PRIMARY HOSPITAL SERVICES AGREEMENT BETWEEN THE SANTA CRUZ/MONTEREY MANAGED MEDICAL CARE COMMISSION AND NATIVIDAD MEDICAL CENTER

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This Primary Hospital Services Agreement ("Agreement") is entered into and is effective as of this 1st day of July, 2007 ("Effective Date") between the Santa Cruz/Monterey Managed Medical Care Commission, a public entity organized under the laws of the State of California, doing business as the Central Coast Alliance for Health ("Plan"), and Natividad Medical Center, a County Hospital ("Contractor").

RECITALS

A. Plan has entered into or will enter into a contract or contracts with the State of California Department of Health Services ("DHS") under which Santa Cruz and Monterey County Medi-Cal beneficiaries will receive, through Plan, all specified health care services ("State Medi-Cal Contract").

B. Plan has entered into or may enter into a contract or contracts with the State of California or other entities under which Plan agrees to arrange for the provision of health care services to other covered individuals ("Other Membership Contracts"). Other Membership Contracts are specifically described in Exhibit 3, including but not limited to Covered Benefits, exclusions, Copayments, Emergency Services, Self-Referral Services and payment for Other Members.

C. Plan desires to arrange for the provision of certain health care services to Members by contracting with providers, such as Contractor. Contractor desires to provide Services to Members in accord with the terms of this Agreement.

NOW THEREFORE, the parties agree as follows:

1.0 DEFINITIONS

1.1 **ALLIED HEALTH SERVICE PROVIDER** means any qualified health care provider who has executed an agreement with Plan to provide health care services to Members, and who is not a Physician, Hospital, Skilled Nursing Facility or Intermediate Care Facility.

1.2 **APPROVAL** means the process of claims approval by Plan after the provision of Emergency or Self-Referral Services as set forth in Section 2.5.

1.3 **ATTENDING PHYSICIAN** shall mean (a) any physician who is acting in the provision of Emergency Services to meet the medical needs of the Member or (b) any physician who is, through delegation from the Member's Primary Care Physician, actively engaged in the treatment or evaluation of a Member's condition.

1.4 **AUTHORIZATION** means the process of prior written approval for the provision of Non-Emergency, Non-Self-Referral Services as set forth in Section 2.6.

1.5 **CASE MANAGEMENT** shall mean providing or approving all Covered Benefits including health assessments, identification of risks, initiation of intervention and health education deemed medically necessary, consultation, referral for consultation and additional health care services; coordination of Medically Necessary Covered Services; maintenance of a medical record with documentation of referral services, and follow-up as medically indicated; ordering of therapy, admission to hospitals, coordinated hospital discharge planning that includes necessary post-discharge care, and referral to services. Case Management includes the responsibility for organizing a pattern of supportive medical resources, so that Members may be appropriately served by medical advice and supervision seven (7) days each week and twenty-four (24) hours per day.

1.6 **COPAYMENTS** are amounts, if any, payable by Members pursuant to the Membership Contracts. There are no copayments payable by Medi-Cal Members pursuant to the State Medi-Cal Contract. Contractor shall not charge any copayments to Medi-Cal Members.

1.7 **COVERED BENEFITS** are the Medically Necessary health care services and benefits which Members are entitled to receive, provided by and through Plan, under the Membership Contracts. Currently, Covered Benefits for Medi-Cal Members as set forth in the State Medi-Cal Contract are medical case management services and all Medically Necessary services set forth in Title 22 of the California Code of Regulations ("CCR"), Division 3, Subchapter 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6842, and certain health assessment and health screening services set forth in the Provider Manual, subject to the exceptions set forth in Section 2.3.

1.8 **COVERED SERVICES** are those Services rendered by Contractor to Members that are (a) Covered Benefits and are (b) Authorized or Approved.

1.9 **DAYS.** Any reference to "days" in this Agreement shall mean calendar days, unless otherwise noted.

1.10 **EMERGENCY SERVICES** shall mean those health care services required by Members that are defined as emergency services in the Membership Contracts. For Medi-Cal Members, emergency services are health care services needed to evaluate or stabilize a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (i) placing the health of Member (or in the case of a pregnant Member, the health of the Member or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. According to California Health and Safety Code Section 1317.1, emergency services and care include (i) screenings, examinations and evaluations for the purpose of determining whether a psychiatric emergency medical condition exists and (ii) the treatment necessary to relieve or eliminate the psychiatric emergency medical condition.

1.11 **FISCAL YEAR OF PLAN** shall mean each twelve (12) month period between January 1st and December 31st.

1.12 **HOSPITAL** shall mean a Primary Hospital or a Limited Service Hospital.

1.13 **IDENTIFICATION CARD** shall mean the card which is prepared and issued by Plan and which bears the name of Plan and contains: Member name and identification number, Member's Primary Care Physician and other identifying data. The card is not proof of Member eligibility.

1.14 **INPATIENT HOSPITAL SERVICES** are Services provided to a Member who is admitted as a registered bed patient in a Hospital. Inpatient Hospital Services shall exclude physician services, unless listed as inclusions in the Hospital's agreement with Plan.

1.15 **INPATIENT DAY** is the twenty-four (24) hour period or portion thereof, ending at midnight in which a Member is receiving Inpatient Hospital Services, including the day of admission, but excluding the day of discharge or death; provided, however, there shall be at a minimum one (1) Inpatient Day for each Member admission for Inpatient Hospital Services.

1.16 **LIMITED SERVICE HOSPITAL** shall mean any hospital which is under contract to Plan, but not as a Primary Hospital.

1.17 **MEDI-CAL PROVIDER MANUAL** shall mean the provider manual of DHS, issued by DHS's Fiscal Intermediary, which is applicable to the type of Services provided by Contractor.

1.18 **MEDI-CAL RATES** shall mean the schedule of Medi-Cal maximum fee-for-service allowances and rates of payment for health care services in effect for California's Medi-Cal fee-for-service program at the time the services were rendered.

1.19 **MEDICAL DIRECTOR** shall mean the medical director of Plan, a physician licensed to practice medicine in the State of California and retained by Plan to monitor the quality assurance and review responsibilities of Plan, or the designee of the medical director.

1.20 **MEDICALLY NECESSARY** means reasonable and necessary Services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

1.21 **MEMBER** refers to a covered individual entitled to health care services under the Membership Contracts. Members include Medi-Cal Members and Other Members. Medi-Cal Members include Santa Cruz Medi-Cal Members and Monterey Medi-Cal Members.

(a) Santa Cruz Medi-Cal Member shall mean any person certified as eligible for Medi-Cal, pursuant to the California Welfare and Institutions Code, who has been determined to be eligible to receive Medi-Cal benefits by the Santa Cruz County Social Services Department or the Social Security Administration and who is a resident of Santa Cruz County, whose Member I.D. number contains Santa Cruz County Code Number 44 as the

first two numbers and whose aid code is included for capitation payment in the State Medi-Cal Contract. A newborn of a Santa Cruz Medi-Cal Member is covered under the mother's membership for the month of birth and the following calendar month. A newborn born in the month immediately preceding the mother's enrollment as a Santa Cruz Medi-Cal Member is covered under the mother's membership during the mother's first month of enrollment.

(b) Monterey Medi-Cal Member shall mean any person certified as eligible for Medi-Cal, pursuant to the California Welfare and Institutions Code, who has been determined to be eligible to receive Medi-Cal benefits by the Monterey County Social Services Department or the Social Security Administration and who is a resident of Monterey County, whose Member I.D. number contains Monterey County Code Number 27 as the first two numbers and whose aid code is included for capitation payment in the State Medi-Cal Contract. A newborn of a Monterey Medi-Cal Member is covered under the mother's membership for the month of birth and the following calendar month. A newborn born in the month immediately preceding the mother's enrollment as a Monterey Medi-Cal Member is covered under the mother's membership during the mother's first month of enrollment.

Members are categorized as either Case Managed Members or Administrative Members. "Case Managed Members" include all Members who are managed by a Primary Care Physician. "Linked Members" are the Primary Care Physician's own Case Managed Members. "Administrative Members" include all Members determined by Plan to be inappropriate for inclusion in the regular Primary Care Physician Case Management system. Administrative Members are those Members who are Case Managed (either on a temporary or permanent basis) by the Medical Director. Some examples are: share of cost members, foster children living out of area, newly eligible members and retroactively eligible members.

1.22 **MEMBERSHIP CONTRACTS** refers to the State Medi-Cal Contract and any other contracts, as amended from time to time, under which Plan has agreed to arrange for the provision of health care services to covered individuals. Membership Contract includes the evidence of coverage issued to a Member, as amended from time to time.

1.23 **NON-PHYSICIAN MEDICAL PRACTITIONER** shall mean physician assistant, nurse practitioner, certified nurse specialist or certified nurse midwife who is under the supervision of a Physician.

1.24 **OTHER SERVICES** shall mean Covered Benefits not included as Primary Care Physician, Referral Physician and Inpatient Hospital Services.

1.25 **OUT-OF-AREA** shall mean the geographic area outside of Santa Cruz and Monterey Counties.

1.26 **PHYSICIAN** shall mean either an Attending Physician, a Referral Physician or a Primary Care Physician.

1.27 **PRIMARY CARE PHYSICIAN** shall mean a physician or group of physicians who have executed an agreement with Plan, to provide primary care physician services. Primary Care Physicians must be general practitioners, family practitioners, internists, obstetricians/gynecologists, pediatricians, or another specialty approved by Plan and DHS.

1.28 **PRIMARY CARE PHYSICIAN SERVICES** shall mean those services provided to Case Managed Members by a Primary Care Physician.

1.29 **PRIMARY HOSPITAL** shall mean any hospital which is under contract to Plan, with which Primary Care Physicians are affiliated by virtue of their agreement with Plan, and which is designated as a Primary Hospital by Plan.

1.30 **PROVIDER** shall mean any health care professional or institution certified to render services to Members and contracted with Plan. "Out-of-Plan Provider" means any health care professional or institution certified to render services to Members and not contracted with Plan.

1.31 **PROVIDER MANUAL** refers to the Plan manual which sets forth operational policies and procedures including but not limited to, authorization, approval, referral, cultural and linguistic Services, utilization management, quality assurance and improvement, notification and transfer, health assessment and screening, Member grievances, billing, coordination of benefits, reporting, credentialing, medical records, care and access standards, provider training and dispute resolution requirements. The Provider Manual is the Medi-Cal Provider Manual as specifically modified by Plan.

1.32 **REFERRAL AUTHORIZATION FORM** or "RAF" shall mean the referral authorization form or number evidencing a referral by the Member's Primary Care Physician, his or her designee or the Medical Director, to render Non-Emergency, Non-Self-Referral Services to Members. Those Non-Emergency, Non-Self-Referral Services that require a referral authorization form are set forth in the Provider Manual.

1.33 **REFERRAL PHYSICIAN** shall mean any qualified physician who has executed an agreement with Plan to provide referral physician services, to whom a Primary Care Physician may refer any Member for consultation or treatment.

1.34 **REFERRAL PHYSICIAN SERVICES** shall mean any services provided by Physicians which are not Primary Care Physician Services, and which are provided by physicians on referral from a Primary Care Physician or are provided by a Primary Care Physician.

1.35 **SANTA CLARA MEDICARE RATE** shall mean the schedule of Medicare maximum fee-for-service allowances and rates of payment for health care services based on the Resource Based Relative Value Scale ("RBRVS") in effect for the federal Medicare Program in Santa Clara County (California locality 9) at the time when the services were rendered.

1.36 **SELF-REFERRAL SERVICES** refers to Services in addition to Emergency Services that Members are allowed to access without an Authorization, as set forth in the Membership Contracts. For Medi-Cal Members, Self-Referral Services include optometry, chiropractic, acupuncture, podiatry, prayer, spiritual healing and sensitive services. Exhibit 3 describes Self-Referral Services with respect to Other Members. Self-Referral Services are subject to utilization controls as specified under the Medi-Cal program.

1.37 **SERVICES** refers to those health care services and supplies, of the type listed in Exhibit 1 that Contractor is licensed to provide and does customarily provide in all applicable treatment settings, including all consults, studies and procedures that are ordinary and necessary for the diagnosis and treatment of Members. Services include all administrative services provided by Contractor pursuant to this Agreement. Services also include all services set forth in Exhibit 1 that are provided directly by Contractor or indirectly by Contractor through a subcontractor.

1.38 **SKILLED NURSING OR INTERMEDIATE CARE FACILITY** shall mean a skilled nursing or intermediate care facility that has executed an agreement with Plan. Services provided by such facilities shall be included as Other Services.

1.39 **STATE OF CALIFORNIA MEDICARE RATE** shall mean the schedule of Medicare maximum fee-for-service allowances and rates of payment for health care services based on the Resource Based Relative Value Scale ("RBRVS") in effect for the federal Medicare Program in the State of California at the time when the services were rendered.

1.40 **TREATMENT AUTHORIZATION REQUEST FORM** or "TAR" means the treatment authorization request form approved by Plan for the provision of Non-Emergency, Non-Self-Referral Services. Those Non-Emergency, Non-Self-Referral Services that require a treatment authorization request form approved by Plan are set forth in the Provider Manual.

2.0 SERVICE OBLIGATIONS

2.1 PRIMARY CARE PHYSICIAN ASSIGNMENT, CASE MANAGEMENT, PATIENT LOAD.

(a) At the time of determining Medi-Cal eligibility, Plan will request each person determined to be a Case Managed Member to select from among those Primary Care Physicians contracting with Plan who are accepting Members. If no selection is made, Plan shall assign Members to a Primary Care Physician in a systematic manner in accordance with Plan policies. Plan will notify all Linked Members if the Member's Primary Care Physician is terminated or terminates so that Linked Members may choose a new Primary Care Physician as soon as practicable. Members may also change their assigned Primary Care Physician upon request, in accordance with Plan's policies.

(b) The Member's Primary Care Physician shall be the sole source of primary medical contact and advice for the Member and shall provide or authorize the referral for all Medically Necessary health care services, except for Emergency Services, Self-Referral Services and excluded Services. The Member's Primary Care Physician shall be responsible for the Member's Case Management until the time such Member's Primary Care Physician is changed in accordance with Plan's policies. The Member's Primary Care Physician shall have the right to refer the Member to any Referral Physician or Allied Health Service Provider. The Provider to whom the Primary Care Physician has delegated the authority to proceed with treatment or the use of resources, shall be responsible for monitoring all medical advice and services performed or prescribed by such Provider for the Member. Such Providers shall furnish a complete report in a timely manner to each Primary Care Physician of all services rendered to the Primary Care Physician's Linked Members.

(c) Each individual primary care physician shall serve at least one hundred (100) Members, unless excepted by Plan. Each Primary Care Physician may designate the maximum number of Members such physician shall serve; provided, however, there shall be at least one FTE primary care physician for every two thousand (2,000) Members. In addition, each individual primary care physician shall maintain an active patient load of no more than two thousand (2,000). Active patients are those patients seen one or more times in a twelve (12) month period. A Primary Care Physician may request that only current patients be included as Linked Members. Otherwise, the Primary Care Physician agrees to accept as patients all Members who have selected or been assigned to the Primary Care Physician, up to the maximum number of Members designated by the Primary Care Physician, without regard to the health status or health care needs of such Members. In addition, a Primary Care Physician may not request Member assignment changes due to a Member's medical condition requiring increased care. Providers shall not be required to accept Members for care if, in the reasonable professional judgment of the Provider, accepting additional Members would endanger Members' access to, or continuity of, care.

2.2 SERVICES TO BE PROVIDED BY CONTRACTOR.

(a) In General. Contractor shall during normal business hours and through licensed physicians and other health care Practitioners (defined in Section 7.3), provide Services to Members that are Authorized, unless such Services are Emergency Services or Self-Referral Services. Contractor shall verify a Member's eligibility with Plan prior to rendering Non-Emergency Services. Referral authorization from a Primary Care Physician is not a guarantee of eligibility. Contractor shall make Services available to Members in the same manner, in accordance with the same standards, and with the same availability, as to its other patients. Contractor shall ensure that Services provided under this Agreement are readily available and accessible, appropriate, provided in a prompt and efficient manner without delays in terms of wait times or scheduling of appointments, and consistent with professionally recognized standards of practice. Referrals to other Providers shall be made on a timely basis. Appropriate care shall not be withheld or delayed for any reason, including a potential financial gain and/or incentive to Contractor, and/or others. Contractor shall have staffing in health care services and in fiscal and administrative services sufficient to result in the effective conduct of its business. Medical decisions shall not be unduly influenced by fiscal and administrative personnel,

policies or considerations. Contractor shall follow the clinical standards and practice guidelines for preventive and other health care Services as set forth in the Provider Manual. Contractor shall be available to provide to Members or arrange for Members prompt urgent Services that are Authorized, on a same-day basis when medically indicated. Contractor shall be available to provide or arrange for the provision of Services that are Emergency Services twenty-four (24) hours per day, seven (7) days per week.

(b) Cultural and Linguistic Services. Contractor shall provide Services to Members in a culturally and linguistically appropriate manner, as set forth in the Provider Manual. Contractor shall recognize and integrate Members' practices and beliefs about disease causation and prevention into the provision of Covered Services. Contractor shall comply with any language assistance standards developed under California Health and Safety Code Section 1367.04 and shall cooperate with Plan by providing any information necessary to assess compliance. Linguistic services obligations are further described in the Provider Manual.

(c) Credentialing. Contractor will provide Services through physicians and other health care professionals who are credentialed as set forth in Section 7.3. Contractor shall notify Plan of the physicians and other health care professionals that will be providing Services to Members, and any changes to such Practitioners; provided, however, all such Practitioners must be credentialed as set forth in Section 7.3 before providing Services to Members.

(d) Location of Services. Contractor shall provide Services at the location set forth on the signature page, unless Contractor notifies Plan of a different or additional location. Such location(s) shall be in Santa Cruz or Monterey county, unless excepted by Plan.

(e) Non-Physician Medical Practitioner Limits. If Contractor provides Services through Non-Physician Medical Practitioners, the number of Non-physician Medical Practitioners who may be supervised by a single Physician shall be limited to the FTE of one of the following: (i) Four (4) nurse practitioners; (ii) Three (3) nurse midwives; (iii) Two (2) physician assistants; or (iv) Four (4) of the above individuals in any combination which does not exceed the limit stated in either subsection (ii) or (iii).

(f) Pharmaceuticals. If Contractor is licensed to prescribe drugs and medications, Contractor shall prescribe drugs and medications in accord with all applicable laws, including but not limited to Title 22 CCR Section 53214, and in accord with Plan's drug formulary. Plan's drug formulary is the Medi-Cal drug contract list, as specifically modified by Plan. When Contractor provides Emergency Services to a Medi-Cal Member and such Member's treatment requires the use of drugs, Contractor shall provide a sufficient quantity of drugs to the Member until the Member can reasonably be expected to have a prescription filled.

2.3 COVERED BENEFITS.

Covered Benefits are the Medically Necessary health care services and benefits which Members are entitled to receive, provided by and through Plan, under the Membership Contracts. Currently, Covered Benefits for Medi-Cal Members as set forth in the State Medi-Cal Contract

are medical case management services and all Medically Necessary services set forth in Title 22 of the California Code of Regulations ("CCR"), Division 3, Subchapter 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6842, and certain health assessment and health screening services set forth in the Provider Manual, except the following excluded services:

(a) Dental Services, as defined in Title 22 CCR Section 51307 and Early Periodic Screening, Diagnosis and Treatment supplemental dental services as described in Title 22 CCR Section 51340.1(a). However, medical services necessary to support dental services are Covered Benefits for Medi-Cal Members and are not excepted;

(b) Home and community based services as defined in Title 22 CCR Section 51176, Multipurpose Senior Services as defined in the California Welfare and Institutions Code Section 9400 et seq., Adult Day Health Care Services as defined in Title 22 CCR Section 54001, Pediatric Day Health Care Services as defined in Title 22 CCR Section 51184(j), alcohol and drug treatment program services (including outpatient heroin detoxification), and Local Education Authority Services as defined in Title 22 CCR Sections 51360 and 51190.4, all as described in the State Medi-Cal Contract;

(c) Short-Doyle/Medi-Cal mental health services (inpatient and outpatient), Medi-Cal fee-for-service mental health services (inpatient and outpatient); provided, however, the following are Covered Benefits for Medi-Cal Members and are not excepted:

(i) outpatient mental health services within the Primary Care Physician's scope of practice, (ii) emergency room professional services except services provided by specialty mental health providers, (iii) facility charges for emergency room visits which do not result in a psychiatric admission, (iv) laboratory, radiological and radioisotope services necessary for the diagnosis, monitoring or treatment of a Medi-Cal Member's mental health condition, (v) emergency medical transportation for emergency mental health services, (vi) certain prescribed non-emergency medical transportation services to access mental health services, (vii) initial health history and physical assessments required upon admission for psychiatric inpatient hospital stays and consultations related to Medically Necessary Covered Services, and (viii) psychotherapeutic drugs that are covered by the Medi-Cal Program and that are not excluded by the State Medi-Cal Contract.

(d) California Children's Services ("CCS") as set forth in the State Medi-Cal Contract;

(e) Services rendered in a State or Federal governmental hospital;

(f) Laboratory services provided under the State serum alphafeto protein testing program administered by the Genetic Disease Branch of the Department of Health Services;

(g) Fabrication of optical lenses;

(h) Targeted Case Management Services as specified in Title 22 CCR Sections 51185 and 51351;

(i) Direct Observed Therapy for tuberculosis;

(j) Personal Care Services as defined in Title 22 CCR Sections 51183 and 51350;

(k) Childhood lead poisoning case management services provided by the Local Health Department; and

(l) Certain Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS), and psychotherapeutic drugs as set forth in the State Medi-Cal Contract.

2.4 SUBCONTRACTS.

If Contractor arranges for the provision of some Services from other health care providers, Contractor shall obtain written arrangements with such providers, specifying that the providers shall (i) seek payment only from Contractor, not from Plan, and not from the Member as set forth in Section 3.4, (ii) maintain and disclose records and other information as set forth in Article 5, (iii) abide by the nondiscrimination and confidentiality of information provisions set forth in Sections 7.2 and 5.6, respectively, (iv) maintain insurance as set forth in Section 6.1, (v) comply with laws and credentialing requirements as set forth in Article 7, (vi) comply with the dispute resolution provisions set forth in Article 8, and (vii) comply with all other applicable provisions of this Agreement. Upon termination of this Agreement, such subcontracts shall terminate with respect to Covered Services provided to Members. Upon request, Contractor shall make such written agreements available to Plan and Government Officials, for review and approval.

2.5 APPROVAL OF EMERGENCY AND SELF-REFERRAL SERVICES CLAIMS.

Subject to applicable law, Contractor shall notify the Member's Primary Care Physician of any Emergency Services provided to a Member immediately upon stabilization of the Member's emergency medical condition. Plan shall review Emergency and Self-Referral Services claims and if approved, such claims shall be deemed "Approved". Compensation for Emergency or Self-Referral Services provided to Members is payable to Contractor only if the Emergency or Self-Referral Services are determined by Plan to be Covered Benefits and there is an Approved claim. Approval procedures are further described in the Provider Manual.

2.6 PRIOR AUTHORIZATION.

Except for Emergency and Self-Referral Services, Contractor shall obtain the following authorization prior to providing Services to Members: (a) a RAF from the Member's Primary Care Physician or his or her designee, and (b) a TAR approved by Plan (if required by Plan) ("Authorization"). The RAF and TAR outline the scope of such Services to be provided. Any Services, including tests, procedures, consulting services, and hospital services, not specifically described in the RAF and TAR (if required), must be Authorized in advance. Except when

Services are Emergency or Self-Referral Services, compensation for Services provided to Members is payable to Contractor only if such Services are Covered Benefits and have been Authorized prior to provision. Contractor shall verify a Member's eligibility with Plan prior to rendering Non-Emergency Services. Authorization is not a guarantee of eligibility. Authorization procedures are further described in the Provider Manual.

2.7 UTILIZATION MANAGEMENT.

Contractor hereby acknowledges that Plan conducts utilization management and review ("UM") programs regarding the care provided to Members. Contractor shall participate in, and cooperate and comply with the provisions of Plan's UM programs and its policies and procedures as set forth in the Provider Manual, including prospective, concurrent and retrospective review by Plan's UM committees and staff. Upon reasonable notification, Contractor shall allow Plan UM personnel, or their designees, physical and telephone access to review, observe and monitor Member care and Contractor's performance of its obligations under this Agreement.

2.8 QUALITY ASSESSMENT AND IMPROVEMENT.

(a) Contractor hereby acknowledges that the quality assessment and improvement programs of Plan require Plan to monitor the quality assessment and improvement activities of contracting providers. Contractor agrees to (i) participate in Plan's quality assessment and improvement programs as set forth in the Provider Manual, including review by Plan's quality assurance and improvement committees and staff, (ii) abide by Plan's quality assessment and improvement plan as set forth in the Provider Manual, and (iii) cooperate with Plan to objectively monitor and evaluate the quality of services provided at Contractor's location(s), including, but not limited to, the availability, accessibility, acceptability, and continuity of such care.

(b) Contractor shall investigate and respond immediately to all quality issues, and shall work with Plan to resolve any accessibility and other quality issues related to Services provided to Members. Contractor will remedy, as soon as reasonably possible, any condition related to patient care which has been determined by Plan, or any governmental or accrediting agency to be unsatisfactory. The parties shall work together to continuously assess and improve the quality and accessibility of care provided to Members and to resolve problems related to the provision of Services.

(c) Contractor will provide information for use in quality assessment and improvement activities conducted by Plan, including but not limited to Provider and patient specific information. Plan will protect the confidentiality of such information to the extent required under State and Federal law. Contractor does not waive its rights to confidentiality protections provided under State or federal law, including California Evidence Code Section 1157. Upon request, Contractor shall provide data, information and records which is required by regulatory or accrediting organizations. Contractor will provide Plan access to all patient care protocols, policies and procedures, and any modifications, upon request.

(d) Contractor shall permit Plan, Government Officials and any other regulatory and accrediting agencies with reasonable notice, during normal business hours, to interview employees, to inspect, audit, evaluate and review Contractor's location(s) (including security areas), information systems, software and documentation and to inspect and copy books, records, accounts and other materials relevant to the provision of services under this Agreement. Contractor will provide any necessary cooperation and assistance during such inspections and reviews. Contractor shall allow such inspections and reviews for the Records retention time period set forth in Section 5.1. Contractor will participate in all utilization management, quality assessment and improvement, credentialing, recredentialing, peer review and any other activities required by Plan, Government Officials and any other regulatory and accrediting agencies. The State reserves the right to conduct unannounced validation reviews to verify compliance with the State's contract requirements.

(e) Access to information under this Agreement shall be subject to all federal and state laws concerning the confidentiality of patient information.

(f) Plan's duty hereunder does not relieve Contractor of any duty of care to provide Members with Services in accord with the appropriate standard of care.

2.9 NOTIFICATION OF CHANGES.

If Contractor decides to cease providing or suspend any Service or reduce the hours at any of its locations, then Contractor shall notify Plan in writing at least ninety (90) days prior to any such cessation, suspension or reduction. Contractor will notify Plan immediately of any changes in operation, emergency conditions or factors such as limited capacity that may significantly affect Services provided to any Member or that may impair Contractor's ability to perform its obligations under this Agreement. Contractor shall notify Plan immediately of any event which materially alters Contractor's financial situation or threatens its solvency. Contractor shall notify Plan promptly of any material change in ownership, control, legal status, name, location, telephone number, tax identification number, Medicare or Medi-Cal number. Any material change of ownership or control is subject to the requirements of Section 9.3.

2.10 PROVIDER MANUAL COMPLIANCE AND MODIFICATION.

Contractor shall comply with administrative requirements set forth in the Provider Manual. Contractor acknowledges that Contractor has received a copy of the Provider Manual at least 15 business days prior to executing this Agreement. Plan may modify the Provider Manual from time to time as set forth in Section 9.5 (c). The Provider Manual as so amended is incorporated herein by reference. In the event the provisions in the Provider Manual, as amended from time to time, are inconsistent with the terms of this Agreement, the terms of this Agreement shall prevail.

2.11 CONSULTATION WITH MEDICAL DIRECTOR.

Contractor may at any time seek consultation with Plan's Medical Director on any matter concerning the treatment of a Member.

2.12 COORDINATION REGARDING NON-COVERED SERVICES.

(a) Contractor shall identify and refer Members with CCS eligible conditions to the local CCS Program, CCS paneled providers, or CCS certified facility. Authorization for services for CCS eligible conditions must be obtained from CCS. Contractor shall promptly inform Plan of such referrals. Procedures for such referrals are outlined in the Provider Manual.

(b) Contractor shall provide assistance to Medi-Cal Members needing specialty mental health services by referring such Medi-Cal Members to the local Medi-Cal mental health plan. If the Medi-Cal mental health plan is not operational or if the Medi-Cal Member's diagnosis is not covered by the local Medi-Cal mental health plan, Contractor shall refer such Member to other appropriate community resources. Contractor shall coordinate services with the Medi-Cal Member's mental health provider, as appropriate.

(c) When applicable, Contractor shall assist Members in obtaining services that are not Covered Services, including but not limited to, coordinating care or referring Members to public programs for which the Member may be eligible.

2.13 STAFF PRIVILEGES.

No Physician shall be entitled to admit, or treat, or prescribe for a Member in a Hospital if the Physician is not a member in good standing of the Hospital's medical staff with appropriate clinical privileges to admit and treat Members in the Hospital. Each Hospital shall expeditiously review, consider and reach a conclusion on any applications for medical staff membership or clinical privileges from Physicians contracted with Plan who are not members of the Hospital's medical staff, in accordance with the Hospital's medical staff bylaws, and all applicable rules and regulations, and on the same substantive basis as applications by other licensed physicians. Each Hospital shall notify Plan when it revokes or materially modifies the privileges of any contracting Physician. Written notification shall be submitted to Plan at the time of the occurrence. No contracting Physician shall be entitled to admit, treat, or prescribe for a Member in a Skilled Nursing Facility or an Intermediate Care Facility who has not met the applicable rules and regulations of such facility.

2.14 DISCHARGE PLANNING AND TRANSFER.

Hospitals, Skilled Nursing Facilities and Intermediate Care Facilities ("Facilities") shall provide discharge planning services for Members. Facilities shall cooperate with Plan to assure timely and appropriate discharge of Members. Discharge planning services shall begin upon the Member's admission and shall be completed by the medically appropriate discharge date. Facilities shall provide to Plan, upon request, documentation of the discharge planning process, including a written discharge summary. Should a Facility contemplate discharging a Member,

such Facility will notify Plan to identify alternative care options, if necessary. In no instance will a Facility cease providing Services to a Member until an alternative care provider has been identified (if necessary), approved by Plan, and appropriate transfer of care arranged. Contractor shall participate in and abide by Plan's notification and transfer obligations as set forth in the Provider Manual.

3.0 BILLING AND PAYMENT

3.1 CLAIM FORMAT AND SUBMITTAL.

Contractor shall submit to Plan all claims for Services rendered to Members. Claims shall be submitted within one (1) year of the provision of such Services and in accordance with the billing procedures set forth in the Provider Manual, as a condition for payment; provided, however, if Plan is the secondary payor, coordination of benefits claims may be submitted within ninety (90) days after the primary payor's date of payment or date of contest, denial or notice, if such period is longer than one (1) year. Plan may deny payment for any claims not submitted to Plan by Contractor within the time period set forth above and in accordance with the billing procedures set forth in the Provider Manual, unless Contractor submits a dispute pursuant to Section 8.1 and shows good cause for the delay.

3.2 PAYMENT OF COMPENSATION.

In accordance with the provisions of Article 3 "Billing and Payment" and Exhibits 2 and 3 of this Agreement, Plan shall pay Contractor for Covered Services rendered to Members. Contractor shall accept such amounts paid by Plan and any applicable Copayments, as payment in full. Emergency and Self-Referral Services must be Approved and other Services must be Authorized as a condition for payment. Payment for Covered Services shall be made within thirty (30) days of receipt of a properly submitted claim as described in Section 3.1.

3.3 ADJUSTMENTS TO PAYMENT RATE.

Plan may review and audit any and all claims, prior to or subsequent to payment, to ensure that coding complies with commonly accepted standards adopted by Plan, that services rendered are appropriate and Medically Necessary, and that payment is in accord with this Agreement. If Plan determines that services rendered are inappropriate or not Medically Necessary, coding practices do not comply with Plan standards, or payment is not in accord with the terms of this Agreement, Plan reserves the right to deny, reduce or otherwise adjust payment to Contractor. If an audit conducted by Plan shows that Contractor owes monies to Plan, Plan shall send a written request for reimbursement to Contractor within three hundred and sixty-five (365) days of the date of claim overpayment. Such time limit shall not apply if the overpayment was caused by Contractor's fraud or misrepresentation. The request for reimbursement will identify the claim, the Member, the date of Service and the reasons why the amount paid was in excess of the amount due. If Contractor does not contest Plan's request for reimbursement of the claim overpayment, then Contractor shall reimburse Plan within thirty (30) working days of receiving the request. After such period, Contractor authorizes Plan to offset the uncontested notice of overpayment from Contractor's current claims submissions. If Contractor contests the request for reimbursement of the claim overpayment, then Contractor shall send a written notice to Plan

stating the basis for which the claim was not overpaid and the parties shall resolve the matter through the provider dispute resolution mechanism set forth in Section 8.1.

3.4 BILLING OTHER SOURCES.

(a) Contractor shall look solely to Plan (or another responsible payer) for compensation for Covered Services rendered to Members under this Agreement, and, except as expressly provided in this Section, Contractor agrees that in no event, including but not limited to non-payment by Plan, insolvency of Plan or breach of this Agreement, shall Contractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, a person acting on the Member's behalf, Santa Cruz County, Monterey County, any entity which holds a Membership Contract with Plan, or the State of California for Services provided pursuant to this Agreement. Contractor shall not seek payment from Members for amounts denied by Plan because clinical data was not submitted promptly, or because Contractor did not submit the claim in accordance with the time limits or other billing procedures set forth in Section 3.1, or in accordance with commonly accepted standard coding practices adopted by Plan. Except for applicable Copayments, Contractor shall not invoice or balance bill a Member for the difference between Contractor's billed charges and the reimbursement paid by Plan for any Covered Service.

(b) Contractor may assert claims for compensation other than claims against Plan as set forth in subsection (a) above, in the following circumstances:

(i) Copayments payable, if any. Contractor shall not collect Copayments from Medi-Cal Members.

(ii) Other Coverage. If a Member is entitled to benefits under other health benefits coverage and such coverage is primary, Contractor will coordinate benefits in accord with Section 3.5 of this Agreement.

(iii) Services After Coverage Exhausted or No Coverage. If a Member elects to continue receiving Services after such Member's coverage has been exhausted, or Plan determines in its sole discretion that such Services are not Covered Benefits, then Contractor shall seek compensation solely from such Member (or such Member's representative) for such Services, or if the Member is not legally responsible for such Services, Contractor shall seek compensation from the legally responsible entity.

(c) Contractor shall not bill or collect from a Member any charges in connection with Services, even though such Services are not Covered Benefits, unless Contractor has obtained a written statement in a form acceptable to Plan, signed by the Member or the person responsible for paying for Services rendered to the Member, acknowledging that the Member or such person is responsible for making such payments.

(d) Contractor understands and agrees that surcharges against Members are prohibited and Plan will take appropriate action if surcharges are imposed. A surcharge is an additional fee which is charged to a Member for a Service but which is not approved by the California Department of Managed Health Care ("DMHC") or provided for under the

applicable Membership Contract. Contractor shall report to Plan all surcharge amounts paid by Members to Contractor.

(e) Contractor shall hold harmless the State of California and Members in the event that Plan cannot or will not pay for Services performed by Contractor pursuant to this Agreement.

3.5 COORDINATION OF BENEFITS/THIRD PARTY LIENS/SUBROGATION RIGHTS.

(a) When Plan is primary under applicable coordination of benefits ("COB") rules, Plan shall pay to Contractor, as set forth in this Agreement, the amount due for Covered Services rendered to Members. When Plan is secondary under applicable COB rules, or another payor is primary to Plan, then Plan shall pay for Covered Services according to Plan's COB policies and procedures.

(b) Contractor shall cooperate with and abide by Plan's COB procedures. Such cooperation shall include, without limitation the following: (i) Contractor shall screen each Member receiving Services to determine if the Member has Medicare coverage, or other health benefits, such as workers' compensation coverage or coverage through the Member's spouse, and shall provide such other coverage information to Plan upon request. (ii) If, following payment by Plan for Services, Contractor discovers that Contractor is entitled to payment or receives payment for the same services from another payer that is primary to Plan, then Contractor shall notify Plan and promptly refund to Plan any amount overpaid by Plan.

(c) The Membership Contracts specify that certain other health care coverage sources (including Medicare) must be billed by Contractor and recoveries made prior to billing Plan. Plan shall return claims to Contractor if it has failed to first make recoveries from such other health care coverage sources. Contractor shall provide proof that Contractor has exhausted such other sources of payment. If Contractor provides Medicare-covered services to a Member, Contractor will bill the Medicare program directly. The requirements concerning notification and recoveries in the Provider Manual shall apply.

(d) Contractor shall make no claim for recovery of the value of Covered Services rendered to Members when such recovery would result from an action involving the tort liability of a third party, recovery from the estates of deceased Members or casualty liability coverage, including Workers' Compensation awards and uninsured motorist coverage. Contractor shall identify and notify Plan of cases in which such an action could result in recovery by the Member. Contractor shall notify Plan immediately upon the discovery of such cases and shall provide any requested information promptly to Plan. DHS retains the right to such third party tort liability and estate recoveries with respect to Medi-Cal Members as set forth in Welfare and Institutions Code Section 14124.70 and following.

(e) Contractor shall not seek reimbursement from Medi-Cal Members for any Covered Services provided under this Agreement, as set forth in the State Medi-Cal Contract and Welfare and Institutions Code Section 14452.6.

4.0 TERM AND TERMINATION

4.1 TERM.

This Agreement will begin on the Effective Date subject to any necessary government approvals, will continue in effect until the next December 31st, and will thereafter automatically renew for successive one (1) year terms, unless terminated in accord with Sections 4.2, 4.3 or 4.4 below.

4.2 WITHOUT CAUSE TERMINATION.

This Agreement may be terminated at any time for any reason or for no reason by either party with at least sixty (60) days prior written notice to the other party; provided, however, if Plan is required to provide notice to the State of contract termination under California Health and Safety Code Section 1373.65, each party shall provide at least eighty (80) days prior written notice of termination to the other party.

4.3 WITH CAUSE TERMINATION.

If a party materially breaches this Agreement and fails to cure the material breach to the satisfaction of the non-breaching party within fourteen (14) days after the non-breaching party gives written notice of the material breach, the non-breaching party may terminate this Agreement immediately upon written notice to the other party. Notwithstanding the above, Plan may immediately suspend this Agreement pending completion of applicable termination procedures, if Plan makes a reasonable determination, supported by written findings, that the health and welfare of Members is jeopardized by continuation of the Agreement.

4.4 IMMEDIATE TERMINATION.

(a) Contractor shall immediately notify Plan and Plan may immediately suspend this Agreement in the event there is a material adverse change in Contractor's insurance coverage. If Contractor does not provide adequate insurance coverage within thirty (30) days of the material adverse change, Plan may terminate this Agreement immediately. Contractor shall immediately notify Plan and this Agreement will terminate without further action of the parties if Contractor's insurance coverage is canceled, not renewed or expires, or if Contractor fails to obtain insurance coverage as required by this Agreement. If this Agreement terminates without further action of the parties, the effective date of termination shall be the date of the occurrence of such event or, at Plan's option, such other date determined by Plan in its sole discretion.

(b) Contractor shall immediately notify Plan and Plan may immediately suspend this Agreement if Contractor's license(s), Medicare or Medi-Cal certification, accreditation or credentialing status with Plan, is suspended or limited. If Contractor's license(s), certification, accreditation or credentialing status is not fully reinstated within thirty (30) days of such suspension or limitation, Plan may immediately terminate this Agreement. Contractor shall immediately notify Plan and this Agreement will terminate without further action of the parties if Contractor's license(s), Medicare or Medi-Cal certification,

accreditation or credentialing status with Plan, is revoked, not renewed or expires, if Contractor's licensure or certification is not obtained as required by this Agreement, or if Contractor is excluded from participation in the Medicare or Medi-Cal programs. If this Agreement terminates without further action of the parties, the effective date of termination shall be the date of the occurrence of such event or, at Plan's option, such other date determined by Plan in its sole discretion.

(c) Contractor shall immediately notify Plan and Plan may terminate this Agreement immediately upon written notice to Contractor if Contractor files a petition in or for bankruptcy, reorganization or an arrangement with creditors; makes a general assignment for the benefit of creditors; is adjudged bankrupt; is unable to pay debts as they become due; has a trustee, receiver or other custodian appointed on its behalf; or has a case or proceeding commenced against it under any bankruptcy or insolvency law.

(d) Contractor shall immediately notify Plan and Plan may terminate this Agreement immediately upon written notice to Contractor if Contractor provides services to Members through a Practitioner and: (i) such Practitioner's license to practice medicine in any state is suspended, revoked, expired or not renewed; (ii) such Practitioner's staff privileges at any hospital is revoked, suspended, not renewed or significantly (in the judgment of Plan) reduced for any medical disciplinary cause or reason (if Practitioner is a physician); (iii) such Practitioner is not or ceases to be covered by professional liability coverage as required under this Agreement; (iv) such Practitioner is criminally charged with any act involving moral turpitude; (v) the credentialing information provided to Plan with respect to such Practitioner was materially false; or (vi) such Practitioner no longer satisfies the credentialing standards of Plan.

(e) Plan may terminate this Agreement immediately upon written notice to Contractor if (i) Contractor surcharges the Members, (ii) Contractor fails to comply with Plan's utilization management procedures as set forth in the Provider Manual, (iii) Contractor fails to abide by Plan's grievance or quality assurance procedures as set forth in the Provider Manual, (iv) Contractor rejects a Legally Required Modification or a Provider Manual Modification pursuant to Section 9.5, or (v) there is any change to the composition of physicians and other health care practitioners providing Services on behalf of Contractor and such Practitioners have not been credentialed by Plan.

(f) This Agreement shall terminate automatically with respect to Members covered under a Membership Contract, on the date such Membership Contract terminates. Plan shall notify Contractor as soon as is practical upon receiving or sending notice of Membership Contract termination. Plan may immediately suspend this Agreement in whole or in part in the event Plan does not receive funds for health care services under the Membership Contract or the State determines that Plan is no longer responsible to arrange for the provision of health care services to Members due to a catastrophic occurrence.

(g) This Agreement shall terminate automatically in the event of the death or withdrawal of Contractor from practice, if Contractor is an individual health care provider.

4.5 EFFECT OF TERMINATION AND SURVIVAL.

(a) Upon termination of this Agreement, Contractor shall continue to provide Services to Members under the care of Contractor at the time of termination, until the Services being rendered are completed, unless Plan makes reasonable and medically appropriate provision for the assumption of such Services by a new provider. Plan shall use best efforts to make such alternate arrangements within ninety (90) days. The terms and conditions of this Agreement will continue to apply to Services provided to each such Member until completion or until transfer to a new provider. Contractor shall act in such a manner as to facilitate any new provider's assumption of services, shall assist in the orderly transfer of care, and shall make Records and other information available for the efficient Case Management of Members. Contractor shall comply with California Health and Safety Code Section 1373.96 regarding the completion of Covered Services upon termination of this Agreement, for the conditions listed in Section 1373.96 (c).

(b) Provisions of this Agreement including, but not limited to, Section 2.7 (Utilization Management), Section 2.8 (Quality Assessment and Improvement), Article 5 (Records and Confidentiality), Article 6 (Insurance and Indemnification) and Article 8 (Dispute Resolution, Complaints and Inquiries) that are not fully performed or are not capable of being fully performed as of the date of termination will survive termination of this Agreement.

(c) Contractor further agrees that Section 3.4 (a) shall (i) survive the termination of this Agreement regardless of the cause giving rise to termination, (ii) be construed to be for the benefit of the Members, and (iii) supersede any oral or written contrary agreement now existing or hereafter entered into by the parties. Any modification to this Section 4.5 (c) shall become effective only after proper state and federal regulatory authorities have received written notification of the proposed change.

4.6 FAIR HEARING.

Notwithstanding time periods for termination set forth in Sections 4.2 through 4.4 above, in all cases in which Plan terminates this Agreement and Contractor is entitled to a fair hearing under Plan's applicable notification and hearing procedures, as amended from time to time, the termination will be final thirty (30) days from notice of the right to request a hearing, unless Contractor requests a hearing within such thirty (30) day period. If such a hearing is requested, this Agreement will continue in effect until a decision is rendered; provided, however, (a) this Agreement may be terminated for other reasons or without cause, and (b) upon the request of Plan, Contractor shall not thereafter render Services to Members until a decision is rendered.

5.0 RECORDS AND CONFIDENTIALITY

5.1 MAINTENANCE OF RECORDS.

Contractor shall maintain books, charts, documents, papers, reports, management information systems, procedures and records (including, but not limited to, financial, accounting, and administrative records, patient medical records, prescription files, laboratory results, subcontracts

and Authorizations) related to Services provided hereunder to Members, to the cost thereof, to payments received from Members or others on their behalf, and to the financial condition of Contractor ("Records"). Records include notes, documents, reports and other information related to Provider disputes and determinations. Records also include all Medi-Cal 35-file paid claims data and any other records that are customarily maintained by Contractor for purposes of verifying claims information and reviewing appropriate utilization of Services. Contractor shall maintain Records in accord with applicable state and federal requirements and obligations of the Membership Contracts, including privacy and confidentiality requirements. Contractor shall maintain records in accord with the general standards applicable to that book or record keeping. Records shall be legible, kept in a secure location with detail (i) consistent with appropriate medical and professional practice and prevailing community standards, (ii) which permits effective internal professional review and external medical audit process, and (iii) which facilitates an adequate system for follow-up treatment. The Member's medical record shall reflect whether the Member has executed an advance directive and any request for or refusal of language interpretation services. The Provider Manual outlines additional medical Records requirements. Contractor shall be fully bound by the requirements in Title 42 of the Code of Federal Regulations Section 2.1 and following, relating to the maintenance and disclosure of Member Records received or acquired by federally assisted alcohol or drug programs. Contractor shall preserve Records for the longer of (i) seven (7) years after termination of this Agreement, and (ii) the period of time required by state and federal law and Membership Contracts, including the period required by the Knox Keene Act and Regulations, and by the Medicare and Medi-Cal programs, unless a longer period is stipulated. If there is any litigation, claim, negotiation, audit, review, examination, evaluation, or other action pending at the end of such period, then Contractor shall retain said Records until such action is completed.

5.2 ACCESS TO AND COPIES OF RECORDS.

Plan and its authorized agents shall have access to and may inspect the Records, subject to reasonable request and notification requirements, and subject to any legal requirements regarding confidentiality. Contractor shall transmit Record information by fax when requested. Contractor shall provide copies of Records to Plan upon request, at no charge for the first copy and at five cents ($.05) per page for any additional copies. Contractor shall, subject to any legal requirements regarding confidentiality, provide access to Records and other information as required by Government Officials and accrediting organizations.

5.3 COPIES OF CLINICAL INFORMATION.

For all Members receiving Services, Contractor will promptly forward copies of initial consultation reports upon completion of consult, and summaries of patient care or patient results upon completion of patient care or discharge, to the Member's Primary Care Physician. Contractor's failure to provide this clinical data promptly will be grounds for denial or reduction of payment to Contractor for Covered Services rendered to Members. Contractor shall provide copies of such clinical information to the Primary Care Physician at no charge.

5.4 DISCLOSURE TO GOVERNMENT OFFICIALS.

Contractor shall comply with all provisions of law regarding access to books, documents, and records. Without limiting the foregoing, Contractor shall maintain, provide access to, and provide copies of Records, this Agreement and other information to the Director of DMHC, DHS, External Quality Review Organizations, the State Bureau of Medi-Cal Fraud, the State Managed Risk Medical Insurance Board, the Bureau of State Audits, the State Auditor, certified Health Plan Employer Data Information Set ("HEDIS") auditors from the National Committee on Quality Assurance, the California Cooperative Healthcare Reporting Initiative, the County of Santa Cruz, the County of Monterey, the U.S. Department of Justice, the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, the Centers for Medicare and Medicaid Services, Peer Review Organizations, their designees, representatives, consultants and specialists and such other officials entitled by law or under Membership Contracts (collectively, "Government Officials") as may be necessary for compliance by Plan with the provisions of all state and federal laws and contractual requirements governing Plan, including, but not limited to, the Knox-Keene Act and Regulations and requirements of the Medicare and Medi-Cal programs. Such information shall be available for inspection, examination and copying at all reasonable times at Contractor's place of business or at some other mutually agreeable location in California. Copies of such information shall be provided to Government Officials promptly upon request. The disclosure requirement includes, but is not limited to, the provision of information upon request by DHS relating to threatened or pending litigation by or against DHS.

5.5 REPORTING.

(a) Contractor shall supply Plan or Plan's designated agent with periodic reports and information pertaining to (i) Services provided to Members by Contractor or its subcontracted health care providers and (ii) Contractor's financial resources, on such forms and within such times as requested by Plan, and which will enable Plan to meet all federal and state legal and contractual reporting requirements. Contractor shall also supply Plan with other reports as reasonably requested. If Contractor is a Federally Qualified Health Center, the Medi-Cal program requires that Contractor keep a record of the number of visits by Medi-Cal Members separate from fee-for-service Medi-Cal beneficiaries.

(b) Contractor certifies and warrants that all reports, invoices, papers, documents, books of account, instruments, data, information, forms of evidence and other Records submitted to Plan or Government Officials pursuant to this Agreement are current, accurate, complete and in full compliance with legal and contractual requirements, and do not contain any material misrepresentations or omissions.

5.6 CONFIDENTIALITY OF INFORMATION.

(a) Notwithstanding any other provision of this Agreement, names of Members receiving public social services hereunder are confidential and are to be protected from unauthorized disclosure in accordance with Title 42, Code of Federal Regulations, Section 431.300 and following and Section 14100.2 of the Welfare and Institutions Code

and regulations adopted thereunder. For the purpose of this Agreement, all information, records, data, and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by Contractor from unauthorized disclosure.

(b) With respect to any identifiable information concerning a Medi-Cal Member that is obtained by Contractor, Contractor (i) will not use any such information for any purpose other than carrying out the express terms of this Agreement, (ii) will promptly transmit to Plan all requests for disclosure of such information, (iii) will not disclose except as specifically permitted by this Agreement, any such information to any party other than Plan, without prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 and following, Welfare and Institutions Code Section 14100.2, and regulations adopted thereunder, and (iv) will, at the expiration or termination of this Agreement, return all such information to Plan or maintain such information according to written procedures sent to Plan by DHS for this purpose. Contractor shall provide a signed Declaration of Confidentiality in the format set forth in the Provider Manual, prior to the Effective Date.

(c) Contractor shall comply with all federal, state and local laws which provide for the confidentiality of Records and other information. Contractor shall not disclose any confidential Records or other confidential information received from Plan or Government Officials or prepared in connection with the performance of this Agreement, unless Plan or Government Officials specifically permits Contractor to disclose such Records or information. Contractor shall promptly transmit to Plan any and all requests for disclosure of such confidential Records or information. Contractor shall not use any confidential information gained by Contractor in the performance of this Agreement except for the sole purpose of carrying out Contractor's obligations under this Agreement. Contractor shall comply with California Welfare and Institutions (W & I) Code Section 10850 and 45 CFR Section 205.50, and all other applicable provisions of law which provide for the confidentiality of records and prohibit their being opened for examination for any purpose not directly connected with the administration of public social services. Whether or not covered by such sections, confidential medical or personnel records and the identities of clients and complainants shall not be disclosed unless there is proper consent to such disclosure or a court order requiring disclosure. Confidential information gained by Contractor from access to any such records, and from contact with its clients and complainants, shall be used by Contractor only in connection with its conduct of the program under this Agreement.

(d) Contractor shall protect the security and confidentiality of all eligibility and enrollment data and all other personal information and protected health information about Members in accordance with the Information Practices Act, Civil Code Section 1798 et seq., and all other applicable State and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated thereunder. All financial, statistical, personal, technical and other data and information relating to the State's operations which are designated confidential by the State and which become available to Contractor shall be protected by Contractor from unauthorized use and disclosure. Contractor shall not use any individual identifiable information or other confidential information for any purpose other than carrying out the provisions of this

Agreement. Upon request by Plan, Contractor shall provide a copy of its policies and procedures for preserving the confidentiality of medical records, as outlined in California Health and Safety Code Section 1364.5.

5.7 USE OF NAME.

Contractor and Plan each reserves to itself the right to, and the control of the use of, its names, symbols, trademarks and service marks, presently existing or hereafter established, and, neither Contractor nor Plan shall use the other's names, symbols, trademarks, or service marks in any advertising or promotional communication of any type or otherwise without the prior written consent of the other party. Notwithstanding the above, Plan may communicate Contractor's name, address(es), telephone number(s), office hours, language capabilities, specialty, affiliations and Practitioners.

6.0 INSURANCE AND INDEMNIFICATION

6.1 INSURANCE.

(a) Contractor shall maintain, at its sole expense, the following insurance covering itself and each Practitioner through whom Contractor provides Services: (i) a policy of commercial general liability and property damage insurance with limits of liability not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate, (ii) a policy of professional liability insurance with limits of liability not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate, (iii) appropriate automobile coverage, and workers' compensation protection and unemployment insurance to the extent required by law, and (iv) such other insurance or self insurance as shall be necessary to insure it against any claim or claims for damages arising under this Agreement, including claims arising by reason of personal injury or death in connection with the performance of any service, or use of any property or facility pursuant to this Agreement. Such insurance coverage shall apply to all location(s) of Contractor.

(b) All insurance required under this Section shall be obtained from a company(ies) that is duly licensed to do business in the State of California and that either (i) has a Best's rating of at least A or has a comparable rating from another rating company or (ii) is acceptable to Plan. Such insurance coverage must not be canceled, terminated, nonrenewed, or modified or must not expire without at least thirty (30) days' prior written notice to Plan. Contractor shall arrange with the insurance carrier to have automatic thirty (30) days prior notification of insurance coverage termination or modification given to Plan. Contractor shall notify Plan at the time of any change in insurance carrier, limits or deductibles. Contractor shall provide certificates of insurance evidencing such coverage to Plan upon execution of this Agreement in a form acceptable to Plan, and from time to time thereafter upon request. Contractor may substitute comparable self-insurance coverage for the insurance coverage required in this Section, only upon the prior written approval of Plan.

(c) If Contractor obtains one or more claims-made insurance policies to fulfill its obligations under this Section, Contractor will (i) maintain coverage with the same company during the term of this Agreement and for at least ten (10) years following termination of this Agreement, or (ii) purchase or provide coverage that assures protection against claims based on acts or omissions that occur during the period of this Agreement but which are asserted after the claims-made insurance policy has expired.

6.2 INDEMNIFICATION.

(a) To the extent permitted by law, Contractor shall indemnify and hold harmless (and at Plan's request, defend) Plan, and each of its respective officers, directors, agents, and employees (each an indemnitee) from and against any and all claims, losses, damages, liability, costs, expenses (including reasonable attorneys' fees), judgments or obligations whatsoever, for or in connection with injury (including death) or damage to any person or property to the extent resulting from the negligent act or failure to act or willful misconduct of Contractor, its officers, directors, employees, subcontractors or agents under this Agreement.

(b) To the extent permitted by law, Plan shall indemnify and hold harmless (and at Contractor's request, defend) Contractor, its officers, directors, agents and employees (each an indemnitee) from and against any and all claims, losses, damages, liability, costs, expenses (including reasonable attorneys' fees), judgments or obligations whatsoever, for or in connection with injury (including death) or damage to any person or property to the extent resulting from the negligent act or failure to act or willful misconduct of Plan, its officers, directors, employees or agents under this Agreement.

(c) The principles of comparative fault shall apply in interpreting this Section. Each party retains such indemnification rights to which it may be entitled under California law. Plan retains all immunities applicable to public entities to which it is entitled by law.

7.0 LEGAL REQUIREMENTS AND CREDENTIALS

7.1 COMPLIANCE WITH LAWS.

(a) Contractor represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable local, State and federal laws and regulations, including, but not limited to, those (i) regarding licensure and certification, (ii) necessary for participation in the Medicare and Medi-Cal programs, including the antifraud and abuse laws and regulations and the patient self-determination amendments of the Omnibus Budget Reconciliation Act of 1990, (iii) regarding advance directives, (iv) regulating the operations and safety of facilities, including but not limited to, Title 22 CCR Section 53230, (v) regarding federal and State Occupational Health and Safety Administration (OSHA) standards, (vi) regarding communicable disease reporting, (vii) regarding not allowing smoking within any portion of any indoor facility used for the provision of health services for children as specified in the U.S. Pro-Children Act of 1994 (20 United States Code Section 6081 and following), (viii) regarding the provision of information to Members concerning Prostate Specific Antigen testing consistent with the

standard set forth in California Business and Professions Code Section 2248, (ix) regarding reporting all cases of suspected fraud and/or abuse as defined in Title 42 CFR Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, (x) regarding provisions of the Health Insurance Portability and Accountability Act of 1996 and regulations, and (xi) regarding provisions of the California Confidentiality of Medical Information Act.

(b) As required by Title 31 U.S.C. Section 1352, if payments under this Contract are $100,000 or more, Contractor certifies to the best of Contractor's knowledge and belief that no Federally appropriated funds have been paid or will be paid, by or on behalf of Contractor, to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Agreement, and the extension, continuations, renewal, amendment, or modification of this Agreement. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Agreement, Contractor shall complete and submit standard form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions. Contractor shall require that the language of this certification be included in all subcontracts at all tiers which exceed $100,000 and that all subcontractors shall certify and disclose accordingly.

(c) Contractor shall not employ or contract with directly or indirectly, entities or individuals excluded from participation in Medicare or Medicaid under Sections 1128 or 1128A of the Social Security Act, for the provision of health care services, utilization review, medical social work, or administrative services in respect to Members.

(d) Contractor shall provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by law or by Plan's Membership Contracts. Contractor shall also provide, as applicable, the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions" and shall comply with its instructions, if required by law or by Plan's Membership Contracts. Such Debarment Certification and its instructions are set forth in the Provider Manual.

(e) If Contractor uses economic profiling information related to any of its individual physicians or other health care Practitioners, it shall provide a copy of such information related to an individual Practitioner, upon request, to that Practitioner in accordance with the requirements of Section 1367.02 of the California Health and Safety Code. Additionally, Contractor, upon request, shall make available to Plan its policies and procedures related to economic profiling used by Contractor. The term "economic profiling" as used in this Section 7.1 (e) shall be defined in the same manner as that term is defined in Section 1367.02 of the Health and Safety Code. The requirement of this

Section 7.1 (e) to provide a copy of economic profiling information to an individual Practitioner shall survive termination of this Agreement in accordance with Section 1367.02 of the Health and Safety Code.

(f) Facilities licensed pursuant to California Health and Safety Code Section 1250 shall permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.

(g) If required by 28 CCR Section 1300.67.8 (f), Contractor shall display in a prominent place in each reception and waiting area a notice informing Members how to contact Plan, file a complaint with Plan, obtain assistance from DMHC, and seek an independent medical review. A "reception and waiting area" shall be defined as a room used for the purpose of Members waiting to receive Services from a Provider. If required, the notice shall be displayed in English and in the languages as set forth in 28 CCR Section 1300.67.8 (f) (1). The notice shall be in a form prescribed, provided and translated by DMHC for posting, and may be obtained at www.dmhc.ca.gov. Hard copies may also be obtained from DMHC at the address set forth in 28 CCR Section 1300.67.8 (f) (3). Display of a notice provided by the Office of the Patient Advocate containing the information required by 28 CCR Section 1300.67.8 (f) and in the appropriate language(s) is also acceptable.

(h) Contractor shall immediately notify Plan of investigations of Contractor in which there are allegations relating to fraud. Contractor shall comply with Plan's antifraud plan, including it policies and procedures relating to the detection of fraud.

(i) If required by Health and Safety Code Section 1375.4, (1) Contractor shall meet the financial requirements that assist Plan in maintaining the financial viability of arrangements for the provision of Services in a manner that does not adversely affect the integrity of the contract negotiation process, (2) Contractor shall abide by Plan's process for corrective action plans if there is a deficiency, and (3) Plan shall disclose information to Contractor that enables Contractor to be informed regarding the financial risk assumed under this Agreement. If required by 28 CCR Section 1300.75.4.1, Plan shall make the disclosure(s) set forth in 28 CCR Section 1300.75.4.1.

7.2 NONDISCRIMINATION.

(a) Contractor shall not discriminate against Members or deny benefits to Members, on the basis of race, color, creed, religion, sex, gender, marital status, political affiliation, ancestry, sexual orientation, sexual preference, national origin, health status, age (over 40), physical or mental disability, medical condition (including cancer), pregnancy, childbirth, or related medical conditions, veteran's status, income, source of payment, status as a Member of Plan, or filing a complaint as a Plan Member. Contractor shall not condition treatment or otherwise discriminate on the basis of whether a Member has executed an advance directive. Contractor shall fully comply with all federal, state and local laws which prohibit discrimination, including but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, 42 U.S.C. Section 2000(d), 45 C.F.R. Part 84, Government Code Section 11135, Civil Code Section 51 and rules and regulations promulgated thereto. Contractor shall

provide reasonable access and accommodation to persons with disabilities to the extent required of a health services provider under the Americans with Disabilities Act and regulations and any applicable state law.

(b) During the performance of this Agreement, Contractor, its employees and agents, shall not unlawfully discriminate, deny benefits to, harass, or allow harassment against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical disability including Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and AIDS-Related Complex (ARC), mental disability, medical condition (including health impairments related to or associated with cancer for which a person has been rehabilitated or cured), marital status, political affiliation, age (over 40), sex, gender, sexual preference, sexual orientation, pregnancy, childbirth, or related medical conditions, or the use of family and medical care leave and pregnancy disability leave pursuant to state and federal law. Contractor, its employees and agents, shall insure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and harassment. Contractor, its employees and agents, shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, and following) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0 and following). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor shall give written notice of its obligations under this clause to labor organizations with which it has a collective bargaining or other agreement.

7.3 LICENSURE, CERTIFICATION AND CREDENTIALS.

(a) Contractor represents, certifies and warrants that all physicians and all health care practitioners, including employees, subcontractors and agents of Contractor, who provide Services to Members (collectively "Practitioners"), Contractor, and each of Contractor's locations are, and shall be at all times during the term hereof, properly licensed by the State of California, certified or registered, qualified and in good standing in accord with all applicable local, state and federal laws and in accord with all applicable legal, professional and technical standards. Contractor and each of its locations shall be properly accredited. Contractor, Contractor's locations and Practitioners shall meet applicable requirements and be properly certified under the Medicare and Medicaid programs, as set forth in Title XVIII and Title XIX, respectively, of the Social Security Act, and Title 22 CCR Section 51200 and following and shall meet any other qualifications as determined by Government Officials or Plan. Contractor represents, warrants and certifies that Contractor and its Practitioners are not under exclusion by the U.S. Department of Health and Human Services from participation under Titles V, XVIII, XIX, XX or XXI of the Social Security Act. Contractor also represents, warrants and certifies, currently and for the term of this Agreement, that no item or service under this Agreement will be (i) made under the medical direction or on the prescription of a physician who is under such exclusion or (ii) provided by an individual or entity who is under such exclusion. Practitioners shall only provide Services within the scope of their

education, training and experience. Upon request, Contractor shall provide satisfactory documentary evidence of licensure, certification, and qualifications of Contractor, Contractor's locations and Practitioners.

(b) Contractor further warrants that each physician through whom it will provide Services shall (i) maintain a current, unrestricted license to practice medicine in California, (ii) be certified to participate in the Medicare and Medi-Cal programs, (iii) be board certified in a specialty approved by Plan, and (iv) maintain active medical staff privileges at one of Plan's Hospitals and all clinical privileges necessary to perform required services or have executed a formal agreement with another physician to admit and follow patients in the Hospital. Contractor shall provide verification of such clinical privileges or formal agreement prior to the Effective Date.

(c) Contractor shall cooperate with Plan's credentialing process. Prior to execution of this Agreement, Contractor will provide to Plan all requested credentialing information, in such form as reasonably requested by Plan. Practitioners must be credentialed as set forth in this Section before providing Services to Members. Contractor shall also provide all re-credentialing information requested by Plan.

(d) Contractor shall immediately notify Plan, by phone and in writing, if (i) the licenses, certifications or clinical privileges of Contractor or any Practitioner are revoked, suspended, restricted, expired or not renewed, (ii) any peer review action, inquiry or formal corrective action proceeding, or investigation is initiated against Contractor or a Practitioner, (iii) Contractor or a Practitioner is the subject of legal (malpractice) action or governmental action, inquiry or formal allegation concerning qualifications or ability to perform Services (including any allegation of malpractice), (iv) there is any formal report submitted to the applicable state licensing board or similar organization or the National Practitioner Data Bank of adverse credentialing or peer review action regarding Contractor or a Practitioner, (v) there is any material change in any of the credentialing information regarding Contractor or a Practitioner, (vi) Contractor or a Practitioner is subject to sanctions under the Medicare or Medicaid programs, or (vii) there is any incident that may affect any license or certification held by Contractor or a Practitioner, or that may materially affect Contractor's or a Practitioner's performance of its obligations under this Agreement. Upon request, Contractor shall provide Plan with copies of survey reports, investigations, assessments, formal evaluations or citations of Contractor by any governmental agency that regulates Contractor.

(e) If at any time during the term hereof, any Practitioner does not meet Plan's credentialing standards, or the license, certifications, or privileges of any Practitioner are suspended, revoked, expired or not renewed, then Contractor shall ensure that such Practitioner shall not thereafter provide Services to Members. If during the term hereof, any of the events listed in Subsection (d) above or Section 4.4(d) occur with respect to a Practitioner, or there is conduct or performance by a Practitioner that could adversely affect the health or welfare of a Member, upon the written request of Plan, such Practitioner shall not thereafter render Services to Members until the matter has been resolved to Plan's satisfaction and Plan consents in writing to the provision of Services by such Practitioner.

8.0 DISPUTE RESOLUTION, COMPLAINTS AND INQUIRIES

8.1 PROVIDER DISPUTE RESOLUTION.

(a) Provider Dispute Resolution Procedure. Contractor may have disputes which may arise as a health care provider under contract with Plan. Such matters shall first be addressed through the mechanism set forth in this Section 8.1 (a). Dispute resolution shall be initiated by Contractor within three hundred and sixty-five (365) days of Plan's action or in the case of inaction, within three hundred and sixty-five (365) days of the expiration of Plan's time for action. If Contractor is not satisfied with the resolution of a dispute as outlined in Section 8.1 (a), Contractor may pursue other available legal remedies as set forth in Section 8.1 (b). Contractor shall exhaust the provider dispute resolution procedure as set forth in Section 8.1 (a) before pursuing other available legal remedies as set forth in Section 8.1 (b). The "date of receipt" and "date of determination" for purposes of Section 8.1 (a) is defined as set forth in Title 28 California Code of Regulations Section 1300.71.38.

A dispute shall be made in writing and sent or delivered to the attention of Plan's Grievance Coordinator (i) to the address set forth in the Notices Section or (ii) electronically to GrievanceCoordinator@ccah-alliance.org. The dispute shall include, at a minimum, Contractor's name, provider identification number, contact information, a clear explanation of the matter at issue, and Contractor's position on the matter. Contractor may include any relevant clinical and other supporting information. If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, Contractor shall include the number assigned to the original claim, a clear identification of the disputed item, the date of Service, and a clear explanation of why Contractor believes the payment amount or other action is incorrect. If a dispute involves a Member(s), Contractor shall also include the name and identification number of the Member(s) and the date of Service. If a dispute is submitted on behalf of a Member, however, the matter shall be resolved through the Member dispute resolution procedure (as long as the Member authorizes it to proceed) and not through the provider dispute resolution procedure. If Contractor's dispute does not contain the above information and such information is not readily accessible to Plan, then Plan shall return the dispute to Contractor and clearly identify the missing information. Contractor may submit an amended provider dispute within thirty (30) working days of the date of receipt of a returned provider dispute. For a dispute inquiry or assistance in filing a dispute, Contractor may call Plan's Grievance Coordinator at one of the following telephone numbers: (831) 430-5500 or (800) 700-3874. Contractor may file substantially similar multiple disputes as one dispute with the consistent numbering scheme set forth in the Provider Manual. Plan shall identify and acknowledge a dispute (i) in writing within five (5) days of the date of receipt for disputes sent or delivered to the address set forth in the Notices Section or (i) electronically within two (2) working days of the date of receipt for disputes sent electronically. If the matter involves a medical or health care delivery matter, Plan's Medical Director shall review the dispute and may consult additional health care providers competent to evaluate the specific clinical issues, at Plan's expense. Plan shall send its determination in writing to Contractor within thirty (30) calendar days of the date of receipt of the dispute or amended dispute. Plan's determination shall state the pertinent facts and the reasoning for its response. Contractor may choose to accept

the determination, or pursue other available legal remedies as set forth in Section 8.1 (b) below.

(b) Provider Dispute Resolution. Any claim, dispute or other matter arising out of, relating to, or in any way connected with this Agreement, including the performance of or failure to perform any term, covenant, or condition herein, shall first be addressed through the provider dispute resolution procedure set forth in Section 8.1 (a). If the procedure set forth in Section 8.1 (a) has been exhausted and such matter is not resolved to the satisfaction of the parties, either party may pursue any available legal remedy. Venue shall be in Santa Cruz or Monterey County. Plan retains all immunities applicable to public entities to which it is entitled by law.

(c) Designated Officer. The Executive Director of Plan is primarily responsible for the maintenance of the provider dispute resolution mechanism, the review of its operations, and noting any emerging patterns of provider disputes. Contractor may contact Plan's Executive Director at any time with any concerns or comments regarding the provider dispute resolution process.

8.2 MEMBER COMPLAINTS, GRIEVANCES, INQUIRIES AND CLAIMS.

(a) When a Member complaint is brought to Contractor's attention, Contractor shall inform the Member of Plan's grievance process. Contractor shall make Plan's grievance descriptions and forms readily available to Members and shall provide such documents to Members promptly upon request. Contractor shall cooperate with Plan in identifying, processing and resolving all Member complaints and grievances pursuant to Plan's Member grievance procedures. Such cooperation will include, but not be limited to, meeting with representatives of Plan upon request, providing information bearing on the complaint to such representatives and taking all reasonable actions suggested by such representatives to resolve the Member's complaint. Contractor will promptly notify Plan of receipt of all complaints from or on behalf of Members. The parties will each promptly notify the other of the receipt of any written complaint letters regarding Services provided to Members by or on behalf of Contractor. Contractor shall comply with Plan's resolution of any such complaints and grievances.

(b) Plan is responsible for administration of Covered Benefits. All inquiries regarding what services and benefits are Covered Benefits are to be referred to Plan.

(c) Contractor will promptly notify Plan of any professional liability claims filed or asserted regarding Services provided to Members by, or on behalf of, Contractor.

9.0 MISCELLANEOUS

9.1 INDEPENDENT CONTRACTOR.

Contractor enters into this Agreement, and will remain throughout the term of this Agreement, as an independent contractor. Nothing in this Agreement is intended to create nor shall it be construed to create between Plan and Contractor a relationship of principal, agent, employee,

partnership, joint venture or association. Neither Plan nor Contractor has authorization to enter into any contracts, assume any obligations or make any warranties or representations on behalf of the other. No individual through whom Contractor renders Services, shall be entitled to or shall receive from Plan compensation for employment, employee welfare and pension benefits, fringe benefits of employment, workers' compensation, life or disability insurance or any other benefits of employment, in connection with rendering Services. Contractor warrants that it will be responsible for all legally required tax withholding for itself and its employees.

9.2 NO THIRD PARTY BENEFICIARIES.

This Agreement is not intended to, nor does it create, any third-party beneficiary rights in any person, including Members, except as provided in Section 4.5(c)(ii). No action to enforce the terms of this Agreement may be brought against a party by a person who is not a party hereto.

9.3 ASSIGNMENT.

Neither this Agreement nor any duties or obligations under this Agreement may be assigned or subcontracted by Contractor without the prior written consent of Plan. Any material change of ownership or control of Contractor shall be deemed an assignment of this Agreement requiring the prior written consent of Plan. Plan may assign this Agreement in whole or in part to another public entity without Contractor's consent. Assignment or delegation of this Agreement shall be void unless prior written approval is obtained from DHS.

9.4 SUCCESSORS AND ASSIGNS.

Subject to the restrictions on assignment contained herein, this Agreement shall inure to the benefit of and be binding upon, the parties hereto and their respective successors and assigns.

9.5 AMENDMENT.

(a) Except as set forth below in Subsections (b) and (c), this Agreement may be amended only by mutual written consent of Plan's and Contractor's duly authorized representatives.

(b) If Government Officials require any modification of this Agreement in order for this Agreement to be in conformity with federal or state law or accreditation requirements or if Plan reasonably concludes that an amendment to this Agreement is required because of a change in federal or state law or accreditation requirements, Plan shall notify Contractor of such proposed modification(s) ("Legally-Required Modification"). Such Legally-Required Modification shall be deemed accepted by Contractor and this Agreement so amended, if Contractor does not, within forty-five (45) business days following the date of the notice, deliver to Plan its written rejection of such Modification; provided, however, if a change in federal or state law or accreditation requirements requires a shorter timeframe for compliance, then the Legally-Required Modification shall be deemed accepted by Contractor and this Agreement so amended, if Contractor does not, within the time period specified in the notice, deliver to Plan its written rejection of such

Modification. Both parties may also agree to a Legally-Required Modification by mutual written consent as set forth in Section 9.5 (a) above.

(c) If Plan desires to modify the Provider Manual, Plan shall notify Contractor of the proposed modification(s) ("Provider Manual Modification"). Such Provider Manual Modification shall be deemed accepted by Contractor and the Provider Manual so amended, if Contractor does not, within forty-five (45) business days following the date of the notice, deliver to Plan its written rejection of or proposed change to such Modification. If Contractor delivers a proposed change to the Provider Manual Modification and the parties cannot mutually agree to a change to the Provider Manual Modification within the forty-five (45) business day timeframe, the Provider Manual Modification shall be deemed rejected by Contractor. If an amendment to the Provider Manual is required because of a change in federal or state law or accreditation requirements, Contractor may amend the Provider Manual as set forth in Section 9.5 (b) above. Both parties may also agree to a Provider Manual Modification by mutual written consent as set forth in Section 9.5 (a) above.

9.6 APPROVAL BY DHS.

This Agreement and any amendment to it shall become effective only after approval by DHS to the form of the Agreement or amendment.

9.7 GOVERNING LAW.

This Agreement will be governed by and construed in accord with California law. Any provision required to be in this Agreement by the Knox Keene Act (California Health and Safety Code Section 1340 and following) and Regulations (California Code of Regulations Title 28 Section 1300 and following) shall bind the parties whether or not provided in this Agreement. This Agreement shall also be governed and construed in accord with applicable contractual requirements of Plan, including requirements of the Membership Contracts.

9.8 AUTHORITY TO CONTRACT.

Contractor represents, certifies and warrants that Contractor has full power and authority to execute and deliver this Agreement on behalf of itself and its Practitioners, including all physicians providing Services hereunder, and that upon execution of this Agreement, this Agreement will be a valid and binding agreement of Contractor enforceable in accord with the terms, conditions, and provisions hereof, including but not limited to, those relating to the restriction against Contractor and all Practitioners providing Services hereunder from balance billing or seeking additional compensation or payment from Plan or Members. Contractor shall have agreements with all physicians providing Services hereunder that meet all requirements of Section 2.4. Upon reasonable request by Plan, Contractor agrees to provide certified copies of documents, including, but not limited to, articles of incorporation, partnership agreements or physician agreements, which will verify its legal and organizational status and operation as described above.

9.9 NOTICES.

Any notices required to be given under this Agreement by either party, or which may be made by either party to the other, shall be in writing, delivered (a) personally, (b) by overnight delivery service with written proof of delivery or (c) by U.S. mail, registered or certified, postage prepaid, with return receipt requested, addressed as set forth on the signature page to Contractor and as follows to Plan:

The Santa Cruz/Monterey Managed Medical Care Commission
Attn: Provider Services Director
1600 Green Hills Road
Scotts Valley, CA 95066

Any such notice shall be deemed to have been served upon and received by the addressee twenty-four (24) hours after the notice has been deposited with the overnight delivery service, or forty-eight (48) hours after the notice has been deposited in U.S. mail. Either party shall have the right to change the place to which notice is to be sent by giving the other party notice as set forth above. Contractor shall provide notice of amendment or termination of this Agreement to DHS, by first class certified mail, postage prepaid at the following address:

California Department of Health Services
Medi-Cal Managed Care Division
1501 Capitol Avenue, Suite 71.4001
Sacramento, CA 95814.

9.10 NON-EXCLUSIVITY.

This is not an exclusive Agreement. Contractor and Plan may enter into similar agreements with other parties. Plan reserves the right to arrange for the provision of any services to Members from any other provider.

9.11 NO VOLUME GUARANTEE.

Plan does not represent, warrant, or covenant any minimum volume of patients or Members to Contractor.

9.12 WAIVER.

A failure of either party to exercise any right provided for herein shall not be deemed a waiver of any right hereunder. No party will be deemed to have waived any rights hereunder unless the waiver is made in writing and is signed by the waiving party's duly authorized representative. The waiver by Plan of any one or more defaults, if any, on the part of Contractor hereunder, shall not be construed to operate as a waiver by Plan of any other or future default in the same obligation or any other obligation of this Agreement.

9.13 SEVERABILITY.

If any one or more of the provisions of this Agreement is held invalid or unenforceable, the remaining provisions shall continue in full force and effect.

9.14 INTERPRETATION OF AGREEMENT.

This Agreement shall be interpreted according to its fair intent and not for or against any one party on the basis of which party drafted the Agreement. Section headings are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

9.15 ENTIRE AGREEMENT.

This Agreement, including the Exhibits attached hereto and the Provider Manual referenced herein, contains the entire agreement of the parties and as of the Effective Date supersedes any prior negotiations, proposals, agreements or understandings relating to the subject matter of this Agreement.

9.16 EXHIBITS.

All Exhibits referenced in this Agreement shall be attached to this Agreement and incorporated herein.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their respective duly authorized representatives as of the dates set forth below.

PLAN	**CONTRACTOR**
Central Coast Alliance for Health	
By: [signature]	By: [signature]
Name: Ellen Pirie	Name: HARRY WEIS
Title: Chairperson	Title: CFO
Date: 10-8-07	Date: 07/01/07

Address for Notices:

MANAGED CARE - OPERATIONS MGR.
NATIVIDAD MEDICAL CENTER
1441 CONSTITUTION BLVD.
SALINAS, CA 93906

Attn: NANCY MAJEWSKI

RECEIVED AUG 2 9 2007

EXHIBIT 1

SERVICES

Type of Services: Inpatient and Outpatient Hospital Services. This Agreement shall exclude inpatient and outpatient hospital services that are mental health and substance abuse services for Other Members.

EXHIBIT 2

RATE SCHEDULE FOR MEDI-CAL MEMBERS
Effective July 1, 2007

A. Hospital Inpatient Services Reimbursement.

(1)

(2) Definitions of Days of Service

(a) "Acute Medical/Surgical Day" shall mean an Inpatient Day approved by Plan in a Hospital for the provision of medical or surgical Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (b) through (h).

(b) "Acute Pediatric Day" shall mean an Inpatient Day approved by Plan in a Hospital for the provision of pediatric Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (a) or (c) through (h).

(c) "Maternity Day" shall mean an Inpatient Day approved by Plan in a Hospital for a mother delivering a baby(ies), through normal or C-Section delivery. The related per diem rate includes payment for Covered Services for mother only.

(d) "Nursery Level I Day" shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level I Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only.

(e) "Nursery Level II Day" shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level II Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only.

(f) "ICU/NICU III /Cardiac Surgery Day" shall mean an Inpatient Day approved by Plan in a Hospital for ICU/NICU III/Cardiac Surgery Services.

(g) "Acute Rehabilitation Day" shall mean an Inpatient Day approved by Plan in a Hospital for acute rehabilitation Services.

(h) "Administrative Day" shall mean an Inpatient Day approved by Plan in a Hospital for which acute inpatient care is not required.

B. Hospital Outpatient and Emergency Room Services Reimbursement. Plan shall pay Contractor for Covered Services that are Hospital outpatient and emergency room Services provided by Contractor to Medi-Cal Members at one hundred percent (100%) of the Medi-Cal Rate. This payment is payment in full for all such Covered Services that are provided to Medi-Cal Members, as well as any necessary administrative services. Payment may be subject to adjustment as described in Section 3.3 of this Agreement, and is subject to the Coordination of Benefits rules set forth in Section 3.5 of this Agreement. All Services that are outpatient laboratory services provided by a clinical laboratory under contract with Plan shall be excluded from this Agreement and shall be referred to such clinical laboratory.

C. Risk Sharing.

1. Budgeting. Plan will set up "Primary Care Physician Accounts" for each Primary Care Physician contract with Plan. A Primary Care Physician contract may include one or more primary care physicians. Primary Care Physician Accounts will be maintained separately for Primary Care Physicians' Linked Santa Cruz Medi-Cal Members and Linked Monterey Medi-Cal Members. Each Primary Care Physician Account Total will be allocated an amount called the "Full Budget Amount" for Linked Members. The Full Budget Amount will consist of budgeted health care costs by three service categories: a) Primary Care Physician Services, b) Referral Physician and Other Services, and c) Inpatient Hospital Services. The Primary Care Physician's Account Totals will consist of

the sum of the balances in such Primary Care Physician's Accounts for these three service categories.

Actual health care costs incurred by each Primary Care Physician's Linked Medi-Cal Members will be allocated against the Full Budget Amount. Health care expenditures for Covered Benefits include, but are not limited to, fee-for-service claims; the incurred cost of acute care hospital inpatient services, including any amounts paid and held in reserve; Primary Care Physician payment, including any amounts paid and held in reserve; capitation payments; and estimated costs for services incurred but not yet reported (IBNR).

2. Hospital Inpatient Expense Limit. Hospital inpatient expenses allocated to a Primary Care Physician's Hospital Inpatient Account will be limited to seventy five thousand dollars ($75,000) per Member annually ("Hospital Inpatient Expense Limit"). Actual paid expenses above seventy five thousand dollars ($75,000) (excluding amounts held in reserve) per Linked Santa Cruz Medi-Cal Member per year shall be shared on a pro rata basis based on Santa Cruz Medi-Cal Member allocations among all Risk Groups. Actual paid expenses above seventy five thousand dollars ($75,000) (excluding amounts held in reserve) per Linked Monterey Medi-Cal Member per year shall be shared on a pro rata basis based on Monterey Medi-Cal Member allocations among all Risk Groups.

3. Risk Sharing Pool. Each Primary Care Physician will be affiliated with a Risk Group. Primary Care Physician Accounts will be maintained for each Primary Care Physician contract. Primary Care Physician Accounts will be maintained separately for Primary Care Physicians' Linked Santa Cruz Medi-Cal Members and Linked Monterey Medi-Cal Members. Risk sharing pools will be maintained at the Risk Group level. Risk Group risk sharing pools are the sum of the Primary Care Physician Accounts affiliated with that Group.

   Each Risk Group is affiliated with a Primary Hospital or group of Primary Hospitals. Primary Hospital(s) shall have Primary Hospital Risk Sharing Pools for each Risk Group affiliated with such Primary Hospital(s). Each Primary Hospital Risk Group Risk Sharing Pool shall consist of the sum of the Primary Care Physician Inpatient Hospital Accounts of Primary Care Physicians within that Risk Group and shall equal the Risk Group's Inpatient Hospital Services Pool. Primary Hospital Risk Sharing Pools are maintained separately for Santa Cruz Medi-Cal Members and Monterey Medi-Cal Members.

   All Administrative Members will be assigned to risk pools, which are maintained separately for Administrative Members that are Santa Cruz Medi-Cal Members and that are Monterey Medi-Cal Members. The Santa Cruz Medi-Cal Member Administrative risk pool and the Monterey Medi-Cal Member Administrative risk pool also include long term care facility benefit costs for all Santa Cruz Medi-Cal Members and all Monterey Medi-Cal Members, respectively.

4. Account Sharing of Surplus and Deficits. An accounting of the transactions and operations of Primary Care Physician Accounts and all Risk Group risk sharing pools shall be rendered by Plan annually four (4) months after the conclusion of each Fiscal

Year and shall be certified by its Finance Director. Such annual accounting shall be based on the Fiscal Year of Plan. Distributions are made following Plan approval of such accounting and are made not later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

Policy regarding actual and proposed budget and cost allocations to the Primary Care Physician Accounts and Risk Group risk sharing pools is subject to the approval of Plan. Plan shall have the sole discretion to establish binding policies regarding determination of account and pool balances.

5. Deficit Funding. Any deficit in the Risk Group's Referral Physician and Other Services pools shall be funded by a surplus in such Risk Group's Inpatient Hospital Services pools, and any deficit in the Risk Group's Inpatient Hospital Services pools shall be funded by a surplus in such Risk Group's Referral Physician and Other Services pools. Deficit accounting and funding shall occur separately for a Risk Group's Santa Cruz Medi-Cal risk sharing pools and Monterey Medi-Cal risk sharing pools.

The Primary Hospital amounts held in reserve for each Risk Group affiliated with that Primary Hospital shall be used to fund deficits in the following Pools of each Risk Group, in the following order and at the following rates:

(a) Referral Physician and Other Services Pool. Primary Hospital amounts held in reserve shall be used to fund one hundred percent (100%) of any deficit of the Referral Physician and Other Services Pool, but only in situations where the Risk Group's Primary Care Physicians' amounts held in reserve have first been fully depleted, and not to exceed the total amount held in reserve from Primary Hospital for such Risk Group.

(b) Inpatient Hospital Services Pool. Primary Hospital amounts held in reserve shall be used to fund one hundred percent (100%) of the deficit of the Inpatient Hospital Services Pool after such Primary Care Physicians' amounts held in reserve have been depleted, and not to exceed the total amount held in reserve from Primary Hospital for such Risk Group.

Accounting for and funding of amounts held in reserve shall occur separately for (i) amounts held in reserve from Santa Cruz Medi-Cal payments, and (ii) amounts held in reserve from Monterey Medi-Cal payments.

6. Distribution of Amounts Held in Reserve. If the Primary Hospital Risk Group Risk Sharing Pool total is in surplus, the Primary Hospital affiliated with that Risk Group will receive in full its amounts held in reserve relating to that Primary Hospital Risk Group Risk Sharing Pool. If the Primary Hospital Risk Group Risk Sharing Pool total is in deficit, but the deficit is less than the aggregate amount held in reserve from the Primary Hospital affiliated with that Risk Group, the Primary Hospital shall receive a portion of the amount held in reserve from the Primary Hospital for that Risk Group, based on the differential between the deficit and the aggregate amount held in reserve. Distribution of amounts held in reserve shall occur separately for (i) amounts held in reserve from Santa

Cruz Medi-Cal payments and (ii) amounts held in reserve from Monterey Medi-Cal payments.

7. Surplus Distribution. If a Primary Hospital Risk Group Risk Sharing Pool total is in surplus after all amounts held in reserve relating to such pool have been distributed, then the Primary Hospital affiliated with such Risk Group shall receive surplus distribution. The amount available for surplus distribution to the Primary Hospital is thirty three and one third percent (33 1/3%) of said surplus of such Primary Hospital Risk Group Risk Sharing Pool balance times the Distribution Percentage. The Distribution Percentage is:

   Total Inpatient Hospital Services Claims at
   the Primary Hospital for such Risk Group
   Total Inpatient Hospital Services Claims at all
   Primary Hospitals for such Risk Group

   The Primary Hospital will also receive a portion of the surplus of Primary Hospital Risk Group Risk Sharing Pools, if there are Inpatient Hospital Services Claims at such Primary Hospital from Risk Groups affiliated with other Primary Hospital(s), and payment shall be based on the above formula. Surplus accounting and funding shall occur separately for a Risk Group's Santa Cruz Medi-Cal risk sharing pools and Monterey Medi-Cal risk sharing pools. A Primary Hospital will not receive surplus distribution for any Primary Hospital Risk Group Risk Sharing Pool totals in deficit.

8. Withhold Distribution and Surplus Sharing in Event of Termination. If this Agreement is terminated by Contractor or Plan, Contractor will be eligible for distribution of amounts held in reserve at the next annual accounting, but not for surplus sharing described in Subsection (C)(7).

EXHIBIT 3

OTHER MEMBERSHIP CONTRACTS

A. Healthy Families Program

1. <u>State Healthy Families Contract</u>.

The State Healthy Families Contract is the Membership Contract that Plan has entered into with the State of California Managed Risk Medical Insurance Board under which Santa Cruz and Monterey individuals eligible for the Healthy Families Program and enrolled with Plan will receive all specified health care services. Plan is currently participating in the Healthy Families Program in Santa Cruz County and in Monterey County.

2. <u>Other Members</u>.

Other Members are Members that are not Medi-Cal Members, and include Healthy Families Members and any other individuals entitled to health care services under the Membership Contracts. Healthy Families Members include Santa Cruz Healthy Families Members and Monterey Healthy Families Members.

(a) Santa Cruz Healthy Families Member means any person who is eligible for and participates in the Healthy Families Program, resides in Santa Cruz County and who is enrolled with Plan pursuant to Plan's State Healthy Families Contract.

(b) Monterey Healthy Families Member means any person who is eligible for and participates in the Healthy Families Program, resides in Monterey County and who is enrolled with Plan pursuant to Plan's State Healthy Families Contract.

3. <u>Covered Benefits</u>.

Covered Benefits for Healthy Families Members are the Medically Necessary health care services and benefits which the Healthy Families Member is entitled to receive, provided by and through Plan, under its State Healthy Families Contract. The State Healthy Families Contract currently covers Medically Necessary health care services and benefits set forth in Article 3, Chapter 5.8, Title 10 of the California Code of Regulations beginning with Section 2699.6700. Of the optional benefits set forth in such Article 3, Plan covers acupuncture, chiropractic and biofeedback benefits set forth in Title 10 California Code of Regulations Sections 2699.6700 (a) (17) and 2699.6700 (a) (18). Covered Benefits for Healthy Families Members are further described in the applicable Member Evidence of Coverage document. With respect to preventive pediatric health care services provided to Healthy Families Members, Contractor will follow the most recent recommendations of the American Academy of Pediatrics. Contractor shall use the most recent Recommended Childhood Immunization Schedule/United States, adopted

by the Advisory Committee on Immunization Practices (the "ACIP"). Contractor shall provide immunizations for adult Healthy Family Members as recommended by the ACIP.

4. Exclusions.

Services excluded under the Healthy Families Program by Article 3, Chapter 5.8, Title 10 of the California Code of Regulations and services excluded under the State Healthy Families Contract are not Covered Benefits for Healthy Families Members under this Agreement and Plan shall not pay Contractor for the provision of such excluded services to Healthy Families Members.

5. Copayments.

Copayments shall be charged by Contractor to Healthy Family Members as set forth in Chapter 5.8, Article 3, Title 10 of the California Code of Regulations. If a family's copayment under the Healthy Families Program exceeds twenty-five dollars ($25) per month to Contractor, Contractor shall offer an extended payment plan to such family. Providers shall not charge copayments in excess of the maximum set forth in the Healthy Families program regulations. Contractor shall waive copayments for American Indian and Alaska Native Healthy Families Members, if Plan identifies such Members as qualifying for the waiver.

6. Emergency Services.

For Healthy Families Members, Emergency Services shall mean twenty-four hour health care services required for a medical condition manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) placing the Member's health in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part. Emergency Services must be provided both in Plan's service area and Out-of-Area and in both Provider and Non-Provider facilities. According to California Health and Safety Code Section 1317.1, emergency services and care include (i) screenings, examinations, and evaluations for the purpose of determining whether a psychiatric emergency medical condition exists and (ii) the treatment necessary to relieve or eliminate the psychiatric emergency medical condition.

7. Self-Referral Services.

For Healthy Families Members, Self-Referral Services include acupuncture, chiropractic and sensitive services.

8. Serious Emotional Disturbance.

Healthy Families Members 18 years of age or younger with a serious emotional disturbance or a serious mental disorder are eligible to receive services from the County Mental Health Department as set forth in the California Welfare and Institutions Code Section 5600.3. Contractor shall identify such Healthy Families Members as early as possible and refer such Members to the County Mental Health Department. Services

must be authorized by the County Mental Health Department. Contractor shall promptly inform Plan of referrals to the County Mental Health Department.

9. Compliance with the Healthy Families Program.

Contractor represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable local, State and federal laws and regulations necessary for participation in the Healthy Families program.

10. Rate Schedule, Effective July 1, 2007.

a.

(1)

(2) Definitions of Days of Service

(a) "Acute Medical/Surgical Day" shall mean an Inpatient Day approved by Plan in a Hospital for the provision of medical or surgical Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (b) through (h).

(b) "Acute Pediatric Day" shall mean an Inpatient Day approved by Plan in a Hospital for the provision of pediatric Inpatient Hospital Services not

specifically designated as another Day of Service category set forth in this Section (2) (a) or (c) through (h).

(c) "Maternity Day" shall mean an Inpatient Day approved by Plan in a Hospital for a mother delivering a baby(ies), through normal or C-Section delivery. The related per diem rate includes payment for Covered Services for mother only.

(d) "Nursery Level I Day" shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level I Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only.

(e) "Nursery Level II Day" shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level II Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only.

(f) "ICU/NICU III /Cardiac Surgery Day" shall mean an Inpatient Day approved by Plan in a Hospital for ICU/NICU III/Cardiac Surgery Services.

(g) "Acute Rehabilitation Day" shall mean an Inpatient Day approved by Plan in a Hospital for acute rehabilitation Services.

(h) "Administrative Day" shall mean an Inpatient Day approved by Plan in a Hospital for which acute inpatient care is not required.

b. Hospital Outpatient and Emergency Room Services Reimbursement.

Families Members shall be reduced by any applicable copayment owed by or on behalf of such Healthy Families Members.

c. Risk Sharing.

(1) Budgeting. Plan will set up "Primary Care Physician Accounts" for each Primary Care Physician contract participating in risk sharing with Plan. A Primary Care Physician contract may include one or more primary care physicians. Primary Care Physician Accounts will be maintained separately for Primary Care Physicians' Linked Santa Cruz Healthy Families Members and Linked Monterey Healthy Families Members. Each Primary Care Physician Account Total will be allocated an amount called the "Full Budget Amount" for Linked Members. The Full Budget Amount will consist of budgeted health care costs by three service categories: a) Primary Care Physician Services, b) Referral Physician and Other Services, and c) Inpatient Hospital Services. The Primary Care Physician's Account Totals will consist of the sum of the balances in such Primary Care Physician's Accounts for these three service categories.

Actual health care costs incurred by the Primary Care Physician's Linked Healthy Families Members will be allocated against the Full Budget Amount. Health care expenditures for Covered Benefits include, but are not limited to, fee-for-service claims; the incurred cost of acute care hospital inpatient services, including any amounts paid and held in reserve; Primary Care Physician payment, including any amounts paid and held in reserve; capitation payments; and estimated costs for services incurred but not yet reported (IBNR).

(2) Hospital Inpatient Expense Limit

Hospital inpatient expenses allocated to a Primary Care Physician's Hospital Inpatient Account will be limited to seventy five thousand dollars ($75,000) per Member annually ("Hospital Inpatient Expense Limit"). Actual paid expenses above seventy five thousand dollars ($75,000) (excluding amounts held in reserve) per Linked Santa Cruz Healthy Families Member per year shall be shared on a pro rata basis based on Santa Cruz Healthy Families Member allocations among all Risk Groups. Actual paid expenses above seventy five thousand dollars ($75,000) (excluding amounts held in reserve) per Linked Monterey Healthy Families Member per year shall be shared on a pro rata basis based on Monterey Healthy Families Member allocations among all Risk Groups.

(3) Risk Sharing Pool

Each Primary Care Physician participating in risk sharing will be affiliated with a Risk Group. Primary Care Physician Accounts will be maintained for each Primary Care Physician contract participating in risk sharing. Primary Care Physician Accounts will be maintained separately for Primary Care Physicians' Linked Santa Cruz Healthy Families and Linked Monterey Healthy Families Members. Risk sharing pools will be maintained at the Risk Group level. Risk Group risk sharing pools are the sum of the Primary Care Physician Accounts affiliated with that Group.

Each Risk Group is affiliated with a Primary Hospital or group of Primary Hospitals. Primary Hospital(s) shall have Primary Hospital Risk Sharing Pools for each Risk Group affiliated with such Primary Hospital(s). Each Primary Hospital Risk Group Risk Sharing Pool shall consist of the sum of the Primary Care Physician Inpatient Hospital Accounts of Primary Care Physicians within that Risk Group and shall equal the Risk Group's Inpatient Hospital Services Pool. Primary Hospital Risk Sharing Pools are maintained separately for Santa Cruz Healthy Families Members and Monterey Healthy Families Members.

(4) Account Sharing of Surplus and Deficits

An accounting of the transactions and operations of Primary Care Physician Accounts and all Risk Group risk sharing pools shall be rendered by Plan annually four (4) months after the conclusion of each Fiscal Year and shall be certified by its Finance Director. Such annual accounting shall be based on the Fiscal Year of Plan. Distributions are made following Plan approval of such accounting and are made not later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

Policy regarding actual and proposed budget and cost allocations to the Primary Care Physician Accounts and Risk Group risk sharing pools is subject to the approval of Plan. Plan shall have the sole discretion to establish binding policies regarding determination of account and pool balances.

(5) Deficit Funding

Any deficit in the Risk Group's Referral Physician and Other Services pools shall be funded by a surplus in such Risk Group's Inpatient Hospital Services pools, and any deficit in the Risk Group's Inpatient Hospital Services pools shall be funded by a surplus in such Risk Group's Referral Physician and Other Services pools. Deficit accounting and funding shall occur separately for a Risk Group's Santa Cruz Healthy Families risk sharing pools and Monterey Healthy Families risk sharing pools.

The Primary Hospital amounts held in reserve for each Risk Group affiliated with that Primary Hospital shall be used to fund deficits in the following Pools of each Risk Group, in the following order and at the following rates:

(a) Referral Physician and Other Services Pool. Primary Hospital amounts held in reserve shall be used to fund one hundred percent (100%) of any deficit of the Referral Physician and Other Services Pool, but only in situations where the Risk Group's Primary Care Physicians' amounts held in reserve have first been fully depleted, and not to exceed the total amount held in reserve from Primary Hospital for such Risk Group.

(b) Inpatient Hospital Services Pool. Primary Hospital amounts held in reserve shall be used to fund one hundred percent (100%) of the deficit of the Inpatient Hospital Services Pool after such Primary Care Physicians' amounts held in reserve have been depleted, and not to exceed the total amount held in reserve from Primary Hospital for such Risk Group.

Accounting for and funding of amounts held in reserve shall occur separately for (i) amounts held in reserve from Santa Cruz Healthy Families payments, and (ii) amounts held in reserve from Monterey Healthy Families payments.

(6) Distribution of Amounts Held in Reserve

If the Primary Hospital Risk Group Risk Sharing Pool total is in surplus, the Primary Hospital affiliated with that Risk Group will receive in full its amounts held in reserve relating to that Primary Hospital Risk Group Risk Sharing Pool. If the Primary Hospital Risk Group Risk Sharing Pool total is in deficit, but the deficit is less than the aggregate amount held in reserve from the Primary Hospital affiliated with that Risk Group, the Primary Hospital shall receive a portion of the amount held in reserve from the Primary Hospital for that Risk Group, based on the differential between the deficit and the aggregate amount held in reserve. Distribution of amounts held in reserve shall occur separately for (i) amounts held in reserve from Santa Cruz Healthy Families payments and (ii) amounts held in reserve from Monterey Healthy Families payments.

(7) Surplus Distribution

If a Primary Hospital Risk Group Risk Sharing Pool total is in surplus after all amounts held in reserve relating to such pool have been distributed, then the Primary Hospital affiliated with such Risk Group shall receive surplus distribution. The amount available for surplus distribution to the Primary Hospital is thirty three and one third percent (33 1/3%) of said surplus of such Primary Hospital Risk Group Risk Sharing Pool balance times the Distribution Percentage. The Distribution Percentage is:

$$\frac{\text{Total Inpatient Hospital Services Claims at the Primary Hospital for such Risk Group}}{\text{Total Inpatient Hospital Services Claims at all Primary Hospitals for such Risk Group}}$$

The Primary Hospital will also receive a portion of the surplus of Primary Hospital Risk Group Risk Sharing Pools, if there are Inpatient Hospital Services Claims at such Primary Hospital from Risk Groups affiliated with other Primary Hospital(s), and payment shall be based on the above formula. Surplus accounting and funding shall occur separately for a Risk Group's Santa Cruz Healthy Families risk sharing pools and Monterey Healthy Families risk sharing pools. A Primary Hospital will not receive surplus distribution for any Primary Hospital Risk Group Risk Sharing Pool totals in deficit.

(8) Withhold Distribution and Surplus Sharing in Event of Termination

If this Agreement is terminated by Contractor or Plan, Contractor will be eligible for distribution of amounts held in reserve at the next annual accounting, but not for surplus sharing described in Subsection c.(7).

B. Healthy Kids Program

1. **Healthy Kids Contracts.** The Healthy Kids Program is the health care services program administered by Plan for children through age 18 who are in families with incomes up to 300% of the federal poverty level and who are ineligible for the Healthy Families and Medi-Cal Programs. The Healthy Kids Contracts are the Membership Contracts that Plan has entered into or will enter into with the County of Santa Cruz, the Community Foundation of Santa Cruz County, and First 5 Santa Cruz County under which Santa Cruz individuals eligible for the Healthy Kids Program and enrolled with Plan will receive all specified health care services. Plan will participate in the Healthy Kids Program in Santa Cruz County.

2. **Healthy Kids Members.** Healthy Kids Members are Other Members. Healthy Kids Members include Santa Cruz Healthy Kids Members.

   (a) Santa Cruz Healthy Kids Member means any person who is eligible for and participates in the Healthy Kids Program, resides in Santa Cruz County and who is enrolled with Plan pursuant to Plan's Healthy Kids Contracts.

3. **Covered Benefits.** Covered Benefits for Healthy Kids Members are the Medically Necessary health care services and benefits which the Healthy Kids Member is entitled to receive, provided by and through Plan, under its Healthy Kids Contracts. Covered Benefits for Healthy Kids Members are further described in the applicable Member Evidence of Coverage document.

4. **Exclusions.** Services excluded under the Healthy Kids Contracts are not Covered Benefits for Healthy Kids Members under this Agreement and Plan shall not pay Contractor for the provision of such excluded services to Healthy Kids Members. Exclusions for Healthy Kids Members are further described in the applicable Member Evidence of Coverage document.

5. **Copayments.** Copayments shall be charged by Contractor to Healthy Kids Members as set forth in the Healthy Kids Contracts. Providers shall not charge copayments in excess of the maximum set forth in the Healthy Kids Contracts. Copayments for Healthy Kids Members are further described in the applicable Member Evidence of Coverage document.

6. **Emergency Services.** For Healthy Kids Members, Emergency Services shall mean twenty-four hour health care services required for a medical condition manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the Member's health in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part. According to California Health and Safety Code Section 1317.1, emergency services and care include (i) screenings, examinations, and evaluations for the purpose of determining whether a psychiatric emergency medical condition exists and (ii) the treatment necessary to relieve or eliminate the psychiatric emergency medical condition.

7. **Self-Referral Services**. For Healthy Kids Members, Self-Referral Services include optometry, acupuncture, chiropractic and sensitive services.

8. **Compliance with the Healthy Kids Program.** Contractor represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable local, State and federal laws and regulations necessary for participation in the Healthy Kids program.

9. **Rate Schedule, Effective July 1, 2007.**

a. Hospital Inpatient Services Reimbursement.

(1)

(2) Definitions of Days of Service

(a) "Acute Medical/Surgical Day" shall mean an Inpatient Day approved by Plan in a Hospital for the provision of medical or surgical Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (b) through (h).

(b) "Acute Pediatric Day" shall mean an Inpatient Day approved by Plan in a Hospital for the provision of pediatric Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (a) or (c) through (h).

(c) "Maternity Day" shall mean an Inpatient Day approved by Plan in a Hospital for a mother delivering a baby(ies), through normal or C-Section delivery. The related per diem rate includes payment for Covered Services for mother only.

(d) "Nursery Level I Day" shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level I Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only.

(e) "Nursery Level II Day" shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level II Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only.

(f) "ICU/NICU III /Cardiac Surgery Day" shall mean an Inpatient Day approved by Plan in a Hospital for ICU/NICU III/Cardiac Surgery Services.

(g) "Acute Rehabilitation Day" shall mean an Inpatient Day approved by Plan in a Hospital for acute rehabilitation Services.

(h) "Administrative Day" shall mean an Inpatient Day approved by Plan in a Hospital for which acute inpatient care is not required.

b. Hospital Outpatient and Emergency Room Services Reimbursement.

C. **In Home Supportive Services Caregiver Program**

1. **In Home Supportive Services (IHSS) Contract.** The IHSS Caregiver Program is the health care services program that is administered or may be administered by Plan for eligible In Home Supportive Services ("IHSS") workers whose employer of record is the Santa Cruz County Public Authority or the Monterey County Public Authority. Plan has entered into or may enter into a Membership Contract with the Santa Cruz County Public Authority under which Santa Cruz IHSS workers eligible for the IHSS Caregiver Program and enrolled with Plan will receive all specified health care services (the "Santa Cruz IHSS Contract"). Plan has entered into or may enter into a Membership Contract with the Monterey County Public Authority under which Monterey IHSS workers eligible for the IHSS Caregiver Program and enrolled with Plan will receive all specified health care services (the "Monterey IHSS Contract"). The Santa Cruz IHSS Contract and the Monterey IHSS Contract are together referred to as the "IHSS Contracts."

2. **IHSS Members.** IHSS Members are Other Members. IHSS Members include Santa Cruz IHSS Members and Monterey IHSS Members.

   (a) Santa Cruz IHSS Member means any person who is eligible for and participates in the IHSS Caregiver Program and who is enrolled with Plan pursuant to Plan's Santa Cruz IHSS Contract.

   (b) Monterey IHSS Member means any person who is eligible for and participates in the IHSS Caregiver Program and who is enrolled with Plan pursuant to Plan's Monterey IHSS Contract.

3. **Covered Benefits.** Covered Benefits for Santa Cruz IHSS Members are the Medically Necessary health care services and benefits which the Santa Cruz IHSS Member is entitled to receive, provided by and through Plan, under its Santa Cruz IHSS Contract. Covered Benefits for Monterey IHSS Members are the Medically Necessary health care services and benefits which the Monterey IHSS Member is entitled to receive, provided by and through Plan, under its Monterey IHSS Contract. Covered Benefits for IHSS Members are further described in the applicable Member Evidence of Coverage document.

4. **Exclusions.** Services excluded under the Santa Cruz IHSS Contract are not Covered Benefits for Santa Cruz IHSS Members under this Agreement and Plan shall not pay Contractor for the provision of such excluded services to Santa Cruz IHSS Members. Services excluded under the Monterey IHSS Contract are not Covered Benefits for Monterey IHSS Members under this Agreement and Plan shall not pay Contractor for the provision of such excluded services to Monterey IHSS Members. Exclusions for IHSS Members are further described in the applicable Member Evidence of Coverage document.

5. **Copayments.** Copayments shall be charged by Contractor to Santa Cruz IHSS Members as set forth in the Santa Cruz IHSS Contract. Copayments shall be charged by Contractor to Monterey IHSS Members as set forth in the Monterey IHSS Contract. Copayments for

IHSS Members are further described in the applicable Member Evidence of Coverage document.

6. **Emergency Services.** For IHSS Members, Emergency Services shall mean twenty-four hour health care services required for a medical condition manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the Member's health in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part. According to California Health and Safety Code Section 1317.1, emergency services and care include (i) screenings, examinations, and evaluations for the purpose of determining whether a psychiatric emergency medical condition exists and (ii) the treatment necessary to relieve or eliminate the psychiatric emergency medical condition.

7. **Self-Referral Services.** For IHSS Members, Self-Referral Services include family planning/sensitive services.

8. **Compliance with the IHSS Caregiver Program.** Contractor represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable local, State and federal laws and regulations necessary for participation in the IHSS Caregiver Program.

9. **Rate Schedule, Effective July 1, 2007.**

   a. Hospital Inpatient Services Reimbursement.

   (1)

(2) Definitions of Days of Service

(a) "Acute Medical/Surgical Day" shall mean an Inpatient Day approved by Plan in a Hospital for the provision of medical or surgical Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (b) through (h).

(b) "Acute Pediatric Day" shall mean an Inpatient Day approved by Plan in a Hospital for the provision of pediatric Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (a) or (c) through (h).

(c) "Maternity Day" shall mean an Inpatient Day approved by Plan in a Hospital for a mother delivering a baby(ies), through normal or C-Section delivery. The related per diem rate includes payment for Covered Services for mother only.

(d) "Nursery Level I Day" shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level I Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only.

(e) "Nursery Level II Day" shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level II Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only.

(f) "ICU/NICU III /Cardiac Surgery Day" shall mean an Inpatient Day approved by Plan in a Hospital for ICU/NICU III/Cardiac Surgery Services.

(g) "Acute Rehabilitation Day" shall mean an Inpatient Day approved by Plan in a Hospital for acute rehabilitation Services.

(h) "Administrative Day" shall mean an Inpatient Day approved by Plan in a Hospital for which acute inpatient care is not required.

b. Hospital Outpatient and Emergency Room Services Reimbursement.