls shall be answered in the same manner regardless of call center location. For each call received, HAI-CA will follow the verification of identity protocol and script provided by BSC.

(b) TDD/TTY. HAI-CA shall maintain TDD (telecommunications device for the deaf)/TTY (text telephone) capacity for hearing- and speech-impaired Members and Eligible Employees.

(c) Languages. HAI-CA will make available staff in the California Care Management Center who are fluent in English and/or Spanish. Consistent with Section 1300.67.04 of Title 28 of the California Code of Regulations, HAI-CA shall engage certified interpreters, trained in customer service and in medical and emergency services terminology, to provide language interpretation service for all Members/Eligible Employees requiring language assistance. Such services shall be made available in at least one hundred and eighty (180) languages and shall be provided in an accurate, clear, and culturally sensitive manner.

(d) Program Referrals. The Work/Life Services will be coordinated with BSC programs and, as requested by BSC, include a process for intake specialists to refer Full-Risk Members when appropriate to programs designated by BSC, including but not limited to: (1) disease management, (2) care management, and/or (3) health promotion, including prenatal programs.

(e) Consumer Operations and Human Resources Department Referrals. HAI-CA will track and report to BSC Member referrals made to BSC's Consumer Operations Group and, with the consent of the Eligible Employee, Eligible Employee referrals made to BSC's Human Resources Department. Tracking will include appropriate follow-up monitoring of Members and Eligible Employees accessing Work/Life Services.

6.3 Transition and Implementation.

(a) Transition. BSC will specify the toll-free number to be utilized by HAI-CA to provide the Work/Life Services at least sixty (60) days prior to the Commencement Date. HAI-CA will transfer payment responsibility for this number effective on the Commencement Date to HAI-CA and ensure the number continues to be active as of midnight on the Commencement Date. Prior to the Commencement Date, HAI-CA shall coordinate with BSC's then current Work/Life Services vendor to ensure there is no interruption in services for Members or Eligible Employees.

(b) Printed Materials. HAI-CA shall provide all printed materials to be made available to Members and Eligible Employees in connection with the provision of Work/Life Services, including without limitation, letters, flyers, educational materials and satisfaction surveys, to BSC for review and approval no fewer than ninety (90) days prior to the Commencement Date.

(c) Phone Scripts. HAI-CA will provide all phone scripts to be made available to Members and Eligible Employees in connection with the provision of Work/Life Services, including but not limited to, verification of identity protocol for Members, validation of Eligible Employees (as specified in Section 5.1 (b)), and initial answering scripts, to BSC for review and approval no fewer than ninety (90) days prior to the Commencement Date.

(d) Web-based Resources. HAI-CA will provide all web-based resources to be made available to Members and Eligible Employees in connection with the provision of Work/Life Services,

including work/life resources, legal resource center, financial resource center and satisfaction surveys, to BSC for review and approval no fewer than ninety (90) days prior to the Commencement Date.

6.4 Quality.

(a) Cooperation with BSC Grievance and Quality Programs. HAI-CA agrees to cooperate reasonably with BSC with respect to Member and Eligible Employee grievances and appeals and in the conduct of BSC's quality assurance program, as each may apply to the Work/Life Services.

(b) Call Recordings. Beginning on the Commencement Date, HAI-CA shall record twenty (20) random calls per staff person per week with Members and Eligible Employees for quality monitoring purposes. HAI-CA management shall audit such calls pursuant to HAI-CA's process and share such calls with BSC. Once BSC has approved the call quality, HAI-CA may scale back to ten (10) calls per staff person per week, and shall sustain that level for the duration of the Work/Life Services. HAI-CA shall retain all such records for a period of one (1) year. BSC may request copies of such recorded calls, which requests shall be limited to twenty-five (25) calls per request and two (2) requests per year and which shall be made upon no fewer than fifteen (15) days prior written notice.

(c) Call Audits. BSC shall have the right to conduct call audits of random, live Member calls twice per year, as well as additional audits as required for BSC compliance with regulatory and accrediting bodies. BSC shall provide no fewer than fifteen (15) days prior notice of each call audit. At BSC's discretion, audits may be conducted at HAI-CA's site or via conference call or web conferencing

6.5 Dashboards and Reports.

(a) Dashboards. HAI-CA shall provide detailed monthly dashboards to enable BSC to monitor delivery and operation of the program. The monthly dashboard shall contain, at a minimum, utilization data regarding assessment/referral, EAP, face-to-face sessions, legal referrals, mediation referrals, financial counseling referrals, child/family care referrals, adult/elder care referrals, chronic condition support resources, income tax preparation, identity theft, follow-up, utilization of web-based Work/Life resources, program referrals, consumer operations referrals and HR department referrals. The dashboard shall contain telemetrics, including calls offered, calls answered, ASA, abandonment rate, telephone service factor, and average handle time. The dashboard shall also include responses to all of the questions on the member satisfaction survey for responses received that month. Each monthly dashboard shall be delivered electronically in a format approved by BSC. Each dashboard must break out the data based on lines of business (treating Eligible Employees as a separate line of business) as specified by BSC. Each dashboard shall be delivered on a monthly basis by the fifteenth (15^{th}) calendar day of the following month. BSC will assist in the design of the dashboard. Data elements and content shall be submitted to BSC for review and approval no fewer than ninety (90) days prior to the Commencement Date.

(b) Employer Group Reports. HAI-CA shall provide reports for BSC review and distribution to BSC customers. Reports are to be branded as "Blue Shield of California" and delivered within thirty (30) calendar days of the end of each reporting period. Each report shall be delivered to BSC electronically in Adobe PDF format. BSC will provide a template and assist in the design of the report. The form and content of the reports shall be approved by BSC, which approval shall not be denied unreasonably. The final layout of each employer group report and the proposed content shall be submitted to BSC for review and approval no fewer than ninety (90) days prior to the Commencement Date. Such reports shall be generated for:

(1) All fully-insured employer groups with three hundred (300) or more Full-Risk Members;

(2) All self-funded employer groups regardless of number of Self-Funded Members; and

(3) All groups with two hundred (200) or more Eligible Employees

(c) Lines of Business Reports: HAI-CA shall provide reports for BSC for lines of business, as specified by BSC, utilizing the same template used for Employer Group Reports. Lines of business include, but are not limited to:

- Blue Shield Book of Business (BOB)
- LPS (excluding CalPERS)
- LGSB
- ISGBU
- Mid/Large Fully-insured HMO book of business (excluding CalPERS)
- Mid/Large Fully-insured HMO book of business (including CalPERS)
- Small/IFP Fully-insured HMO book of business
- Mid/Large Fully-insured PPO book of business
- Small/IFP Fully-insured PPO book of business
- CalPERS non GMAPD
- CalPERS GMAPD
- Self-funded/ASO/Shared Advantage book of business
- Medicare GMAPD (excluding CalPERS GMAPD)

(d) Ad Hoc Reports. HAI-CA shall provide ad hoc reporting related to Work/Life Services, as requested, free of charge.

(e) Member/Eligible Employee Information. BSC shall provide HAI-CA with all information relating to Members and Eligible Employees as may be reasonably required by HAI-CA to complete the reports identified above.

(f) Privacy/Confidentiality. All reports furnished pursuant to this Section 6.2 shall comply with the Health Insurance Portability and Accountability Act of 1996 and its accompanying regulations at 45 C.F.R. Parts 160 and 164, each as amended from time to time (**"HIPAA"**) and applicable state confidentiality laws.

6.6 Service Periods and Termination. BSC shall retain the right to discontinue the provision of Work/Life Services to Members and/or Eligible Employees or to assume full and complete responsibility for performance of Work/Life Services and all associated functions or obligations associated therewith, including without limitation, reporting and quality management. BSC may exercise this right and may assume or transfer to another vendor full and complete responsibility for providing Work/Life Services, or cease to offer the Work/Life Services, at any time by providing HAI-CA no fewer than ninety (90) days prior written notice. In the event that BSC assumes or transfers responsibility for providing Work/Life Services, the reimbursement payable to HAI-CA shall be reduced accordingly. However, the assumption or transfer of responsibility for Work/Life Services shall not terminate or affect any provision of the Definitive Agreements unrelated to the Work/Life Services. BSC also retains the right to determine the eligible population for the Work/Life Services and to change such eligible population at its sole discretion upon no fewer than ninety (90) days prior written notice.

ARTICLE7
QUALITY MANAGEMENT AND REPORTING REQUIREMENTS

7.1 Quality Management and Other Programs.

(a) HAI-CA shall establish and maintain its own quality management program, as described in Exhibit H hereto, that is cooperative with the BSC quality management and improvement program and compliant with the applicable requirements of the Knox-Keene Act, NCQA and URAC and CMS. HAI-CA shall comply with and accept as final, the decisions of the BSC quality management and improvement programs, and pending resolution of any dispute between BSC and HAI-CA through the dispute resolution process described in Sections 4.6 and 15.1, comply with the decisions of the BSC quality management and improvement programs.

(b) HAI-CA shall, and shall require HAI-CA Providers to, fully cooperate with and participate in BSC's quality improvement and utilization management programs, including its peer review functions, quality improvement committees, and Health Employer Data Information Sets (**"HEDIS"**) measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring and quality improvement studies and initiatives. BSC and HAI-CA agree to cooperate in identifying and implementing additional operational and data exchange opportunities for ensuring timely follow-up of all HEDIS qualified discharges.

(c) Work/Life Services shall be included in HAI-CA's Quality Management and Improvement Program, including proper follow-up and monitoring.

7.2 Reporting Requirements. HAI-CA shall provide to BSC the following reports, in such form as shall be agreed upon by the parties, consistent with HAI-CA's standard report package described in the provisions of the Proposal attached hereto as Appendix 7.2. HAI-CA shall provide such reports to BSC no later than thirty (30) working days after the end of each month or calendar quarter, as appropriate.

(a) monthly and quarterly cumulative utilization reports;

(b) monthly encounter/claims data, in accordance with BSC specifications;

(c) weekly claims co-accumulation reports;

(d) detailed monthly service and clinical dashboards, for the purpose of monitoring program delivery and operations;

(e) quarterly executive summary dashboard, detailing by key lines of business summary utilization and cost information, such as actual vs. budget;

(f) quarterly employer group reports for groups with at least three hundred (300) Members as required by BSC and any standard or ad hoc reporting required for compliance with state, federal and accreditation agencies; and

(g) such other custom and/or ad hoc reporting for Covered MHSA Services provided or authorized by HAI-CA as reasonably requested by BSC (at no additional cost to BSC).

7.3 Encounter Data and Other Reporting. Subject to all applicable laws relating to confidentiality, HAI-CA shall submit to BSC encounter/claims data (**"Encounter Data"**) in accordance with the requirements set forth in the Administrative Manual. HAI-CA also shall provide

to BSC such data regarding HAI-CA turn-around time for authorizations and other administrative services as set forth in the Administrative Manual. It is understood and agreed that all Full-Risk Member-specific Encounter Data provided to BSC by HAI-CA shall be treated as confidential by BSC and shall be utilized by BSC only for such authorized purposes set forth in applicable state and federal law, including, but not limited to, California Civil Code § 56.10.

ARTICLE 8
BRANDING/PRIVATE LABELING; STAFFING AND SUPPORT

8.1 Branding/Private Labeling.

(a) Except as required by law, all communications to be received by Members, or which may reasonably be expected to be received by Members (if, for example, HAI-CA copied the Member on the communication) from HAI-CA or any agent on HAI-CA's behalf, including, without limitation, HAI-CA's website, claim processing communications, financial documents, telecommunications offered through designated telephone lines, clinical communications, email addresses (other than HAI-CA email addresses, which shall be branded under the "Magellan" name), medical/behavioral integrated solutions, appeal letters, and satisfaction surveys, and all communications to be received by BSC contracted behavioral health providers (**"BSC Providers"**), or which may reasonably be expected to be received by BSC Providers, from HAI-CA or any agent on HAI-CA's behalf (collectively **"Communications"**) shall be "private labeled", such that all such Communications satisfy all branding guidelines and requirements of BSC applicable to similar communications of BSC's own, and otherwise satisfy all Association Brand Regulations and Inter-Plan Program Policies, as reasonably interpreted and communicated to HAI-CA by BSC (the **"Private Labeling Requirements"**). On or before April 1, 2011, or such other date mutually agreed to by the parties in good faith, BSC shall provide to HAI-CA, in writing, the Private Labeling Requirements. Thereafter, BSC shall provide HAI-CA written notice of any alterations, modifications or changes to the Private Labeling Requirements and HAI-CA shall use best efforts to implement such changes within one hundred twenty (120) days of such notice or, if such change is made effective by the Association with fewer than one hundred twenty (120) days notice to BSC, such earlier date as may be required by the Association.

(b) HAI-CA shall indemnify BSC for any penalties imposed upon BSC by the Association as a result of the failure of HAI-CA to comply with the Private Labeling Requirements.

8.2 Dedicated Resources; Staffing. HAI-CA shall provide the personnel, facilities, equipment, software, technical knowledge, expertise and other resources necessary to provide services to BSC, Members, Eligible Employees and HAI-CA Providers, and to otherwise satisfy its obligations under this Agreement. Without limiting the foregoing, HAI-CA will provide the support of a dedicated team of HAI-CA staff located within the State of California who will be accountable for establishing and maintaining control over processes related to HAI-CA's performance of services and who are committed to supporting the BSC account throughout the term of this Agreement. Such staff shall work with BSC to create and implement additional managed behavioral health products and services specific to BSC, in an effort to differentiate BSC from the market. Such staff shall be knowledgeable of BSC utilization trends, and shall provide BSC with analytical support, including, but not limited to, the provision of utilization reports supporting BSC quality management and pharmacy initiatives, behavioral health and medical integration, enhanced employer data reporting, and all national benchmarking data used and/or maintained by HAI-CA and its Affiliates. In addition, HAI-CA shall provide on-site medical management services consistent with the medical management co-location program described in the provisions of the Proposal attached hereto as Appendix 8.2.1. If at any time BSC reasonably determines that a designated HAI-CA senior/executive staff member is providing poor or sub-standard service, BSC may request that

HAI-CA replace such staff Member and HAI-CA shall consider such request in good faith. Services performed by HAI-CA in the State of California shall include customer and member services, Work/Life Services administration, utilization management, case management, and medical management, appeals and complaints/grievances, quality management and reporting, provider relations and network management including coordination with IPAs, medical groups, primary care physicians and specialty providers, claims processing, IT systems management, account management, and pharmacy integration. Subject to Section 16 of Exhibit G to this Agreement, HAI-CA may perform other services outside of the State of California, such as limited claims payment functions (as set forth in the provisions of the Proposal attached hereto as Appendix 8.2.2), credentialing, and after hours call center services, to the extent permitted by the Knox-Keene Act. Without limiting the foregoing, HAI-CA will log and scan claims in California; such claims shall be processed and paid in St. Louis, Missouri, subject to oversight by HAI-CA management in California. HAI-CA shall provide BSC with reasonable advance written notice of any change in the location of services provided outside of California.

8.3 Sales Support. Upon reasonable request, HAI-CA agrees to provide the appropriate staff (*e.g.*, Medical Director or other senior management staff) to accompany the BSC sales team in their presentations to employers, brokers, and any other sales-related venue in support of group sales and renewals.

8.4 Commitment of Resources; Transition Services. The parties acknowledge that substantial resources may be required to successfully implement the arrangement contemplated by this Agreement. Each of the parties shall use its best efforts to devote sufficient resources to the arrangement contemplated by this Agreement in order to achieve the objectives set forth in this Agreement. Without limiting the foregoing, HAI-CA shall perform all services, functions, and responsibilities reasonably necessary to accomplish the transition of mental health and substance abuse services and Work/Life services from BSC's current mental health and substance abuse services vendor to HAI-CA (the **"Transition Services"**). HAI-CA shall perform the Transition Services in accordance with a mutually agreeable transition plan to be developed by the parties, and without causing material disruptions to BSC's business operations. HAI-CA shall designate an individual who shall be responsible for managing and implementing the Transition Services (the **"HAI-CA Transition Manager"**). There shall be no charges for the Transition Services. Until the completion of the Transition Services, the HAI-CA Transition Manager shall review with the BSC network manager the status of the Transition Services, as requested by the BSC network manager.

8.5 Implementation Costs. Upon the execution and delivery of this Agreement and the DOI Agreement (as defined in Section 10.4(a)), HAI-CA shall pay to BSC the amount of [redacted] to assist in defraying the costs to be incurred by BSC during 2011 and 2012 associated with implementing the arrangements contemplated by this Agreement and the DOI Agreement, including but not limited to, the costs associated with information technology expenses necessary to establish connectivity and provider communications regarding the arrangement. The amount of implementation costs specified in this Section is a combined single amount under both this Agreement and the DOI Agreement.

ARTICLE 9
NETWORK EQUIVALENCY; PERFORMANCE STANDARDS

9.1 Network Equivalency. HAI-CA acknowledges that BSC's agreement to the MHSA Capitation Rates set forth in Section 1 of Exhibit C hereto (the **"MHSA Capitation Rates"**) is

expressly conditioned on HAI-CA's agreement to provide an HAI-CA Provider Network that includes many of the professional and facility providers that are contracted with and a part of the provider network made available to BSC and its affiliate, Blue Shield Life & Health Insurance Company, as of October 1, 2011, by their then current mental health and substance abuse vendors (the **"Incumbent Provider Network"**). Accordingly and in addition to any other network access standards specified in this Agreement or under the Knox-Keene Act:

(a) HAI-CA shall contract with a sufficient number of professionals in the Incumbent Provider Network such that those professionals who represent:

(1) [redacted]

(b) For purposes of the above percentage calculations, the parties shall exclude from the calculation (denominator) any provider who is no longer providing mental health or substance abuse services in the State of California. In addition, all percentages shall be calculated on a combined basis under this Agreement and the DOI Agreement.

(c) If HAI-CA fails to meet the Network Equivalency Standard as of the Commencement Date, then, until the Network Equivalency Standard is met, HAI-CA shall permit any Member to be treated by a Key Professional Provider or Key Facility Provider who/that is not a participating provider in the HAI-CA Provider Network as if such Key Professional Provider or Key Facility Provider was a participating provider in the HAI-CA Provider Network (*i.e.*, at the "in-network" or "preferred" level of Covered MHSA Services) and shall bear the full financial risk of

Covered MHSA Services furnished by such Key Professional Provider or Key Facility Provider through the earlier of the date such Key Professional Provider or Key Facility Provider becomes a participating provider in the HAI-CA Provider Network or December 31, 2012, notwithstanding anything in this Agreement to the contrary.

(d) In addition, if, HAI-CA fails to meet the Network Equivalency Standard applicable to professionals as of January 1, 2013, then, HAI-CA's composite capitation rate for all lines of business will be reduced by the same percentage HAI-CA fails to meet the percentage target for Key Professional Providers set forth in Section 9.1(a)(3) of this Agreement (*i.e.*, for every one percent (1%) that HAI-CA's professional provider network fails to meet the percentage target for Key Professional Providers, the composite capitation rate for all lines of business will be reduced by one percent (1%)); provided that the total reduction specific to the Network Equivalency Standard for professional providers under this Agreement and the DOI Agreement combined shall not exceed [redacted]

(e) In addition, if, HAI-CA fails to meet the Network Equivalency Standard for facilities by January 1, 2013, then, HAI-CA's composite capitation rates for all lines of business will be reduced by the same percentage HAI-CA fails to meet the percentage target for Key Facility Providers set forth in Section 9.1(a)(6) of this Agreement (*i.e.*, for every one percent (1%) that HAI-CA's facility provider network fails to meet the percentage target for Key Facility Providers, the composite capitation rate for all lines of business will be reduced by one percent (1%)); provided that the total reduction specific to the Network Equivalency Standard for facilities under this Agreement and the DOI Agreement combined shall not exceed [redacted]

(f) Regardless of whether the Network Equivalency Standard is met, the parties shall determine by mutual agreement an adjustment to the MHSA Capitation Rates for the PPO and POS Benefit Plans effective January 1, 2012, January 1, 2013, and January 1, 2014 based upon any changes to the in-network and out-of-network utilization in 2012 compared to 2009 due to the composition of HAI-CA Provider Network as of the Commencement Date.

(g) During each of the twelve (12) months preceding the Commencement Date, BSC shall provide to HAI-CA, on a monthly basis, professional and facility provider and utilization data for both in-network and out-of-network utilization necessary for HAI-CA to identify and target the Incumbent Provider Network's professional and facility providers.

9.2 Performance Standards for MHSA Services; Penalties. In performing its obligations pursuant to this Agreement, HAI-CA shall satisfy the annual performance standards set forth in Exhibit F hereto (collectively, the **"MHSA Performance Standards"**). Such MHSA Performance Standards will be measured as of each anniversary of the Commencement Date. HAI-CA shall pay the penalties set forth in Exhibit F for failure to perform the MHSA Performance Standards as set forth therein; provided, however, that the aggregate penalties payable by HAI-CA for failure to satisfy the MHSA Performance Standards during each year of the Initial Term shall not exceed twenty percent (20%) of the "Administrative Costs" (as defined in Exhibit F to this Agreement) payable to HAI-CA for MHSA Services during such year. The penalties associated with the failure to meet each such MHSA Performance Standard, if any, shall be assessed within one (1) month after each such anniversary of the Commencement Date, or as otherwise noted in Exhibit F with respect to a specific MHSA Performance Standard. Any such penalties shall, at BSC's option, be paid by HAI-CA to BSC within fifteen (15) days of assessment or deducted from the next monthly Capitation Payment payable by BSC. No later than December 1, 2012, and each December 1 thereafter, BSC and HAI-CA will in good faith negotiate and reach agreement upon MHSA Performance Standards and associated penalties to be effective January 1 of the following calendar

year. If, by December 1, 2012, or any January 1 thereafter, the parties have not reached agreement upon MHSA Performance Standards and associated penalties to be effective January 1 of the following calendar year, the MHSA Performance Standards and associated penalties then in effect shall apply to MHSA Services provided during the following calendar year. To the extent that the MHSA Performance Standards under this Agreement are identical to the MHSA Performance Standards under the DOI Agreement, such MHSA Performance Standards shall be reported, measured, and any penalties calculated on a combined basis under this Agreement and under the DOI Agreement.

9.3 Performance Guarantees & Penalties for Work/Life Services. In performance of its obligations under this Agreement with respect to Work/Life Services, HAI-CA shall satisfy the performance standards set forth in Exhibit K hereto (collectively, the **"Work/Life Standards"**). The Work/Life Standards will be measured and assessed quarterly within one (1) month following the end of each quarter beginning with the quarter commencing on the Commencement Date, or as otherwise noted for a specific Work/Life Standard. HAI-CA shall pay the penalties set forth in Exhibit K for failure to perform the Work/Life Standards as set forth therein. Any such penalties shall, at BSC's option, be paid by HAI-CA to BSC or deducted from the next monthly Capitation Payment payable by BSC. To the extent that the Work/Life Standards under this Agreement are identical to the Work/Life Standards under the DOI Agreement, such Work/Life Standards shall be reported, measured, and any penalties calculated on a combined basis under this Agreement and under the DOI Agreement.

ARTICLE 10
PAYMENT

10.1 Capitation Payments; Work/Life Service Fees.

(a) BSC shall pay to HAI-CA the Capitation Payment, and in exchange for the provision of Work/Life Services, the monthly per Member per month/per Eligible Employee per month fee set forth in the attached Exhibit J (the **"Work/Life Services Fee"**), pursuant to Section 10.2, based on the then current information available to BSC regarding the number of eligible Members. The Capitation Payment and Work/Life Services Fees shall be reconciled each month for retroactive adjustments of eligibility from previous months, subject to Section 5.1(c) of this Agreement.

(b) If the Capitation Payment and Work/Life Services Fees are not made in full by BSC on or prior to the due date, a thirty-one (31)-day grace period shall be granted to BSC for payment without interest charge. Payments, which remain outstanding subsequent to the grace period, shall be subject to a late penalty charge of one percent (1.00%) for each thirty-one (31)-day period or portion thereof which the payment remains outstanding.

10.2 Transfers of Funds.

(a) BSC shall be responsible for paying to HAI-CA the Capitation Payments and Work Life Services Fees on or before the twentieth (20^{th}) day of each month for which such payment is due. Such payments shall be made via electronic transfer to a bank account designated in writing by HAI-CA. No such amounts paid by BSC to HAI-CA shall be considered plan assets, as that term is defined in the Employee Retirement Income Security Act ("**ERISA**").

10.3 Adjustments Resulting From Changes in Membership. If at any time during the Initial Term, baseline membership in any product category identified below increases or decreases by more than twenty five percent (25%) and by at least ten thousand (10,000) Full-Risk Members, the parties shall negotiate in good faith an adjustment to the MHSA Capitation Rates applicable to all products

within such category:

Product Category	Baseline Membership
CalPERS HMO	[redacted]
FEHBP	[redacted]
Large Group HMO/POS	[redacted]
Small Group HMO/POS	[redacted]
Large Group PPO	[redacted]
IFP PPO	[redacted]
Small Group PPO	[redacted]
Healthy Family HMO & EPO/PPO	[redacted]
GMAPD	[redacted]
IFP HMO	[redacted]

*Combined enrollment in benefit plans administered by HAI-CA under this Agreement and the DOI Agreement.

10.4 Material Changes – Full-Risk Membership. The parties shall negotiate in good faith an adjustment to the MHSA Capitation Rates in the event of a material change (as defined below) (whether by reason of changes to state or federal laws or regulations or otherwise) to the scope of Covered MHSA Services, administrative or service level requirements, BSC Medical Policy, or Full-Risk Member benefit levels (*i.e.*, Full-Risk Member co-pays, deductibles, or co-insurance amounts).

(a) For purposes of this Section, a change to the scope of Covered MHSA Services or administrative or service level requirements shall be deemed "material" if such change will increase or decrease either party's cost of claims for covered services or cost of providing administrative services under this Agreement and that certain Administrative Services Agreement by and between HAI-CA and Blue Shield Life & Health Insurance Company, of even date herewith, as from time to time amended (the **"DOI Agreement"**) by more than zero percent (0.0%) per year across all across all membership in support of which HAI-CA provides services pursuant to this Agreement and the DOI Agreement, combined.

(b) For purposes of this Section, a change to Full-Risk Member benefit levels (*i.e.*, Full-Risk Member co-pays, deductibles, or co-insurance amounts) shall be deemed "material" if such change will increase or decrease either party's cost of claims for covered services or cost of providing administrative services under this Agreement and the DOI Agreement by more than four percent (4.0%) per year across all membership in support of which HAI-CA provides services pursuant to this Agreement and the DOI Agreement, combined.

10.5 Material Changes – Self-Funded Membership. The parties shall negotiate in good faith an adjustment to the administrative fees payable for services provided in support of Self-Funded Buy-Up Plans in the event of a material change (as defined below) (whether by reason of changes to state or federal laws or regulations or otherwise) to the scope of Covered MHSA Services, administrative or service level requirements, or Member benefit levels (*e.g.*, Member co-pays, deductibles, or co-insurance amounts). For purposes of this Section, a change to the scope of Covered MHSA Services (as defined below), administrative or service level requirements, or Member benefit levels (e.g., Member co-pays, deductibles, or co-insurance amounts) shall be deemed "material" if such change will increase or decrease either party's cost of providing administrative services under this Agreement by more than ten percent (10%) per year across all Self-Funded Buy-Up Plan membership. Additionally, a minimum of fifty thousand (50,000) Self-Funded Member lives is needed to trigger

the material change provision for purposes of re-evaluating the Self-Funded Administrative Fees.

10.6 Coordination of Benefits and Third Party Liability for Full-Risk Members. All amounts recovered by HAI-CA for Covered MHSA Services through the coordination of benefits or third party liability recovery shall be retained by HAI-CA. Coordination of benefits shall be conducted in accordance with the Knox-Keene Act and the regulations promulgated thereunder. Third party liability recovery shall be sought by HAI-CA only to the extent permitted by the Full-Risk Member's Full-Risk Benefit Plan and shall be conducted in accordance with the requirements of California law. In the event BSC receives any amounts through coordination of benefits or third party liability recovery for Covered MHSA Services, such amounts shall be transmitted to and shall belong to HAI-CA.

ARTICLE 11
INSURANCE AND INDEMNIFICATION

11.1 Insurance.

(a) HAI-CA shall procure and maintain, at its own sole expense, professional and general liability insurance and other insurance as may be necessary to protect itself and its employees, agents, and representatives against any claims, liabilities, damages or judgments that arise out of services provided by or to be provided by HAI-CA or its employees, agents or representatives in the discharge of its or their responsibilities under this Agreement. HAI-CA shall provide proof of such insurance to BSC upon request and shall notify BSC if such insurance coverage is reduced, cancelled or not renewed. HAI-CA agrees to notify BSC not less than fifteen (15) days prior to any reduction in coverage, cancellation, or nonrenewal of the policy(s). HAI-CA's agreements with individual, non-physician HAI-CA Providers shall require such HAI-CA Providers to procure and maintain, at their sole expense, professional and general liability insurance covering the acts of the HAI-CA Provider of at least One Million Dollars ($1,000,000) per occurrence and One Million Dollars ($1,000,000) in the aggregate annually and shall require all other HAI-CA Providers to procure and maintain, at their sole expense, professional and general liability insurance covering the acts of the HAI-CA Provider of at least One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate annually.

(b) BSC shall procure and maintain, at its own sole expense, professional and general liability insurance and other insurance as may be necessary to protect itself and its employees, agents, and representatives against any claims, liabilities, damages or judgments that arise out of services provided by or to be provided by BSC or its employees, agents or representatives in the discharge of its or their responsibilities under this Agreement. BSC shall provide proof of such insurance to HAI-CA upon request and shall notify HAI-CA if such insurance coverage is reduced, cancelled or not renewed.

11.2 Indemnification.

(a) Without limiting Section 8.1(b) of this Agreement, HAI-CA shall defend, hold harmless and indemnify BSC from any and all claims, liabilities, damages or judgments asserted against, imposed upon or incurred by BSC that arise out of: (i) HAI-CA's negligence or intentional wrongdoing in the discharge of its responsibilities under this Agreement; or (ii) any act of an individual, non-physician HAI-CA Provider to the extent that such claims, liabilities, damages or judgments exceeds the liability insurance coverages applicable to such HAI-CA Provider set forth in Section 11.1(a) of this Agreement, up to the amount of such claims, liabilities, damages, or judgments not covered by such insurance that would have been covered if the HAI-CA Provider had maintained insurance in the amounts of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate annually. Pursuant to Section 4.5, HAI-CA shall also indemnify

BSC against any arbitration awards or judgments rendered against BSC and in favor of a Full-Risk Member for services and/or supplies that an arbitrator, jury or judge finds to constitute Covered MHSA Services for which HAI-CA has financial responsibility under the terms of this Agreement, but only to the extent of the cost of such Covered MHSA Services if the Full-Risk Member appealed the HAI-CA decision to BSC and BSC made a determination regarding the service. The indemnification granted under this Section expressly includes indemnification with respect to expense costs, legal fees, defense costs, court costs, or amounts paid in settlement or in satisfaction of any judgment or award, and expressly excludes consequential, incidental, punitive, special or exemplary damages.

(b) BSC agrees to defend, hold harmless and indemnify HAI-CA from any and all claims, liabilities, damages or judgments asserted against, imposed upon or incurred by HAI-CA that arises out of BSC's negligence or intentional wrongdoing in the discharge of its responsibilities under this Agreement. The indemnification granted under this Section expressly includes indemnification with respect to expense costs, legal fees, defense costs, court costs, or amounts paid in settlement or in satisfaction of any judgment or award, and expressly excludes consequential, incidental, punitive, special or exemplary damages.

ARTICLE 12
LEGAL & REGULATORY COMPLIANCE, FILING REQUIREMENTS AND ACCREDITATION REQUIREMENTS

12.1 Regulatory Compliance. BSC shall be solely responsible for ensuring that its activities are in compliance with all applicable federal, state or local laws and regulations. HAI-CA shall be solely responsible for ensuring that the services it provides under this Agreement comply with any such applicable laws and regulations. Each party shall cooperate with the other party in its efforts to achieve and/or maintain regulatory compliance.

12.2 ERISA Compliance. In the event any Benefit Plan is subject to ERISA, HAI-CA shall not be identified as, or understood to be, the "Plan Administrator" or a "Named Fiduciary" of the plan, as those terms are used in ERISA. HAI-CA has no responsibility for the preparation or distribution of the "Plan Document" or "Summary Plan Descriptions", as those terms are used in ERISA, or for the provision of any notices or for the filing of any reports or information required to be filed in regard to the Benefit Plan.

12.3 Regulatory Filing. Each party shall be responsible for filing this Agreement with federal, state and local agencies to the extent it is required to do so by any applicable law or regulation. If, following any such filing, an agency requests changes to this Agreement, HAI-CA and BSC shall jointly discuss such request with the agency.

12.4 Accreditation Compliance.

(a) At all times during the term of this Agreement, HAI-CA shall be accredited by NCQA and URAC.URAC accreditation shall not apply to credentialing activities; provided, however, that HAI-CA shall comply with URAC standards with respect to credentialing. Such accreditations shall not apply to Work/Life Services.

(b) HAI-CA shall establish and maintain processes and programs for HAI-CA Providers and BSC Behavioral Health Provider credentialing and recredentialing, utilization management and quality assessment/improvement, as described in Sections 2.4, 2.9, 2.12, and 7.1 respectively. With respect to such activities, HAI-CA shall meet NCQA and URAC accreditation standards, as described in the most recent revision of NCQA's publication, *Standards for Managed Behavioral Healthcare Organizations*, and in URAC's most recent accreditation standards. HAI-CA shall submit its policies

and procedures on credentialing, recredentialing, utilization management and quality assessment/improvement to BSC for review and, as applicable, approval.

(c) BSC may, in accordance with Section 13.4, audit HAI-CA's records regarding the above processes and programs. At least annually, BSC shall provide written feedback to HAI-CA regarding the results of BSC's review of HAI-CA's reports. BSC shall provide written feedback to HAI-CA thirty (30) days following any audit activities. In the event BSC reasonably determines, including pursuant to any audit, that HAI-CA does not meet the requirements of the Knox-Keene Act, CMS, or NCQA or URAC accreditation standards, BSC shall notify HAI-CA of the alleged deficiency. Within thirty (30) days of such notice, BSC and HAI-CA shall meet to assess the alleged deficiency and, if appropriate, develop a mutually satisfactory plan of correction. In the event of a plan of correction, HAI-CA shall submit regular reports to BSC documenting progress on the plan of correction until the corrective action plan has been completed. BSC and HAI-CA shall also exchange information about, and BSC shall give HAI-CA regular feedback on, HAI-CA Provider and BSC Behavioral Health Provider credentialing and recredentialing, utilization management and quality assessment/improvement processes and programs.

(d) The provisions of this Section shall apply only as long as BSC continues to seek or maintain accreditation by NCQA and/or URAC.

12.5 Disclosure of Provider Profiling. To the extent that HAI-CA utilizes "economic profiling", as defined in Section 1367.02, HAI-CA shall (i) upon request from BSC and as further described in the Administrative Manual, provide BSC with information regarding any "economic profiling" of HAI-CA Providers by HAI-CA in order to permit BSC to comply with the provisions of Section 1367.02 of the Knox-Keene Act and (ii) provide copies of economic profiling information to HAI-CA Providers in accordance with the requirements of Section 1367.02 of the Knox-Keene Act.

12.6 Site Evaluations. HAI-CA shall, and shall require HAI-CA Providers to, permit Government Officials and BSC to conduct reasonable periodic site evaluations and inspections of their respective facilities and records. In the event that Government Officials or BSC identify any deficiencies in such facilities or records, HAI-CA, or the HAI-CA Provider, as applicable, shall have thirty (30) days to substantially correct such deficiencies.

12.7 Accreditation Surveys. HAI-CA shall, and shall require HAI-CA Providers to, cooperate in the manner described in Sections 12.8 and 13.4 hereof with respect to surveys and site evaluations relating to accreditation of BSC by NCQA, URAC or any other accrediting organization. Further, HAI-CA agrees to implement any changes reasonably required as a result of any such survey.

12.8 Compliance Monitoring. HAI-CA shall cooperate with BSC in the performance of any monitoring, studies, evaluations analyses or surveys required by Government Officials or accrediting organizations of HAI-CA's performance of services hereunder.

ARTICLE13
BOOKS AND RECORDS

13.1 Medical Records. HAI-CA shall require that HAI-CA Providers maintain usual and customary records for Full-Risk Members in the same manner as for other patients of such HAI-CA Providers. HAI-CA will require that all HAI-CA Providers establish and maintain, in an accurate and timely manner, for each Full-Risk Member who has obtained care from such physician, a medical record which contains such demographic and clinical information as is necessary to provide documentation as to the mental health and substance abuse problems and mental health and substance abuse services provided to the Full-Risk Member. Such record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the HAI-

CA Provider. Such record shall be in such a form as to allow trained health professionals, other that the HAI-CA Provider, to readily determine the nature and extent of the Full-Risk Member's medical problem and the services provided, and to permit peer review of the care provided. Such record shall, upon request, and within reasonable time requirements, be made available without charge to BSC and its designated agents. Without limiting the foregoing, and except as prohibited by law, HAI-CA Providers shall, upon request and without charge, transmit Full-Risk Member's medical record information to a Full-Risk Member's other providers, to Government Officials, and to BSC for purposes of utilization management, quality improvement and other BSC administrative purposes. Subject to applicable laws regarding confidentiality, upon termination of this Agreement, one (1) copy of such record shall be provided without charge to the Full-Risk Member's new provider upon request.

13.2 Maintenance of Patient Records. Upon request of BSC, a Full-Risk Member or a referring and/or attending physician, and provided the Full-Risk Member appropriately consents to such disclosure, HAI-CA shall provide copies of the Full-Risk Members' assessment and termination reports to the Full-Risk Member's referring and/or attending physician. HAI-CA and BSC shall endeavor to promote communication to such referring and/or attending physician regarding the Full-Risk Member's referral, subject to restrictions arising under state or federal law. HAI-CA shall develop and require that HAI-CA Providers comply with procedures to obtain the consent of Full-Risk Members to permit the HAI-CA Provider to communicate with and provide records to the Full-Risk Members' referring and/or attending physician.

13.3 Privacy of Records. HAI-CA and BSC shall maintain the confidentiality of all information regarding Members, in accordance with applicable statutes and regulations, including without limitation the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2. If the provisions of 42 C.F.R. Part 2 are applicable, HAI-CA and BSC shall undertake to resist in judicial proceedings any effort to obtain access to information pertaining to Members otherwise than as expressly provided for in such federal confidentiality regulations. HAI-CA and HAI-CA Providers shall develop and maintain policies and procedures to ensure that medical records of Members are not disclosed in violation of the California Civil Code §§ 56, *et seq*.

13.4 Disclosure of Records.

(a) HAI-CA and each HAI-CA Provider shall comply with all provisions of the Omnibus Reconciliation Act of 1980 regarding access to books, documents, and records to the extent applicable. Without limiting the foregoing, HAI-CA shall maintain such records and provide such information to BSC, as well as to the California Department of Managed Health Care or any successor agency (the **"DMHC"**), CMS, any Peer Review Organization (**"PRO"**) with which BSC contracts as required by CMS, the U.S. Comptroller General, their designees and any other governmental officials entitled to such access by law (collectively, **"Governmental Officials"**), as required by law and as may be necessary for compliance by BSC with the provisions of all state and federal laws governing BSC. BSC and Government Officials shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to HAI-CA's provision of services hereunder, the cost of such services, and payment received by HAI-CA or an HAI-CA Provider from Full-Risk Members (or from others on their behalf). Such records described herein shall be maintained at least ten (10) years from the end of each Agreement Year, and, to the extent applicable to BSC Medicare Advantage Benefit Plans, ten (10) years from the close of CMS's fiscal year in which the contract was in effect (or for a particular record or group of records, a longer time period when CMS or DMHC requests such longer record retention and HAI-CA is notified of such request by BSC), and in no event for a shorter period than as may be required by the Knox-Keene Act. All records of HAI-CA and HAI-CA Providers shall be maintained in accordance with the general standards applicable to such book or record keeping and shall be maintained during any governmental audit or investigation.

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

(c) Upon reasonable notice, HAI-CA shall make any records of its quality improvement and utilization review activities pertaining to Full-Risk Members and provider credentialing files available to BSC's quality and utilization review committee. Such sharing of records between the two committees shall be in accordance with, and limited to, Sections 1157 of the California Evidence Code and 1370 of the California Health and Safety Code, and shall not be construed as a waiver of any rights or privileges conferred on either party by those statutes.

(d) BSC, at its sole cost and expense, and with reasonable prior notice to HAI-CA, may from time to time audit the books and records of HAI-CA as they relate to its services, claims payments, authorization turn-around times, reporting, and billings under this Agreement.

13.5 Release of Records.

(a) Upon reasonable request by BSC, HAI-CA shall be responsible for obtaining and releasing to BSC all information and records or copies of records regarding Covered MHSA Services to Full-Risk Members and/or UM Services provided to Members. Such information shall be provided to BSC, at no charge, within thirty (30) days from the date of such request; provided, however, that records relating to expedited grievances/appeals or to inquiries from Government Officials shall be provided to BSC within forty-eight (48) hours of such request. In the event that BSC requests individually identifiable information from HAI-CA, HAI-CA shall submit the requested information to BSC. BSC represents that BSC has obtained signed releases from Members which allow HAI-CA to release confidential information regarding Members to BSC where such release is not authorized under California Civil Code §§ 56, *et seq*. In the event that additional Member releases are required for HAI-CA to release confidential information to BSC or third parties, BSC shall obtain such releases.

(b) BSC will defend, indemnify and hold HAI-CA harmless from any liability of any type arising directly or indirectly from HAI-CA's provision of confidential information to and use of such information by BSC.

13.6 Full-Risk Member Access to Records. HAI-CA and HAI-CA Providers shall ensure that Full-Risk Members have access to their medical records in accordance with the requirements of state and federal law.

13.7 Access to the Other Party's Records. During regular business hours and upon reasonable notice and demand, each party shall have access to information and records or copies of records held by the other party, which are reasonably related to its obligations under this Agreement. The party conducting the audit or inspection shall pay for the other party's personnel's time in excess of sixteen (16) hours and the cost of the copies of any records which it requests. No third party may be allowed or designated to conduct an audit or inspection without the prior written consent of the party whose records are being audited or inspected.

13.8 Additional Disclosures.

(a) Annually, within one hundred-twenty (120) days following the end of HAI-CA's fiscal year, HAI-CA shall provide to BSC a copy of its most recent annual income statement, balance

sheet, and statement of cash flow, which shall be prepared in accordance with generally accepted accounting principles and shall be certified by HAI-CA's chief executive officer or chief financial officer. HAI-CA shall provide a copy of any audited financial statements it may have to BSC. A narrative or work sheet describing the calculation of HAI-CA's IBNR shall accompany the submitted financial statements. The information set forth in this Section shall also be provided by HAI-CA to BSC in the event there is a change in ownership of HAI-CA. HAI-CA shall also, upon request, provide BSC with copies of quarterly financial statements, which shall include a balance sheet, statement of income and statement of cash flow prepared in accordance with generally accepted accounting principles.

(b) HAI-CA shall provide BSC with monthly claims reports required by BSC in order to comply with state and federal law and to ensure compliance by HAI-CA with the requirements of Section 2.7 of this Agreement.

(c) BSC agrees that it shall treat as confidential all financial information provided by HAI-CA in accordance with this Section, unless such information is publicly available, and shall not disclose such information to others except as required by law or as requested by BSC's regulators.

ARTICLE14
PROTECTION OF MEMBERS

14.1 Non-discrimination. Except as otherwise provided in this Agreement, HAI-CA shall, and shall require HAI-CA Providers to, make Covered MHSA Services available to Full-Risk Members in the same manner, in accordance with the same standards, and with no less availability as HAI-CA Providers provide services to their other patients. HAI-CA Providers shall not discriminate against any Full-Risk Members in its provision of Covered MHSA Services on account of race, sex, color, religion, national origin, ancestry, age, physical or mental handicap, health status, disability, need for medical care, sexual preference, or veteran's status, or status as a Member of BSC.

14.2 Charges to Full-Risk Members.

(a) HAI-CA shall, and shall require HAI-CA Providers to, accept as payment in full for Covered MHSA Services provided to Full-Risk Members such amounts as are paid pursuant to this Agreement and HAI-CA's agreements with the HAI-CA Providers, respectively; provided that HAI-CA Providers shall be permitted to collect authorized Copayments from Full-Risk Members and/or charges for services not covered under the Member's Full-Risk Benefit Plan. In no event, including but not limited to nonpayment by BSC or HAI-CA, or BSC's or HAI-CA's insolvency or breach of this Agreement (or breach by HAI-CA of its agreement with HAI-CA Providers), shall HAI-CA or HAI-CA Providers bill, charge, collect a deposit from, impose a surcharge on, seek compensation, remuneration or reimbursement from or have any recourse against Full-Risk Members, or individuals responsible for their care, for Covered MHSA Services. Neither HAI-CA nor any HAI-CA Provider shall seek payment from Full-Risk Members, or individuals responsible for their care, for payments for Covered MHSA Services denied by BSC or HAI-CA because the bill or claim for such services was not timely or properly submitted, or because the rendered services were not Medically Necessary or authorized. Whenever BSC receives notice of a violation of this Section, it shall take appropriate action (including without limitation the right to reimburse the Full-Risk Member the amount of any payment and offset the amount of such payment from any amounts then or thereafter owed by BSC to HAI-CA).

(b) HAI-CA shall not, and shall require that HAI-CA Providers not, bill or collect from a Full-Risk Member any charges in connection with non-covered services, non-authorized services, or services determined not to be Medically Necessary, unless HAI-CA or, as applicable, the HAI-CA Provider, has first obtained a written acknowledgment from the Full-Risk Member that such services

are either not Covered MHSA Services, not authorized, or not Medically Necessary, and that the Full-Risk Member, or the Full-Risk Member's legal representative, is financially responsible for the cost of such services. Such acknowledgment shall be obtained prior to the time that such services are provided to the Full-Risk Member and shall be in such form as meets the applicable requirements set forth in the Administrative Manual.

(c) HAI-CA agrees that, in the event of BSC's insolvency or other cessation of operations, Covered MHSA Services to Full-Risk Members will continue through the period for which their premiums have been paid, and Covered MHSA Services to Full-Risk Members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the Full-Risk Member's discharge.

(d) The provisions of this Section shall: (i) survive the termination of this Agreement (and any agreement between HAI-CA and HAI-CA Providers), regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Full-Risk Members; and (ii) supersede any oral or written contrary agreement (now existing or hereafter entered into) between HAI-CA or the HAI-CA Provider and the Full-Risk Member.

(e) For services rendered prior to the termination of this Agreement, the provisions of this Section shall be incorporated into any agreement between the HAI-CA and its contracted HAI-CA Providers.

14.3 Protection of Full-Risk Members. In the event that BSC or a Full-Risk Member notifies HAI-CA that an HAI-CA Provider or other provider who provided Covered MHSA Services to the Full-Risk Member is billing, suing, or otherwise attempting to collect (**"Collection"**) payment from the Full-Risk Member or a person responsible for the Full-Risk Member's care, other than Copayments, HAI-CA shall immediately take all reasonable and appropriate actions to stop such Collection. In the event that HAI-CA is unable to timely stop such Collection, as determined by BSC, BSC may take any steps it deems appropriate, including payment of the claim, to stop such Collection. In such event, BSC may deduct and offset such payment from any amount then or thereafter payable by BSC to HAI-CA.

14.4 Full-Risk Member Complaints and Grievances. HAI-CA shall promptly notify BSC of receipt of any claims, including professional liability claims filed or asserted by a Member against HAI-CA, an HAI-CA Provider or a BSC Behavioral Health Provider. Subject to Section 4.5 and 4.6 hereof, HAI-CA shall cooperate with BSC in identifying, processing, and resolving all Full-Risk Member grievances and other complaints, in accordance with BSC's complaint/grievance process and time limits set forth in the Administrative Manual, as well as in accordance with such time limits as required by state and/or federal law. HAI-CA shall comply with BSC's resolution of any such complaints or grievances, including specific findings, conclusions and orders of the DMHC, subject to its right to contest such resolutions under this Agreement or otherwise pursuant to applicable law.

14.5 Medical Necessity Assistance. In all cases where HAI-CA has made a determination regarding the Medical Necessity of a service requested or provided to a Member, HAI-CA shall, upon the request of BSC, assist BSC in determining the Medical Necessity of such service, provide relevant medical records to BSC, participate in any grievance, arbitration, and/or other proceedings in which such Medical Necessity determination is an issue. Moreover, HAI-CA agrees to cooperate with and abide by the Medical Necessity determination of any external review entity to which BSC is either obligated by law to submit such disputes or with which BSC has implemented a program to submit such disputes.

14.6 Free Exchange of Information. No provision of this Agreement shall be construed to prohibit, nor shall any provision in any contract between HAI-CA and any HAI-CA Providers

prohibit, the free, open and unrestricted exchange of any and all information of any kind between health care providers and Members regarding the nature of the Member's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Member's health plan, and the Member's right to appeal any adverse decision made by HAI-CA or BSC regarding coverage of treatment which has been recommended or rendered. Moreover, HAI-CA shall not penalize nor sanction any health care provider in any way for engaging in such free, open and unrestricted communication with a Member nor for advocating for a particular service on a Member's behalf.

14.7 Protection Against Improper Termination. HAI-CA may request termination of a Full-Risk Member only in accordance with the procedures established by HAI-CA and approved by BSC. In the event an HAI-CA Provider terminates his/her relationship with a Full-Risk Member, HAI-CA shall assist the Full-Risk Member in selecting another HAI-CA Provider for the provision of Covered MHSA Services. In no event may HAI-CA terminate or request the termination of a Full-Risk Member because of such Full-Risk Member's medical condition, or the amount, variety, or cost of Covered MHSA Services that are required by the Full-Risk Member.

ARTICLE15
DISPUTE RESOLUTION; ARBITRATION

15.1 Dispute Resolution; Arbitration. Except as contemplated by Section 4.6 of this Agreement, in the event of a dispute between HAI-CA and BSC which arises out of or is related to this Agreement, HAI-CA and BSC shall meet and negotiate in good faith to attempt to resolve the dispute. In the event the dispute is not resolved within thirty (30) days of the date one party sent written notice of the dispute to the other party (unless such time frame is extended by mutual written agreement of the parties), and if either party wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association. In no event may arbitration be initiated more than one year following the sending of written notice of the dispute. Any arbitration proceeding under this Agreement shall be conducted in San Francisco County, California. The arbitrators shall have no authority to award any punitive or exemplary damages or to vary or ignore the terms of this Agreement and shall be bound by all controlling California and federal law. The arbitrators shall issue written findings of fact and conclusions of law.

ARTICLE 16
EXCLUSIVITY

16.1 Exclusivity.

(a) Except as otherwise agreed upon by the parties, during the term of this Agreement, (i) HAI-CA shall be the exclusive entity with which BSC contracts for the provision of MHSA Services and related administrative services with respect to all Full-Risk Benefit Plans or any other benefit plans that may in the future be underwritten and implemented by BSC (**"Benefit Plans"**) in the Service Area or in any future service area, and (ii) BSC shall not itself, directly or indirectly, or otherwise, except through HAI-CA, provide or arrange for the provision of such MHSA Services and related administrative services in the Service Area. The parties acknowledge and agree that the exclusivity granted hereunder shall not extend to services supporting Non-Risk Benefit Plans, benefit plans not underwritten by BSC, disease management services, or Work/Life Services.

(b) If, following the Commencement Date, BSC develops and offers in the Service Area a Benefit Plan that is not identified in Exhibit A to this Agreement, the parties shall negotiate in good faith the compensation payable to HAI-CA for services provided in support of such new Benefit Plan, based upon the compensation then payable to HAI-CA for services provided in support of the closest

comparable existing Benefit Plan and with such actuarial and demographic adjustments as may be appropriate. The rates shall follow the rate determination methodology set forth in this Agreement. The provision of such services and the compensation payable to HAI-CA services shall be subject to the execution of a mutually agreeable agreement or amendment to this Agreement to be developed and executed by the parties.

(c) In the event of a breach of this Section by BSC, HAI-CA shall have the right, in addition to any and all rights it may otherwise have under the law and at equity, to seek specific performance of the obligations of BSC under this Section. Should HAI-CA seek specific performance of the obligations of BSC under this Section, BSC waives any right to demand that HAI-CA post a bond or other security as a condition to the issuance of a temporary restraining order, preliminary injunction or permanent injunction against BSC.

ARTICLE 17
TERM AND TERMINATION

17.1 Term. The term of this Agreement shall commence on the Effective Date and end December 31, 2019 (the **"Initial Term"**), unless earlier terminated as set forth herein. Thereafter, this Agreement shall automatically renew for successive one (1) year terms, unless and until either party provides written notice to the other party, no later than July 1 of the then current term, of its intent to not renew this Agreement, or this Agreement is otherwise terminated as set forth herein.

17.2 Termination. This Agreement may be terminated as follows:

(a) By HAI-CA:

(1) upon one hundred eighty (180) days prior written notice to BSC, in the event of a material breach by BSC of any term of this Agreement. The written notice shall specify the precise nature of the breach. In the event BSC cures the breach to the reasonable satisfaction of HAI-CA within ninety (90) days of HAI-CA's written notice, this Agreement shall not terminate.

(2) immediately upon written notice to BSC, if BSC becomes insolvent, which for purposes of this Agreement shall mean that BSC voluntarily files, or has filed involuntarily against it, a petition under the United States Bankruptcy Code, including a petition for Chapter 11 reorganization as set forth in the United States Bankruptcy Code.

(b) By BSC:

(1) upon ninety (90) days prior written notice to HAI-CA, in the event of a material breach by HAI-CA of any term of this Agreement. The written notice shall specify the precise nature of the breach. In the event HAI-CA cures the breach to the reasonable satisfaction of BSC within ninety (90) days of BSC's written notice, this Agreement shall not terminate.

(2) immediately upon written notice to HAI-CA, if HAI-CA becomes insolvent, which for purposes of this Agreement shall mean that HAI-CA voluntarily files, or has filed involuntarily against it, a petition under the United States Bankruptcy Code, including a petition for Chapter 11 reorganization as set forth in the United States Bankruptcy Code.

(3) immediately upon written notice to HAI-CA, if required by state or federal regulatory agencies.

(4) if: (A) required by the Association or the rules or regulations promulgated

thereby; or (B) BSC receives notice from the Association that continuation of the arrangements contemplated by this Agreement is reasonably likely to result in (a) the loss of BSC's license from the Association to use the BSC Service Mark or (b) the imposition by the Association upon BSC of a penalty which BSC reasonably determines to be material, and BSC, using reasonable good faith efforts, has objected to such notice and defended the arrangements contemplated hereby, in writing (a copy of which, together with the Association's response thereto, and the Association's original notice, if written, shall be furnished by BSC to HAI-CA); provided that BSC (X) shall meet and confer with HAI-CA for a period thirty (30) days, or such shorter time period as may be made necessary by the requirements or threat of penalty imposed by the Association or the rules or regulations promulgated thereby, and negotiate in good faith to attempt to amend this Agreement in order to comply with the requirements or threat of penalty imposed by the Association or the rules or regulations promulgated thereby, and (Y) notifies HAI-CA of such termination the lesser of (x) one hundred eighty (180) days prior thereto, or (y) such shorter notice period as may be made necessary by the requirements or threat of penalty imposed by the Association or the rules or regulations promulgated thereby.

(5) without cause, effective January 1, 2018, upon no fewer than three hundred sixty-five (365) days prior written notice to HAI-CA.

(6) without cause, effective January 1, 2019, upon no fewer than three hundred sixty-five (365) days prior written notice to HAI-CA.

(c) Change of Control:

(1) In the event of a Change in Control of HAI-CA to any BSC Competitor, BSC shall have the right to terminate the this Agreement within ninety (90) days of the earlier of such Change of Control or receipt of notice of such agreement with respect thereto. At the request of BSC, HAI-CA will continue to provide services pursuant to the terms of this Agreement for up to one hundred eighty (180) days after such termination at the rates set forth herein. In the event BSC terminates this Agreement pursuant to this Section 17.2(c)(1), HAI-CA shall reimburse BSC for all costs incurred by BSC in connection with the termination and replacement of this Agreement (including, without limitation, all transition costs incurred in connection with the disengagement from this Agreement and the engagement or implementation of a replacement vendor or solution), which amount, when combined with such amounts, if any, payable by HAI-CA pursuant to Section 17.2(c) of the DOI Agreement, shall not exceed [redacted]

(2) "**Change of Control**" means (i) a merger or consolidation of HAI-CA with or into any other corporation or other entity or person, (ii) a sale, lease, exchange or other transfer in one transaction or a series of related transactions of all or substantially all of HAI-CA's outstanding securities or all or substantially all of HAI-CA's assets, (iii) the acquisition by a Person or group (within the meaning of Securities and Exchange Commission Rule 13d-5 promulgated under the Exchange Act) of beneficial ownership of fifty percent (50%) or more of HAI-CA's outstanding capital stock, (iv) the acquisition by a person or group (within the meaning of SEC Rule 13d-5 promulgated under the Exchange Act) of the right, whether by management agreement or otherwise, to control the management or direction of HAI-CA, or (v) any transaction in which HAI-CA sells or otherwise transfers to a third party not an Affiliate (as defined below) of HAI-CA any equity interests or a material portion of the assets of any subsidiary that is party to this Agreement (or any of the agreements contemplated therein) or in which HAI-CA ceases to have the sole right to control the management and direction of any such subsidiary; provided, however, that the following events shall not constitute a "Change of Control": (a) a merger or consolidation of HAI-CA in which the holders of the voting securities of HAI-CA immediately prior to the merger or consolidation hold at least a majority of the voting securities in the successor corporation immediately after the merger or consolidation; (b) a sale, lease, exchange or other transaction in one transaction or a series of related

transactions of all or substantially all of HAI-CA's assets to a wholly owned subsidiary corporation; (c) a mere reincorporation of HAI-CA; or (d) a transaction undertaken for the sole purpose of creating a holding company that will be owned in substantially the same proportion by the persons who held HAI-CA's securities immediately before such transaction. For purposes of this Section, **"Affiliate"** shall have the meaning ascribed to it in that certain Share Purchase Agreement by and between the parties of even date herewith.

(3) "**BSC Competitor**" means Blue Cross of California/Wellpoint, United Healthcare/Pacificare, Kaiser Permanente, Health Net, Aetna, CIGNA and any other entity that is a bona fide full service health care service plan, health insurer, or health maintenance organization in the State of California, or any entity engaged in the business of administering, arranging, financing or providing health care benefits that competes with the business of BSC in California, and any successors or Affiliates of the forgoing.

(d) Termination Resulting From Government Action:

(1) In the event of any Government Action (as defined below), the parties shall, within ten (10) days after one party gives written notification of such Government Action to the other party, meet and confer and negotiate in good faith to attempt to amend this Agreement in order to comply with the Government Action.

(2) If the parties, after good faith negotiations that shall not exceed thirty (30) days, are unable to mutually agree upon the amendments necessary to comply with the Government Action, or, alternatively, either party determines in good faith that compliance with the Government Action is impossible or infeasible, either party may terminate this Agreement effective one hundred eighty (180) days after a written notice of termination is given to the other party.

(3) For the purposes of this Section, **"Government Action"** shall mean any legislation, statute, law, regulation, rule or procedure passed, adopted or implemented by any federal, state or local government or legislative body or any private agency, or any decision, finding, interpretation or action by any governmental or private agency, court or other third party which, in the opinion of counsel to either party, as a result or consequence, in whole or in part, of the arrangement between the parties contemplated by this Agreement, if or when implemented, could reasonably be expected to result in or present a material risk of any one or more of the following:

(A) revocation or threat of revocation of the status of any license, certification or accreditation granted to any party or any Affiliate of such party;

(B) violation by either party of, or threat of prosecution of either party under, any law, regulation, rule or procedure applicable to such party; or

(C) subject either party or such party's officers, directors, employees or agents, to civil action or other enforcement action by any governmental authority, including, without limitation, the California Department of Managed Health Care.

(e) Early Termination – Association Action. If BSC terminates this Agreement at any time during the Initial Term pursuant to Section 17.2(b)(4) of this Agreement, BSC shall pay to HAI-CA an early termination fee as follows:

Effective Date of Termination	Early Termination Fee
Prior to January 1, 2012	[redacted]
On or before December 31, 2014	[redacted]
January 1, 2015 – December 31, 2016	[redacted]
January 1, 2017 – December 31, 2017	[redacted]
January 1, 2018 – December 31, 2018	[redacted]
January 1, 2019 – December 31, 2019	[redacted]

(f) Early Termination Without Cause.

(1) If BSC terminates this Agreement without cause effective January 1, 2018, BSC shall pay to HAI-CA an early termination fee which, when combined with any termination fee payable by Blue Shield Life & Health Insurance Company pursuant to Section 17.2(f)(1) of the DOI Agreement, equals [redacted] In addition, notwithstanding Section 2(b)(3) of Exhibit C to this Agreement, the administrative fee payable to HAI-CA during calendar year 2017 shall be fixed at [redacted]

(2) If BSC terminates this Agreement without cause effective January 1, 2019, BSC shall pay to HAI-CA an early termination fee which, when combined with any termination fee payable by Blue Shield Life & Health Insurance Company pursuant to Section 17.2(f)(2) of the DOI Agreement, equals to [redacted] In addition, notwithstanding Section 2(b) (3) of Exhibit C to this Agreement, the administrative fee payable to HAI-CA during calendar year 2018 shall be fixed at [redacted]

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

(a) Except as set forth in Sections17.2(c)(i) and 17.3(f), the obligation of HAI-CA to provide and reimburse inpatient and outpatient Covered MHSA Services provided to Full-Risk Members shall cease as of the date of termination.

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

(c) Prior to termination of this Agreement, BSC shall notify Full-Risk Members subject to this Agreement of such termination and shall, on request, provide HAI-CA with a copy of the notice and documentation that the notification was provided.

(d) Both parties shall cooperate reasonably to facilitate a smooth transition out of the arrangement contemplated by this Agreement. Without limiting the foregoing, HAI-CA shall cooperate reasonably with BSC and/or BSC's new mental health and substance abuse vendor(s) (**"Vendor(s)"**) in transitioning the care and management of Full-Risk Members undergoing treatment on the date of termination of this Agreement. Upon reasonable request, HAI-CA shall provide to BSC or its Vendor(s) copies of all medical records in HAI-CA's possession upon such terms and conditions as are agreed to by BSC, Vendor(s) and HAI-CA, provided that HAI-CA is granted subsequent access to such records.

(e) HAI-CA shall transfer or release, or cause to be transferred or released, as applicable, to BSC all BSC-dedicated telephone numbers used by HAI-CA in the performance of the provision of services pursuant to this Agreement (*e.g.*, Work-Life Services numbers, toll-free informational and/or contact numbers used by Members, Full-Risk Members, and/or providers, etc.), effective upon the effective date of termination of this Agreement.

(f) With respect to Full-Risk Members receiving inpatient and residential care Covered MHSA Services on the date of termination of this Agreement, HAI-CA shall continue to arrange for and be financially responsible for such Covered MHSA Services for a period of up to twenty-two (22) days following the date of termination or until the Full-Risk Member is discharged or transferred to a lower level of care, whichever occurs first. With respect to outpatient Covered MHSA Services after the effective date of termination of this Agreement or with respect to inpatient and residential care Covered MHSA Services from and after the twenty-second (22nd) day following the date of termination of this Agreement, HAI-CA shall, at BSC's option, continue arranging for Covered MHSA Services to Full-Risk Members undergoing medical treatment after the termination of this Agreement in exchange for compensation equal to the schedule of fees paid by HAI-CA to HAI-CA Providers in effect on the date of notice of termination, for the duration of the contracts in effect with BSC through which Full-Risk Members are enrolled with BSC for which subscription charges are paid to BSC, or until such time as BSC has arranged for an alternative source of services for each such Full-Risk Members from other contracting providers; provided, however, that in no event shall such continuation obligation exceed one hundred and eighty (180) days from the date of termination.

(g) Except as specifically set forth in this Agreement, neither party shall be entitled to, nor shall demand as a condition to fulfilling its responsibilities pursuant to this Section, any termination fee or other fee or compensation as a consequence of the expiration or termination of this Agreement.

17.4 Specific Post-Termination Responsibilities. Without limiting the terms of Sections 17.2(c)(i) and 17.3:

(a) Upon the effective date of termination and as reasonably requested by BSC prior thereto, HAI-CA shall provide to BSC a listing of Members then receiving any care in an acute or inpatient facility;

(b) Within one hundred twenty (120) days of the effective date of termination, HAI-CA shall provide to BSC a complete paid claims file for the ninety (90) day period immediately following the effective date of termination;

(c) HAI-CA shall continue to review Member and BSC Provider appeals related to any coverage denials issued prior to the effective date of termination and during the ninety (90) day period immediately following the effective date of termination and HAI-CA Provider appeals for the

three hundred and sixty-five (365) day period following the effective date of termination, pursuant to Section 4.5 of this Agreement.

(d) Within one hundred twenty (120) days of the effective date of termination, HAI-CA shall provide to BSC a final file of all co-accumulation data for all claims processed prior to the effective date of termination and during the ninety (90) day period immediately following the effective date of termination;

(e) HAI-CA shall provide forwarding information to BSC for all mail received during the six (6) month period immediately following the effective date of termination;

(f) Within one hundred twenty (120) days of the effective date of termination, HAI-CA shall provide to BSC a final billing for injectable drugs for reimbursement;

(g) Within one hundred twenty (120) days of the effective date of termination, HAI-CA shall provide to BSC a final year – end financial report (including PMPM and utilization data); and

(h) Within one hundred twenty (120) days of the effective date of termination, HAI-CA shall provide to BSC a final -year-end dashboard and Performance Guarantee reports, and shall remit to BSC all amounts owed to BSC as a result of HAI-CA's failure to satisfy any performance standards pursuant to Sections9.2 and/or 9.3.

17.5 Provisions that Survive Termination. The following portions of this Agreement shall survive the termination of this Agreement, whether such termination is the result of rescission or otherwise: Sections 2.6(e), 2.7, 2.8 4.5, 4.6, 5.1(c) 10.6, 11.1, 11.2, 12.1, 13.1-13.7, 13.8(b), 13.8(c), 14.2-14.5, 15.1, 17.2(c), 17.2(e), 17.2(f) 17.3, 17.4, 19.8, 19.11, and this Section 17.5.

ARTICLE 18
SYSTEMS REQUIREMENTS

18.1 Data Exchange Capabilities. HAI-CA shall establish and maintain systems capabilities that are compatible with BSC's information systems and comply with the requirements set forth in Exhibit I hereto. Without limiting the foregoing, HAI-CA shall maintain the ability to provide the services described in this Agreement using, and to interface with, both BSC's legacy claims system(s) and its new FACETS claims system, at no additional cost to BSC.

18.2 IT Services. HAI-CA will provide the following information technology services in support of claims processing for BSC:

(a) Eligibility processing;

(b) Maintenance of and access to Member service tracking;

(c) Claims adjudication;

(d) Provider capitation;

(e) Provider assignment maintenance;

(f) Eligibility, provider, claim and financial data transfers;

(g) Voice recognition and telecommunications routing and tracking system; and

(h) Other systems needed to support services outlined in this Agreement.

18.3 Facilities. HAI-CA will provide the information technology services described in Section 18.1 at office locations in California and St. Louis, Missouri. HAI-CA may relocate data center operations or other information technology services to another HAI-CA data processing center or other HAI-CA facility at any time during the term of this Agreement, provided that: (a) HAI-CA develops a migration plan reasonably acceptable to BSC which is designed to avoid disruptions or degradation in service to BSC during the migration period; (b) HAI-CA demonstrates to BSC's reasonable satisfaction that the service levels achieved at the new data center are as high as the service levels achieved at the then existing data processing center; (c) HAI-CA assumes financial responsibility for any increased costs and expenses incurred by BSC as a result of the relocation.

18.4 Changes in System Requirements. HAI-CA shall use best efforts to accommodate any system changes requested by BSC, subject to Sections 10.4 and 10.5 of this Agreement. BSC shall give HAI-CA reasonable advance notice of any requested system changes. HAI-CA shall give BSC reasonable advance notice of any planned change to HAI-CA's computing infrastructure which could impact accurate and timely processing of BSC data.

18.5 Provider File Maintenance. HAI-CA shall be responsible for preparing and maintaining, in its ordinary course of business, the files and records negotiated by HAI-CA and relating to HAI-CA Providers, as reasonably necessary or reasonably requested by BSC, and as required by the state or federal government, to document the identity and credentials of all HAI-CA Providers, including, without limitation, provider demographic data, National Provider Identifier (**"NPI"**) number, tax identification number, and contract status.

18.6 Method of Access. Each party shall have access to the other party for the data exchanges described herein via Secure File Transfer Protocol (**"SFTP"**). HAI-CA and BSC agree to utilize only SFTP for all electronic data exchanges.

18.7 IT and Data Security.

(a) Each party shall use commercially reasonable efforts, including, but not limited to, the most current and updated virus detection and data security software, to attempt to reduce the likelihood that data sent and received during any data transmissions described herein contains any unauthorized material, including without limitation, a computer virus or other contaminant.

(b) Each party shall use reasonable physical and software based measures commonly used in the electronic data interchange field and to protect data from unauthorized access and disclosure. Each party shall implement and comply with and shall not attempt to circumvent or bypass the other party's security policies and procedures including, without limitation, those regarding transmission of confidential information, encryption and compliance with the applicable provisions of HIPAA.

(c) Each party agrees to immediately notify the other should it experience any compromise of its security safeguards that has or is likely to lead to an inappropriate use or disclosure of Confidential Information or PHI.

18.8 Redundancy/Backup. HAI-CA shall implement and maintain a data recovery program to back up and restore the Confidential Information or PHI in the event of any data loss. HAI-CA agrees to document such safeguards, and agrees to provide such documentation to BSC upon request. The documentation will include the following:

(a) A description of the HAI-CA's information architecture identifying the computers, applications, and networks that will maintain or process the Confidential Information or PHI and identifying any interface to networks that are outside the HAI-CA's management, including Internet and wireless gateways, as well as networks belonging to the HAI-CA's business partners and service providers;

(b) Identification of internal and external risks to the confidentiality, integrity, and availability of the Confidential Information that could result in the unauthorized disclosure, misuse, loss, alteration, destruction or other compromise of the Confidential Information;

(c) A description of the physical, electronic and procedural safeguards that the HAI-CA implements to protect against the above identified risks;

(d) A description of the HAI-CA's procedures to monitor and test the proper and consistent operation of the above identified safeguards; and

(e) The HAI-CA's certification of the accuracy of the Security Plan.

18.9 Outage Notification. HAI-CA agrees to notify BSC of any system outage in accordance with the outage notification documentation in the Administrative Manual.

18.10 IT Controls. HAI-CA shall perform and complete an SSAE 16 Type 2 audit each year during the term of this Agreement. HAI-CA shall retain a reputable auditor, registered with the Public Company Accounting Oversight Board, to conduct such audits. Each SSAE 16 audit shall use the inclusive method in describing and attesting to the information technology controls of any subservice organization on which HAI-CA relies in order to provide services under this Agreement. Each SSAE 16 audit shall specifically address all appropriate control objectives of HAI-CA's services for BSC. Such audit shall address the twelve (12) month period ended September 30 of each year. HAI-CA shall make available to BSC the results of the most recent audit on or before the third business day after November 15th of the calendar year. HAI-CA must provide, upon request, documentation of processes and procedures that have been implemented that address the controls listed in Exhibit I hereto.

18.11 Change Control Process. HAI-CA shall implement, document, and maintain a change control process to ensure the correctness, completion and appropriate approval of all changes introduced into the production system environment. The change control process must provide reasonable assurance that the changes to existing applications and the development of new applications and system software are authorized, tested, and approved, properly. HAI-CA agrees to provide documentation of the change control process upon request.

18.12 Disaster Recovery.

(a) HAI-CA shall provide Disaster Recovery Services so as to provide the required availability of the services described in this Agreement during a **"Disaster."** A Disaster is defined as a significant loss of service capacity, loss of significant IT processing or operating capacity, physical damage to an IT processing site, equipment and/or personnel which causes a loss of significant IT processing or operating capacity, or an interruption of connectivity to, or availability of, personnel or physical workspace of personnel or third parties supplying such services or process or operating capacity to HAI-CA.

(b) Disaster Recovery Services are the activities required to restore the computing

environment and business operations locations, personnel availability, and connectivity to needed resources to its operating condition prior to the Disaster, and shall include, without limitation, the activities required to ensure the continuous, uninterrupted provision of services described in Sections 2.4(b), 3.2(a) and 6.2 of this Agreement.

(c) HAI-CA shall document and maintain a Disaster Recovery Plan that is tested annually. Results of the test shall be forwarded to BSC no later than thirty (30) days following completion of the test.. If IT and/or business facilities and personnel are situated in different geographic locations not susceptible to the same natural disaster, HAI-CA may conduct separate tests for each such location. Test results provided to BSC shall document the results of the test in reasonable detail and shall indicate how the test verified that the services would be available in the event of a real Disaster. If any such test reveals a material weakness, HAI-CA shall remediate such weaknesses within sixty (60) days of the original test.

(d) Within sixty (60) days of the Effective Date, HAI-CA shall provide the results of its most recent Disaster Recovery Plan test(s) or, if no such tests have been performed within the twelve (12) month period immediately preceding the Effective Date, specific plans for the next test, which shall occur no later than November 30, 2011.

(e) Prior to November 30, 2011, HAI-CA will work with BSC to specify any change in routing or other information required for BSC to interact with HAI-CA's recovered capability.

(d) Prior to November 30, 2011, BSC will work with HAI-CA to specify any change in routing or other information required for HAI-CA to interact with BSC if BSC has a disaster recovery or relocation.

(e) No later than November 30, 2011, HAI-CA will define the process for any required joint testing of disaster or business recovery at either party's site(s).

(f) Prior to November 30, 2011, HAI-CA will work with BSC to establish a process for notification of any service disruptions, whether caused by a Disaster or not. The immediacy and urgency of disruption reporting and coordination shall be indexed by the severity of the disruption.

(g) HAI-CA controls related to disaster recovery shall include those controls identified in Exhibit I hereto.

18.13 BSC System Maintenance Requirements. BSC shall establish and maintain systems capabilities that comply with the requirements set forth in Exhibit I hereto.

ARTICLE 19
GENERAL PROVISIONS

19.1 Amendment. This Agreement may be amended only by the written consent of both parties.

19.2 Assignment. Neither party shall assign, transfer, or subcontract any of its rights, interests, duties, or obligations under this Agreement, whether by sale, assignment, negotiation, pledge or otherwise, without the prior written consent of the other party. Notwithstanding the foregoing sentence, HAI-CA may engage its affiliates Magellan Behavioral Health, Inc. (**"MBH"**) and Magellan Health Services, Inc. (**"MHS"**) to provide claims services (as described in Section 8.2), credentialing, IT services, provider operations services, and after-hours call center services; provided that MBH and MHS shall be subject to all applicable requirements under this Agreement and further provided that HAI-CA shall remain ultimately responsible for services performed under this Agreement. Without

limiting the foregoing, the following events shall constitute an assignment of this Agreement for purposes of this Section: (i) the sale, transfer or other disposition of all or substantially all of the issued and outstanding voting securities or interests of HAI-CA; (ii) the merger, consolidation or other reorganization of HAI-CA if, immediately following such transaction, either HAI-CA or its shareholders or other equity holders (as existing immediately preceding such transaction) do not own a majority of all classes of the issued and outstanding membership interests or voting securities of the surviving, consolidated or reorganized entity; and (iii) the issuance of any class of voting securities or interests by HAI-CA (or its successor) if, immediately following such transaction, HAI-CA's shareholders or other equity holders existing immediately preceding such issuance do not own a majority of all classes of the issued and outstanding voting securities or interests of HAI-CA. Subject to the foregoing, this Agreement shall be binding on and shall inure to the benefit of the parties and their respective heirs, successors, assigns and representatives.

19.3 Entire Agreement. The attached Exhibits and Appendices, together with all documents incorporated by reference in the Exhibits and Appendices, and the Administrative Manual, as from time to time amended in accordance with this Agreement, form an integral part of this Agreement and are incorporated by reference into this Agreement; provided that to the extent there is a conflict between the terms of this Agreement and the terms of any Appendix to this Agreement, the terms of this Agreement shall govern. This Agreement constitutes the entire understanding and agreement of the parties regarding its subject matter, and supersedes any prior oral or written agreements, representations, understandings or discussions between the parties regarding the subject matter herein, including, without limitation, that certain Letter of Agreement Effective January 28, 2011, by and between the parties. No other understanding between the parties regarding the subject matter herein shall be binding on them unless set forth in writing, signed and attached to this Agreement.

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

19.5 Termination of Full-Risk Members. Subject to any restrictions in the Benefit Plans, BSC shall act promptly to disenroll Full-Risk Members who meet criteria for termination.

19.5 Compliance with Law. Each party shall perform its obligations under this Agreement in accordance with applicable federal and state law, including, without limitation, the requirements of the Knox-Keene Act, the Social Security Act, ERISA and the regulations promulgated under each. Any provision required to be in this Agreement by applicable federal and state law which relates to the services provided under this Agreement shall bind BSC and HAI-CA, whether or not provided in this Agreement. HAI-CA shall require that all HAI-CA Providers similarly comply with all applicable federal and state laws.

19.6 Governing Law. This Agreement shall be construed in accordance with and governed by the internal laws of the State of California, without giving effect to any choice of law or conflict of law rules or provisions that would cause the application of the laws of any jurisdiction other than the State of California.

19.7 Notices. Any notice under this Agreement shall be in writing and hand-delivered or sent by prepaid, first class mail to the addresses and addressees identified below, except as otherwise provided in this Agreement. The addresses and the addressees to which notices are sent for either party may be changed by proper notice.

BSC	**HAI-CA**
Senior Vice President, Network Management Blue Shield of California 50 Beale Street San Francisco, CA 94105	General Manager Human Affairs International of California 3131 Camino Del Rio Suite 401 Mission Valley, CA 92108
With a copy to:	With a copy to:
Senior Network Manager for Behavioral Health Blue Shield of California 50 Beale Street San Francisco, CA 94105	Chief Financial Officer Human Affairs International of California 300 N. Continental Blvd. Suite 320 El Segundo, CA 90245

19.8 Confidentiality of Proprietary Information.

(a) For purposes of this Section, the party receiving Confidential Information (as defined below) is hereinafter referred to as the **"Receiving Party"**, and the party providing the Confidential Information is hereinafter referred to as the **"Disclosing Party."**

(b) The Receiving Party agrees to treat all ideas, knowledge, data or other information, whether in written, oral or any other form, concerning the Disclosing Party and its subsidiaries and Affiliates (for purposes of this Section, collectively the **"Disclosing Party"**), including, without limitation, its Members, Full-Risk Members, Full-Risk Members, subscribers, business plans, products, proposed new products and concepts, underwriting data or information, pricing data or information, market research, trade secrets, employees, proprietary systems, information technology systems and software, financial data and operating procedures, and any third party (e.g., vendors and contractors) confidential and proprietary information (e.g., computer software and related information), furnished to the Receiving Party by or on behalf of the Disclosing Party, or which is observed, ascertained, learned or obtained by the Receiving Party while negotiating with the Disclosing Party or providing services to the Disclosing Party pursuant to this Agreement (such information, along with all analyses, compilations, data, studies, notes, memoranda, documents, electronic files, records, drawings, work papers or other work that is prepared by the Receiving Party or the Receiving Party's employees or agents and which is based in whole or in part on such information is collectively referred to herein as **"Confidential Information"**) strictly confidential, in accordance with this Section. The term "Confidential Information" shall not include information which the Receiving Party can demonstrate by contemporaneous documentation: (i) is already in the Receiving Party's possession prior to its disclosure by the Disclosing Party to the Receiving Party, provided that such information is not known by the Receiving Party to be subject to another confidentiality agreement with or other obligation of secrecy to the Disclosing Party or another party; (ii) is made or generally becomes available to the public by the Disclosing Party; (iii) is or becomes available to the Receiving Party on a non-confidential basis from a source other than the Disclosing Party, provided that such source is not bound by a confidentiality agreement with or other obligation of secrecy to the Disclosing Party or another party; (iv) is developed jointly by the Disclosing Party and the Receiving Party in connection with the parties' performance of this Agreement; or (v) is

developed by the Receiving Party without the use of, or reference to, the Disclosing Party's Confidential Information.

(c) The Receiving Party agrees that the Confidential Information made available to it shall be kept strictly confidential. Without the prior written consent of the Disclosing Party, the Receiving Party shall not: (i) copy or otherwise reproduce for, or distribute to, third parties any Confidential Information or the substance of such Confidential Information; (ii) disclose to any person, by any means, any Confidential Information that has been made available to it, or the substance of the Confidential Information, except as may be required by law or regulation as is addressed in Sections 19.8(d) and (e); (iii) use the Confidential Information for any purpose other than solely to discuss/provide/receive services pursuant to this Agreement; and (iv) use the Confidential Information in any manner not specifically authorized in writing by the Disclosing Party. In addition, when the Confidential Information includes Member, Full-Risk Member, Full-Risk Member, subscriber or patient specific information or protected health information and/or individually identifiable personal information, the Receiving Party shall use such Confidential Information as mutually agreed to by the parties or otherwise as directed by the Disclosing Party and in accordance with all applicable state and federal law, including without limitation California Civil Code Section 56, *et seq.*, and, to the extent applicable to the Receiving Party, the requirements of the Privacy and Security Regulations 45 C.F.R. Parts 160 and 164.

(d) Notwithstanding Section 19.8(c), Confidential Information may be disclosed, without the prior written consent of the Disclosing Party, to those the Receiving Party employees and agents who need to know such Confidential Information for the purpose of assisting the Receiving Party in connection with the Receiving Party's authorized use of such Confidential Information; provided that, prior to the receipt of any Confidential Information by employees or agents of the Receiving Party, such employees or agents shall be informed by the Receiving Party of the confidential nature of such information and directed by the Receiving Party to treat such information as confidential and shall have agreed to comply with and be bound by the confidentiality terms and conditions of this Section. The Receiving Party agrees to be responsible for any breach of this Agreement by any of its employees or agents.

(e) In the event the Receiving Party or any of its employees or agents is requested or required (by oral questions, interrogatories, requests for information or documents, subpoenas, civil investigative demands or similar processes) to disclose any Confidential Information, the Receiving Party shall provide the Disclosing Party with prompt written notice of such request(s) and notice of the documents or information requested, so that the Disclosing Party may seek an appropriate protective order and/or waive the Receiving Party's compliance with the provisions of this Section. If, in the absence of a protective order or the receipt of a written waiver from the Disclosing Party, the Receiving Party is, nonetheless, in the opinion of its legal counsel, compelled to disclose any of the Confidential Information to any person or else stand liable for contempt or suffer other censure or penalty, the Receiving Party agrees to disclose to such tribunal only such Confidential Information as is legally required, which disclosure shall be without liability hereunder; provided, however, that the Receiving Party shall give the Disclosing Party written notice of the Confidential Information to be so disclosed as far in advance of its disclosure as is practicable and shall use all commercially reasonable efforts to obtain reliable assurance that confidential treatment shall be accorded to such portion of the Confidential Information required to be disclosed.

(f) Upon the Disclosing Party's written request, the Receiving Party shall promptly collect from the Receiving Party's employees and agents all Confidential Information and any other information, including documents, memoranda and notes containing or reflecting or based upon any information in the Confidential Information, whether prepared by the Receiving Party, its employees or agents or otherwise, as well as any Confidential Information and any other material containing or

reflecting or based upon the Confidential Information the Receiving Party has in its possession (said Confidential Information and material are collectively hereinafter referred to as the **"Material"**) and upon the Disclosing Party's direction either (i) deliver such Material to the Disclosing Party, or (ii) destroy such Material, without retaining any copies, extracts or other reproductions in whole or in part. In addition, the Receiving Party shall direct that written certification by an authorized officer of the Receiving Party of the delivery or destruction of the Material be delivered to the Disclosing Party no later than twenty (20) business days following delivery of the request by the Disclosing Party.

(g) It is understood and agreed that no failure or delay by the Disclosing Party in exercising any right, power or privilege pursuant to this Section shall operate as a waiver thereof, nor shall any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any right, power or privilege hereunder. It is further understood and agreed that money damages may not be a sufficient remedy for any breach of this Agreement by the Receiving Party and that the Disclosing Party shall be entitled to an injunction and/or specific performance as a remedy for any such breach. In the event an injunction and/or specific performance is sought in connection herewith, the Receiving Party agrees to waive, and to use its reasonable efforts to cause its respective representatives to waive, any requirement for the securing or posting of any bond in connection with such remedy. Such remedy shall not be deemed to be the exclusive remedy for a breach of this Agreement, but shall be in addition to all other remedies available at law or in equity.

(h) Confidential Information disclosed hereunder shall at all times remain, as between the parties, the property of the Disclosing Party. No rights, expressed or implied, by license or otherwise, to any Confidential Information, trade secrets, copyrights, or other rights are granted by this Agreement or any disclosure of Confidential Information hereunder, except as provided for in Section 19.8(c).

19.9 Headings. The headings in this Agreement are intended solely for convenience of reference and shall be given no effect in the construction or interpretation of this Agreement.

19.10 Severability. If any provision of this Agreement, in whole or in part, or the application of any provision, in whole or in part, is determined to be illegal, invalid or unenforceable by a court of competent jurisdiction, such provision, or part of such provision, shall be severed from this Agreement. The illegality, invalidity or unenforceability of any provision, or part of any provision, of this Agreement shall have no affect on the remainder of this Agreement, which shall continue in full force and effect.

19.11 No Solicitation of Employees. Unless otherwise agreed to, during the term of this Agreement and for one (1) year after the termination or expiration thereof, neither party nor such party's Affiliates shall, without the prior consent of the other party, directly or indirectly solicit, employ or engage any employee of the other party or the other party's Affiliates.

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

19.13 Disclosure of Certain Events. HAI-CA shall notify BSC immediately in writing when HAI-

CA becomes aware of the occurrence of any of the following events: (a) HAI-CA's liability insurance is canceled, terminated, not renewed, or materially modified; (b) HAI-CA receives a cease and desist order from the DMHC (or any successor agency) or the DMHC (or any successor agency) takes any action to restrict the activities of HAI-CA; (c) HAI-CA or an HAI-CA Provider becomes a defendant in a lawsuit filed by a Full-Risk Member or is required or agrees to pay damages to a Full-Risk Member for any reason; (d) any act of nature or any event occurs which has a materially adverse effect on HAI-CA's ability to perform its obligations hereunder; (e) a petition is filed to declare HAI-CA bankrupt or for reorganization of HAI-CA under the bankruptcy laws of the United States or a receiver is appointed over all or any portion of the HAI-CA's assets; (f) HAI-CA is sued by a healthcare provider for nonpayment of compensation for Covered MHSA Services; or (g) any other situation arises which could reasonably be expected to materially affect HAI-CA's ability to carry out its obligations under this Agreement. HAI-CA shall also provide BSC with notice, once the information is available to the public, of any proposed material change in the ownership of HAI-CA, a change in its management services organization (if any), or the sale of all or substantially all of the assets of the HAI-CA.

19.14 Force Majeure. If and to the extent that a party's performance of any of its obligations pursuant to this Agreement is prevented, hindered or delayed by fire, flood, earthquake, elements of nature or acts of God, acts of war, terrorism, riots, civil disorders, rebellions or revolutions, or a similar cause beyond the reasonable control of such party (but specifically excluding labor and union-related activities with respect to HAI-CA's workforces, failures of HAI-CA's employees, agents, contractors, personnel and representatives (**"HAI-CA Agents"**), except to the extent that a Force Majeure Event applies to that HAI-CA Agent, and inability to obtain supplies) (each, a "**Force Majeure Event**"), and such non-performance, hindrance or delay could not have been prevented by reasonable precautions undertaken by the party claiming a Force Majeure Event, then such party shall be excused for such non-performance, hindrance or delay of those obligations affected by the Force Majeure Event for as long as such Force Majeure Event continues and such party continues to use all reasonable efforts to recommence performance whenever and to whatever extent possible without delay, including through the use of alternate sources, workaround plans and other means. The party whose performance is prevented, hindered or delayed by a Force Majeure Event shall immediately notify the other party of the occurrence of the Force Majeure Event and describe in reasonable detail the nature of the Force Majeure Event. The occurrence of a Force Majeure Event does not excuse, limit or otherwise affect HAI-CA's obligation to provide either normal recovery procedures or any other disaster recovery services described in this Agreement. HAI-CA shall not have the right to any additional payments from BSC as a result of its efforts to provide services during a Force Majeure Event.

19.15 Ongoing Obligation. Each party acknowledges and agrees to cooperate with and participate in good faith in the performance of the terms and conditions herein, including without limitation the timely delivery of all necessary information to the other party to allow the other party to perform and meet its obligations herein.

19.16 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be an original as regards to any party whose signature appears thereon (which may be by fax, followed up with hard copy, but effective upon fax), and all of which together shall constitute one and the same instrument. This Agreement shall become binding when one or more counterparts of it, individually or taken together, bear the signature of each of the parties.

19.17 Third Party Beneficiaries. The parties do not intend to confer and this Agreement shall not be construed to confer any rights or benefits to any person, firm, group, corporation or entity other than the parties.

HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA

By _____

Print Name Pamela Masters

Print Title President

Date 6/20/11

BLUE SHIELD OF CALIFORNIA

By _____

Print Name Juan C Davila

Print Title SNR VP Network Mgmt

Date 6-20-11

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SECOND ADDENDUM
TO THE
BEHAVIORAL HEALTH SERVICES AGREEMENT
BETWEEN
HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA
AND
BLUE SHIELD OF CALIFORNIA

This Second Addendum (this "Second Addendum") is entered into by and between California Physicians' Service, dba Blue Shield of California, a California, nonprofit mutual benefit corporation ("BSC"), and Human Affairs International of California, a California corporation ("HAI-CA"), and amends and supplements the terms of that certain Behavioral Health Services Agreement, with an original effective date of June 15, 2011, by and between BSC and HAI-CA, as supplemented and amended to date (the "Agreement"). Except as otherwise defined herein, all capitalized terms shall have the meaning ascribed to them in the Agreement.

RECITALS

A. The State of California recently enacted Section 1367.27 of the Health & Safety Code and Section 10133.15 of the Insurance Code (collectively "Provider Directory Statutes"), both of which require BSC to publish and maintain a provider directory (or directories) with information on contracting providers that deliver health care services to BSC's enrollees and insureds (collectively, "Enrollees").

B. BSC has delegated to HAI-CA the responsibility for maintaining HAI-CA's directory of Specialized Health Plan Providers (as defined below).

C. The Provider Directory Statutes obligate BSC to contractually require its contracted specialized health care service plans to comply with certain provisions that are required by BSC to satisfy the requirements for each of the providers that contract with the specialized health care service plan ("Specialized Health Plan Provider").

AGREEMENT

The parties hereto agree as follows:

1. HAI-CA shall create, maintain, and update provider directory(ies), in accordance with the Agreement, containing accurate and current information on Specialized Health Plan Providers that deliver services to Enrollees in compliance with the requirements of the Provider Directory Statutes for each BSC benefit program to which this Agreement applies.

2. HAI-CA shall publish and make available both electronic and paper copies of the directory(ies) to Enrollees and the general public in accordance with the requirements of the Provider Directory Statutes. Furthermore, HAI-CA shall distribute a paper copy of HAI-CA's directory(ies) to Enrollees, potential Enrollees, and the general public upon request.

3. HAI-CA's directory(ies) shall contain all Specialized Health Plan Provider information required by the Provider Directory Statutes, including, but not limited to: (a) the Specialized Health Plan Provider's name, practice location or locations, and contact information; (b) type of practitioner; (c) National Provider Number (NPI); (d) California license number and type of license; (e) the area of specialty, including board certification, if any; (f) the Specialized Health Plan Provider's office email address, if available; (g) the name of each affiliated provider group currently under contract with HAI-CA through which the Specialized Health Plan Provider sees Enrollees; (h) the names of each allied health care professional to the extent there is a direct contract for those services covered through a contract with HAI-CA; (i) for physicians, the admitting privileges, if any, at hospitals contracted with HAI-CA; (j) the non-English language, if any, spoken by a Specialized Health Plan Provider or by a qualified medical interpreter, if any, on Specialized Health Plan Provider's staff; (k) identification of Specialized Health Plan Providers who no longer accept new patients for some or all of HAI-CA's products; and (l) all other applicable information necessary to conduct a Specialized Health Plan Provider search.

4. The contract between HAI-CA and a Specialized Health Plan Provider shall include a requirement that the Specialized Health Plan Provider inform HAI-CA within five (5) business days when either of the following occur:

   (a) the Specialized Health Plan Provider is not accepting new patients;

   (b) if the Specialized Health Plan Provider had previously not accepted new patients, the Specialized Health Plan Provider is currently accepting new patients.

5. HAI-CA shall investigate and undertake corrective action within thirty (30) business days to ensure the accuracy of the directory(ies) if HAI-CA is informed of a possible inaccuracy in the provider directory. When investigating a report, HAI-CA shall, at a minimum, do the following: (a) contact the affected Specialized Health Plan Provider no later than five (5) business days following receipt of the report; (b) document the receipt and outcome of each report. The documentation shall include the provider's name, location, and a description of the plan's investigation, the outcome of the investigation, and any changes or updates made to its provider directory or directories; and (c) update HAI-CA's online Specialized Health Plan Provider directory(ies), as applicable, no later than the next scheduled weekly update, or, if inadequate time, the update immediately following that update, or sooner if required by federal law or regulations, and HAI-CA's printed Specialized Health Plan Provider directory(ies), as applicable, no later than the next required update, or sooner if required by federal law or regulations.

6. It is the responsibility of HAI-CA to ensure the accuracy of provider directory information for each Specialized Health Plan Provider and update the online directory(ies) at least weekly, or more frequently, if required by federal law, and printed directory(ies) at least quarterly, or more frequently, if required by federal law, in accordance with requirements of the Provider Directory Statutes.

7. HAI-CA shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in HAI-CA's directory(ies) in accordance with the Provider Directory Statutes.

8. HAI-CA's directory(ies) shall include both an email address and a telephone number for members of the public and Specialized Health Plan Providers to notify the plan if the provider directory(ies) information appears to be inaccurate. This information shall be disclosed prominently in the directory(ies) and on HAI-CA's Internet Web site.

9. HAI-CA's directory(ies) shall include disclosures informing Enrollees that they are entitled to both of the following: (a) language interpreter services, at no cost to the Enrollee, including how to obtain interpretation services in accordance with the Provider Directory Statutes; and (b) full and equal access to Covered Services, including Enrollees with disabilities as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

10. In accordance with the Provider Directory Statutes, HAI-CA shall notify Specialized Health Plan Providers at least once every six months and comply with all provider notification requirements of the Provider Directory Statutes.

11. HAI-CA shall remove Specialized Health Plan Providers from the directory(ies) as required by the Provider Directory Statutes and notify BSC of the removals.

12. HAI-CA shall ensure processes are in place to allow Specialized Health Plan Providers to promptly verify or submit changes to information to be in the directory(ies) pursuant to the requirements in the Provider Directory Statutes. Those processes shall, at a minimum, include an online interface for Specialized Health Plan Providers to submit verification or changes electronically and shall generate an acknowledgment of receipt from HAI-CA. Specialized Health Plan Providers shall verify or submit changes to information required to be in the directory or directories pursuant to the Provider Directory Statutes using the process required by HAI-CA.

13. HAI-CA shall cooperate with BSC in making the HAI-CA's directory(ies) available via a link on BSC's website.

14. Notwithstanding anything in the Agreement to the contrary, failure to comply with the requirements of the Provider Directory Statutes shall be deemed a material breach of the Agreement.

15. HAI-CA shall notify BSC immediately, in writing, of any enforcement action taken by, or deficiencies cited by, the Department of Managed Health Care or the California Department of Insurance related to HAI-CA's compliance with the Provider Directory Statutes.

16. When executed by both parties, this Second Addendum shall be effective as of July 1, 2016. Except as specifically set forth in this Second Addendum, all other conditions contained in the Agreement shall continue in full force and effect. After the effective date of this Second

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Addendum, any reference to the Agreement shall mean the Agreement as supplemented by this Second Addendum. Notwithstanding anything to the contrary in the Agreement, in the event of a conflict between the terms and conditions of this Second Addendum and those contained within the Agreement, the terms and conditions of this Second Addendum shall prevail.

15. This Second Addendum may be executed in one or more counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

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

BLUE SHIELD OF CALIFORNIA

Signature: Armine Papouchian

Print Name: Arminé Papouchian, MBA, FLMI

Title: Vice President, Provider Contracting, Relations and Analytics

Date: 9/30/16

HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA

Signature: Richard T. Clarke

Print Name: Richard T. Clarke

Title: CEO

Date: 9/26/16