CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
REFERRAL PHYSICIAN SERVICES AGREEMENT

Natividad Medical Center Specialty Clinic

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Central California Alliance for Health
Referral Physician Services Agreement

RECITALS

This Referral Physician Services Agreement ("Agreement") is made and entered into as of the Commencement Date specified herein, by and between Santa Cruz-Monterey-Merced Managed Medical Care Commission, doing business as Central California Alliance for Health ("Plan"), and the County of Monterey, a political subdivision of the State of California, doing business as Natividad Medical Center, on behalf of its Natividad Medical Center Specialty Clinic ("Provider"), with reference to the following facts:

WHEREAS, Plan has entered into or will enter into a contract or contracts with the State of California Department of Health Care Services ("DHCS") or other entities under which the Plan has agreed to arrange for the provision of health care services and benefits to eligible Santa Cruz, Monterey, and Merced County Medi-Cal beneficiaries or other covered individuals under the programs identified in Exhibit A hereto.

WHEREAS, Provider desires to participate in Plan's network of contracting providers by providing Covered Services, including Referral Services, to Members.

NOW THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the parties hereto agree as follows:

ARTICLE I.
DEFINITIONS

Whenever used in this Agreement, the following terms shall have the definitions contained in this Article I. Terms used in this Agreement which are defined by Law shall be interpreted consistent with such Laws.

1.1. Accreditation Organization. Accreditation Organization means any organization engaged in accrediting or certifying Plan or Providers.

1.2. Complete Claim. Complete Claim shall have the meaning set forth in Title 28 of the California Code of Regulations, Section 1300.71 (a)(2).

1.3. Commencement Date. Commencement Date is the date this Agreement becomes effective, as specified in Section 5.1.

1.4. Covered Services. Covered Services are those Medically Necessary health care services, supplies and benefits which are required by a Member pursuant to the coverage provisions of a Program, as further specified in the Program Requirements and in the applicable Member Group Contracts and Membership Contracts.

1.5. Covered Services Documentation. Covered Services Documentation means documentation developed by Referral Physicians to support the Covered Services, including Referral Services, provided hereunder, including, without limitation, claims for payment, discharge summaries, medical records, emergency visit records and diagnostic reports.

1.6. Covering Physicians. Covering Physicians are Referral Physicians who have entered into contracts with Provider to provide Referral Services under the terms of this Agreement when Provider is not available and who are Participating Providers or have been approved by the Plan.

1.7. DHCS. DHCS is the State of California Department of Health Care Services, the agency responsible for administering the Medi-Cal program in California.

1.8. Emergency Services. Emergency Services are health care services furnished by a qualified provider and needed to evaluate or stabilize a medical condition, including a psychiatric emergency medical condition (as defined in California Health and Safety Code Section 1317.1(k)(1)), 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.

1.9. Fiscal Year. Fiscal Year of Plan shall mean each twelve (12) month period beginning January 1st and ending December 31st.

1.10. Law. Law means any and all laws and regulations of the State of California or of the United States and all orders, instructions and other requirements of any government agency which are applicable to this Agreement.

1.11. Medi-Cal Provider Manual. Medi-Cal Provider Manual means the DHCS provider manual, issued by DHCS' fiscal intermediary.

1.12. Medically Necessary. Medically Necessary means, unless otherwise defined in a Membership Contract, Program Attachment or by Law, those 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. No service or supply is a Covered Service unless it is Medically Necessary.

1.13. Member. Member is an individual who is enrolled in a Program and who is determined to be eligible for membership in the applicable Program as of the date of service.

1.14. Member Group Contract(s). Member Group Contract(s) refers to the contracts between the Plan and various government agencies, including the State Medi-Cal Contract, as amended from time to time, under which the Plan has agreed to arrange for the provision of Covered Services to Members.

1.15. Member Payment. Member Payment means an amount (whether expressed as either a percentage of cost or as a specific dollar amount) that a Member is obligated to pay directly to a Participating Provider for a specific service in accordance with the Program under which he or she is covered and in accordance with any applicable Membership Contract. Member Payments shall include, but not be limited to, those payments commonly referred to as "coinsurance," "copayments," and/or "deductibles."

1.16. Membership Contract(s). Membership Contract(s) refers to the evidences of coverage or member handbooks, as amended from time to time, that the Plan issues to its Members and that include complete descriptions of the terms, conditions and benefits available to Members under applicable Programs.

1.17. Never Event. Never Event is an event included in the list of "adverse events" identified by the Centers for Medicare and Medicaid Services ("CMS"). This definition shall be deemed to include updates to the listings of adverse events upon the publication of such updates by CMS.

1.18. Participating Provider(s). Participating Provider(s) are physicians, medical groups, IPAs, health care professionals, hospitals, facilities and other providers of health care services or supplies that have entered into written contracts directly or indirectly with Plan to provide Covered Services to Members pursuant to a Program.

1.19. Primary Care Physician ("PCP"). PCP is a Participating Provider who supervises, coordinates and provides initial and basic care to certain Members assigned or linked to such PCP. PCP must meet Plan's criteria for

participation as a PCP. Primary Care Physicians must be physicians practicing in the fields of general medicine, internal medicine, family practice, pediatrics, or obstetrics and gynecology, or another specialty approved by Plan and DHCS.

1.20. Program. Program means any health care plan for the provision of Covered Services as more fully described in the Exhibits hereto, the Provider Manual, and any applicable Membership Contract(s), as each may be amended from time to time. The specific Program(s) under which Provider renders Covered Services are set forth on the Schedule of Programs attached as Exhibit A hereto, as may be amended from time to time.

1.21. Program Requirements. Program Requirements are those requirements as established under Law and through any Member Group Contracts and Membership Contracts applicable to specific Programs as summarized in the Exhibits hereto.

1.22. Provider Manual. Provider Manual means that document or series of documents created, maintained, updated and distributed from time to time by Plan that describes the Plan's policies and procedures and provides administrative and Program Requirements for Provider. The Provider Manual is incorporated into this Agreement and made a part hereof.

1.23. Provider Professional(s). Provider Professional(s) are Participating Providers who are physicians and other professionals who are shareholders or partners of, employed by or contract with Provider to deliver Covered Services hereunder. Provider Professionals must meet Plan's criteria for participation as a Participating Provider. References to Provider hereunder shall include Provider and its Provider Professionals.

1.24. Quality Management and Improvement ("QI") Program. Quality Management and Improvement ("QI") Program are those standards, protocols, policies and procedures adopted by Plan to monitor and improve the quality of clinical care and quality of services provided to Members. A summary of the QI Program is included in the Provider Manual, which may be updated from time to time by Plan.

1.25. Referral Services. Referral Services shall mean any Covered Services provided by physicians which are provided by physicians upon referral from a Primary Care Physician or as otherwise permitted by and in accordance with the Plan's UM Program.

1.26. Self-Referral Services. Self-Referral Services are those Covered Services, including Emergency Services, that Members may access without a referral as set forth for each Program in the Membership Contracts and Provider Manual. Self-Referral Services are subject to the Plan's UM Program.

1.27. Utilization Management ("UM") Program. Utilization Management ("UM") Program are those standards, protocols, policies and procedures adopted by Plan regarding the management, review and approval of the provision of Covered Services to Members. The UM Program is included in the Provider Manual, which may be updated from time to time by Plan.

ARTICLE II.
DUTIES OF PROVIDER

2.1. Referral Services. Provider shall provide Covered Services, including Referral Services, in accordance with the terms and conditions set forth in this Agreement, the Provider Manual, the Plan's QI and UM Programs, the applicable Program Requirements, applicable Accreditation Organization standards and the Law. Provider shall verify a Member's eligibility with Plan prior to rendering non-Emergency Services. Provider shall comply with prospective, concurrent and post-service review requirements as specified in the UM Program. Provider shall ensure that Covered Services provided under this Agreement are readily

available, accessible, appropriate, and provided in a prompt and efficient manner as required by applicable Law.

2.2. Referrals Initiated by Provider. Provider shall refer Members who are in need of Covered Services that are not within Provider's scope of specialization to the extent permitted by and in accordance with the Plan's UM Program, except for Emergency Services, Self-Referral Services, and in other cases where the Plan authorizes such a referral.

2.3. Professional Standards. The primary concern of Provider shall be the quality of Covered Services provided to Members. All Covered Services provided by Provider shall be provided by duly licensed, certified or otherwise authorized professional personnel in accordance with (i) the generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment, (ii) Plan's QI and UM Programs, (iii) applicable rules and regulations of California state medical boards, (iv) Law, and (v) the standards of Accreditation Organizations.

2.3.1. Licensure of Provider. Provider shall maintain in good standing at all times and ensure that any and all professionals that provide or assist Provider in the provision of Covered Services hereunder maintain in good standing at all times, any and all licenses, certificates, and/or approvals required under Law and by the Plan.

2.3.2. Hospital Privileges. Provider shall maintain in good standing at all times medical staff membership and clinical privileges, or have executed a formal agreement with another physician to admit and follow patients, at one or more of the Plan's contracted network hospital(s) as necessary to provide Covered Services to Members.

2.3.3. No Conflicts. Provider is not subject to any agreements or obligations that would interfere with Provider's ability to enter into or perform its obligations under this Agreement in accordance with its terms.

2.3.4. Credentialing. Provider and its Provider Professionals shall meet Plan's credentialing standards as specified in the Provider Manual and must be approved by the Plan before providing Covered Services to Members. Provider shall respond to requests from Plan for credentialing information. Failure to timely respond to such requests shall be grounds for termination pursuant to Section 5.2 hereto.

2.3.5. Right to Withdraw. Plan reserves the right to immediately withdraw from Provider any or all Members in the event that the health or safety of Members is endangered by the actions of Provider or if Provider ceases to maintain required licenses, hospital privileges, or ceases to meet Plan's credentialing criteria.

2.3.6. Change in Status or Information. Provider shall immediately notify Plan in writing of any change in licensure or hospital privilege status, any change in information provided to Plan through the credentialing process, and any change in address or practice status.

2.4. Access and Availability. Provider shall comply with the access and availability requirements and conditions for each applicable Program as required by Law and as further delineated in the Provider Manual, including but not limited to prompt scheduling of appointments and availability of Referral Services.

2.5. Covering Physicians. If Provider and its Provider Professionals are unable to provide Covered Services from time to time, Provider shall secure the services of qualified Covering Physicians who are Participating Providers or who otherwise meet the Plan's credentialing criteria and who are approved by the Plan to provide Referral Services to Members. Provider shall enter into written agreements with Provider Professionals and Covering Physicians consistent with the terms and conditions of this Agreement and the requirements of Law. Provider shall provide the Plan with a complete list of its Provider Professionals and

Covering Physicians, together with the information required by the Plan for credentialing and plan administration, which this Agreement is signed and thereafter whenever requested by the Plan. Upon request, Provider shall make such written agreements available to Plan or any applicable government agency, for review and approval.

2.6. Acceptance and Transfer of Members. Provider may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients. Provider shall not request or demand the transfer, discharge, or removal of any Member for reasons of the Member's need for, or utilization of, Covered Services, except in accordance with the procedures established by Plan for such action. Provider shall not request or demand the transfer, discharge or removal of any Member while the Member is hospitalized or is in the middle of a course of treatment and a determination has been made that interruption of care would be detrimental to the health of the Member. Provider shall not refuse or fail to provide or arrange Referral Services to any Member.

2.7. Medical Records. Provider shall maintain all patient medical records relating to Covered Services provided to Members, in such form and containing such information as required by the Provider Manual, QI and UM Programs, Accreditation Organizations and Law. Medical records shall be maintained in a manner that is current, detailed, organized and permits effective patient care and quality review by Provider and Plan pursuant to the QI Program. Medical records shall be maintained in a form and physical location which is accessible to Provider, Plan, government agencies and Accreditation Organizations. Upon request and within the timeframe requested, Provider shall provide to Plan, at Provider's expense, copies of Member medical records for purposes of conducting quality assurance, case management and utilization review, credentialing and peer review, claims processing, verification and payment, resolving Member grievances and appeals and other activities reasonably necessary for the proper administration of the applicable Program consistent with Law. The provisions of this Section shall survive termination of this Agreement for the period of time required by Law.

2.8. Insurance. Provider shall maintain professional and general liability insurance in the minimum amounts required by Law but not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate, to apply separately for each physician and health care practitioner who is insured under the policy (or policies) and for a period of seven (7) years following termination. In the event Provider procures a "claims made" policy as distinguished from an occurrence policy, Provider shall procure and maintain prior to termination of such insurance, continuing tail or extended reporting coverage for a period of not less than seven (7) years following such termination.

Provider, at its sole cost and expense, shall also maintain throughout the term of this Agreement, workers' compensation insurance as required by the State of California and general liability insurance, including but not limited to premises, personal injury and contractual liability insurance, in a minimum amount of one million dollars ($1,000,000) per occurrence, combined single limit, bodily injury and property damage, to insure Provider and its employees, agents, and representatives against claims for damages arising by reason of (i) personal injuries or death occasioned in connection with the performance of any Covered Services provided under this Agreement, (ii) the use of any property and facilities of the Provider, and (iii) activities performed in connection with this Agreement.

All insurance required of Provider under this Agreement shall be provided by insurers licensed to do business in the State of California and who have obtained an A.M. Best financial strength rating of A- or better and are classified by A.M. Best as being of financial size category VIII or greater. Provider may substitute comparable self-insurance coverage for the insurance coverage required by this Section only upon the prior written approval of Plan.

A certificate of insurance shall be issued to Plan prior to the Commencement Date and upon each renewal of the insurance coverage specified in this Section. The certificate shall provide that Plan shall receive thirty (30) days prior written notice of cancellation or material reduction in the insurance coverage specified in this Section. Notwithstanding anything to the contrary, if Provider has a claims-made based policy and such policy (or policies) is cancelled or not renewed, Provider agrees to exercise any option contained in the policy (or policies) to extend the reporting period to the maximum period permitted;

provided, however, that Provider need not exercise such option if the superseding insurer will accept all prior claims. Notwithstanding any other provision of this Agreement, Provider's failure to provide the certificate of insurance shall be grounds for immediate termination of this Agreement.

2.9. Notice of Charges. Provider shall notify Plan immediately of the issuance of any formal charges against Provider or any professional delivering Covered Services on behalf of Provider by any governmental authority or licensing or Accreditation Organization which would, if sustained, impact the Provider's ability to comply with its duties and obligations pursuant to this Agreement. Provider shall further notify the Plan immediately of the initiation of any formal inquiry, investigation, or review with or by any licensing or regulatory authority, peer review organization, hospital committee, or other committee, organization or body which reviews quality of medical care which complaint, inquiry, investigation, or review directly or indirectly, evaluates or focuses on the quality of care provided by Provider either in any specific instance or in general. Provider does not waive its rights to confidentiality protections provided under State or federal law, including California Evidence Code Section 1157.

2.10. Administrative Requirements. Provider agrees to perform its duties under this Agreement in accordance with Plan's administrative guidelines, policies and procedures as set forth in this Agreement, the Provider Manual, the Medi-Cal Provider Manual and Law. In the event of a conflict between this Agreement and the Provider Manual, the terms of this Agreement shall govern. In the event of a conflict between the Medi-Cal Provider Manual and either this Agreement or the Provider Manual, this Agreement or the Provider Manual, as applicable, will govern.

2.11. Data Requirements.

2.11.1. General Data and Information. Provider shall maintain and provide at no cost to Plan, upon written request, any and all information as reasonably required by Plan, Law, government agencies or Accreditation Organizations. Provider shall submit such information and data to Plan in the format and within the time periods specified by Plan. Upon reasonable request, Provider shall allow Plan personnel reasonable on-site access to Provider records in connection with Plan's QI Program, UM Program or for other valid purposes. Provider shall accurately and completely maintain all information and data required by this Agreement, including medical records, necessary to characterize the scope and purpose of Covered Services provided to Members for the time period required by Law.

2.11.2. Covered Services Documentation. Upon reasonable request and as required by the Provider Manual, Provider shall provide Plan with Covered Services Documentation at no cost to Plan. Provider will utilize and cooperate with Plan reporting tools for Covered Services Documentation as set forth in the Provider Manual. All Covered Services Documentation shall be provided on a timely basis and shall be supported by information recorded in the applicable Member's medical chart. By signing this Agreement, Provider hereby attests to the accuracy, completeness and truthfulness of all Covered Services Documentation provided pursuant to this Agreement. Provider shall provide additional attestations as requested by the Plan to support the accuracy, completeness and truthfulness of the Covered Services Documentation.

2.12. Pharmaceuticals. If Provider is licensed to prescribe drugs and medications, Provider shall prescribe drugs and medications in accordance with all applicable Law and the Plan's drug formulary. Plan's drug formulary is the Medi-Cal drug contract list as specifically modified by Plan. Provider may access the Plan's formulary online at http://www.ccah-alliance.org/formulary.html to find out if a particular medication is listed.

2.13. HIPAA Compliance. Provider represents and warrants that it is presently and shall remain at all relevant times compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). Provider represents and warrants with respect to all Protected Health Information ("PHI"), (as defined under 45 C.F.R. § 164.501), that it is a Covered Entity under 45 C.F.R. Section 164.501 (and not a business associate of Plan), and that it shall use all appropriate safeguards to prevent the use or disclosure of PHI other than as allowed by Law.

2.14. Identification of California Children's Services Eligible Conditions. Provider will comply with Plan's policies and procedures as described in the Provider Manual for the identification and referral of Members with suspected California Children's Services ("CCS") eligible conditions to the local CCS Program Office. If a CCS eligible Member is identified, Provider shall continue to provide all Referral Services other than those services necessary to treat the CCS eligible condition. Provider agrees to coordinate services for such CCS eligible Members with CCS specialty providers and the CCS Program.

2.15. Training. Provider and its practitioners and staff will participate in applicable training programs available through the Plan as required by any applicable Member Group Contract or as required by the Plan to address any Plan policies and procedures. The Plan will notify Provider of any training program that must be completed pursuant to a Member Group Contract and the timeframe for completing such required training.

ARTICLE III.
DUTIES OF PLAN

3.1. Assignment of Members. Plan shall allow Members whose Program and status requires assignment of a Primary Care Physician to select and then be assigned to a Primary Care Physician and shall assign Members who do not make such a selection in accordance with Plan policies.

3.2. Plan Communications. Plan shall establish a system of Member identification, communicate the requirements of the Provider Manual to Participating Providers, and identify Participating Providers to Members. Plan shall be responsible for providing applicable notification to Members upon notification of termination of Provider.

3.3. Records. Plan shall maintain and furnish such records and documents as may be required by applicable Law, and shall create, maintain and transmit such records and documents in accordance with generally accepted industry standards and the requirements of applicable Laws.

3.4. Licensure. Plan shall maintain such licenses as are necessary for the performance of its obligations hereunder.

3.5. Limitations. Plan makes no representations or guarantees concerning the number of Members it can or will assign to Provider under this Agreement. Plan shall not be obligated to include Provider in all Participating Provider directories or in all Programs or to utilize or market Provider for all services available from Provider.

3.6. Continuation of Care. In the event this Agreement is terminated due to Plan's insolvency, Plan shall provide for continuation of Covered Services to Members for the duration of the period for which payment has been made by DHCS to Plan, as well as for inpatient admissions until discharge. Plan shall comply with its legal obligations to ensure continuity of care for its Members pursuant to California Law.

ARTICLE IV.
COMPENSATION

4.1. Submission of Claims. Provider agrees to submit to Plan all fee-for-service Complete Claims for Covered Services rendered to eligible Members. Complete Claims shall be submitted to the location described in the Provider Manual within one (1) year of the provision of Covered Services and in the format specified in the Provider Manual. Complete Claims will be paid within the timeframe required by Law as applicable to each Program. 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 claims not submitted by Provider within the timeframe set forth above and in accordance with the billing procedures set forth in the Provider Manual. Provider agrees that Plan will be materially damaged by late claim submittals and agrees to waive any right to assert that it is entitled to payment for claims asserted beyond the time periods specified above, unless Provider submits a dispute pursuant to Section 6.5 and shows good cause for delay.

4.2. Payment. Plan shall pay Provider for Covered Services rendered to eligible Members in accordance with the provisions of this Agreement, including Exhibit H hereto, and the Provider Manual. Provider agrees to accept such amounts paid by Plan, and any applicable Member Payment, as payment in full.

4.3. Adjustments to Payments. Only those charges for Covered Services billed in accordance with the Plan's claims coding standards will be payable. If Plan determines that services rendered are inappropriate or not Medically Necessary, coding practices do not comply with Plan standards, payment is not in accordance with the terms of this Agreement or services were provided to a patient who was not an eligible Member as of the date of service, Plan may deny, reduce, or otherwise adjust payment to Provider. The Plan may also adjust payment rates as specified in Exhibit H for the following reasons:

4.3.1. Adjustments to Fee Schedules. In the event a government program (including, without limitation, the Medi-Cal Program, as defined in Exhibit B) revises a payment rate or a procedure or revenue code under a Program fee schedule pursuant to which payments are determined under this Agreement, Plan shall, in order to ensure payment according to the current fee schedule, adopt such adjustments in the same manner and on the same effective date as adopted by the government program.

4.3.2. Audit and Recovery. Plan, or the Plan's third party designee, shall have the right to conduct periodic audits of all records maintained by the Provider with respect to all payments received by Provider from Plan for Covered Services rendered to Members during the term of this Agreement. If an audit shows that the Plan has overpaid any claim or if Plan identifies an overpayment through any other process, Plan will send a written request for the reimbursement of the overpayment within one year (365 days) of the date of the claim overpayment as required by applicable Law, unless the overpayment was caused in whole or in part by Provider's fraud or misrepresentation, in which case Plan shall not be limited to 365 days. If Provider does not contest the Plan's request for reimbursement of the overpayment within thirty (30) days in writing or reimburse the Plan, the Plan may offset or recoup the amounts overpaid against amounts due and owing from Plan to Provider. If Provider contests a request for reimbursement, then Provider shall send a written notice to Plan stating the basis for which the claim was not overpaid and the matter shall be resolved in accordance with the Plan's provider dispute resolution process in Section 6.5 of this Agreement and the Provider Manual. This provision shall survive the termination of this Agreement.

4.3.3. Never Event. Provider agrees to waive all charges directly related to a Never Event regardless of whether the charges are the responsibility of the Plan or Member.

4.4. Coordination of Benefits. Provider agrees to comply with the Plan's coordination of benefits ("COB") policies and procedures as specified in this Agreement, the Provider Manual, the Membership Contracts, and any applicable Law.

4.4.1. Member Screening. Provider agrees to screen each Member receiving Covered Services to determine if the Member has Medicare coverage or other health coverage, and agrees to provide such information to Plan upon request.

4.4.2. Plan is Primary. When Plan is primary under the Plan's coordination of benefits rules, Plan shall pay Provider, as set forth in this Agreement, the amount due for Covered Services rendered to Members.

4.4.3. Plan is Secondary. When Plan is secondary under the Plan's coordination of benefits rules, Plan shall pay for Covered Services according to the Plan's policies and procedures as set forth in the Provider Manual. Plan will deny claims from Provider if it fails to first make recoveries from other health care coverage sources.

4.4.4. Refund. If following payment by Plan for Covered Services Provider discovers that it is entitled to payment or receives payment from another payor that is primary to Plan, Provider shall notify Plan and refund any amount overpaid by Plan within thirty (30) days.

4.5. Claim Correction Requests and Disputes. If Provider believes Provider is entitled to any payment for a Covered Service from Plan, or for payment in excess of the amount the Plan has paid or indicated it will pay, then Provider shall not directly or indirectly bill for or seek to collect from Plan any such payment or additional payment for Covered Services beyond the amount that Plan has paid or indicated it will pay for such Covered Services except pursuant to either a request for a claim correction submitted to the Claims Department as specified in the Provider Manual, or pursuant to a dispute filed with Plan as specified in Section 6.5 of this Agreement and the Provider Manual.

4.6. Hold Harmless. Provider agrees that, in no event, including but not limited to nonpayment by Plan, insolvency of Plan, breach of this agreement, or denial of claims by Plan due to Provider's failure to properly submit claims, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Member or any person acting on behalf of a Member to whom Covered Services have been provided in accordance with the terms of this Agreement or any Program, or the State of California for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting Member Payments as specifically provided under any applicable Member Group Contract or Membership Contract or from pursuing claims against the applicable primary payor. Failure to comply with this Section shall be deemed a material breach of this Agreement and Provider may be terminated for cause pursuant to Section 5.2.2 of this Agreement as the result of such failure. This provision shall survive the termination of the Agreement, regardless of the reason for termination, including insolvency of Plan.

4.7. No Surcharges. Provider understands that surcharges against Members are prohibited and that Plan will take appropriate action if surcharges are imposed. A "surcharge" is an additional fee which is charged to a Member for a Covered Service but which is not a Member Payment as provided for under the applicable Member Group Contract and Membership Contract.

4.8. Reporting of Surcharges and Member Payments. Provider will report to Plan all surcharge and Member Payment monies paid by Member directly to Provider and shall refund all surcharges.

4.9. No Charge for non-Covered Services. Provider shall not charge a Member for a service which is not a Covered Service unless, in advance of the provision of such service, the Member has been notified by Provider that the particular service will not be covered and Provider obtains a written statement in a form acceptable to the Plan, signed by the Member or the person responsible for paying for services rendered that he or she shall be responsible for payment of charges for such service.

4.10. Payments Following Termination of this Agreement. Following termination of this Agreement and during the continuing care period described in Section 5.10 hereto, Plan shall compensate Provider at the applicable Program payment rates set forth in Exhibit H to this Agreement for providing Covered Services to Members until such Members are assigned to other Plan Participating Providers.

4.11. Incentive Programs. Provider shall participate in Plan's Utilization Management Incentive Program, as described in Addendum 1 hereto, for the term of such program.

4.12. No Inducement to Deny Covered Services. Provider acknowledges and agrees that this Agreement does not contain any financial incentive or make any payment that acts directly or indirectly as an inducement to limit Medically Necessary health care services.

ARTICLE V.
TERM AND TERMINATION

5.1. Term. The term of this Agreement shall commence on January 1, 2011 (the "Commencement Date"), and shall expire on December 31 of the same year of the Commencement Date. Thereafter, the term of this Agreement shall be automatically extended for a one (1) year term on each succeeding January 1 (the "Renewal Date"), unless terminated by either party as provided herein.

5.2. With Cause Termination of Agreement. Either Plan or Provider may terminate this Agreement for cause as set forth below, subject to the notice requirement and cure period set forth below.

5.2.1. Cause for Termination of Agreement by Provider. The following shall constitute cause for termination of this Agreement by Provider:

5.2.1.1. Non-Payment. Material failure by Plan to make any payments due Provider hereunder within forty-five (45) days of any such payment's due date and Plan's failure to cure such failure to make such payments due to Provider within the cure period provided at Section 5.2.3, below.

5.2.1.2. Breach of Material Term and Failure to Cure. Plan's material breach of any material term, covenant, or condition and subsequent failure to cure such breach as provided in Section 5.2.3, below.

5.2.2. Cause for Termination of Agreement by Plan. The following shall constitute cause for termination of this Agreement by Plan:

5.2.2.1. Breach of Material Term and Failure to Cure. Provider's material breach of any material term, covenant, or condition and subsequent failure to cure such breach as provided in Section 5.2.3, below.

5.2.2.2. Insolvency. Provider becomes insolvent, as reasonably determined by Plan.

5.2.2.3. Failure to Comply with Standards. Provider fails to provide Covered Services in accordance with the standards set forth in this Agreement and Plan's QI Program and UM Program. Plan reserves the right to immediately transfer from Provider any Members and cease referrals of any or all Members in the event the health or safety of Members is endangered by the actions of Provider, or as a result of continuation of this Agreement.

5.2.3. Notice of Termination, Cure Period and Effective Date of Termination. The party asserting cause for termination of this Agreement (the "terminating party") shall provide written notice of termination to the other party specifying the breach or deficiency with sufficient information to allow the receiving party to identify the actions necessary to cure such breach. The party receiving the written notice of termination shall have thirty (30) calendar days from the receipt of such notice to cure the breach or deficiency to the satisfaction of the terminating party (the "Cure Period"). If such party fails to cure the breach or deficiency to the reasonable satisfaction of the terminating party within the Cure Period or if the breach or deficiency is not curable, the terminating party shall have the right to provide written notice of failure to cure the breach or deficiency to the other party following expiration of the Cure Period. The Agreement shall terminate thirty (30) calendar days following receipt of the written notice of failure to cure or at such later date as may be specified in such notice. During the Cure Period and the period following the Cure Period, Plan may begin transferring Members to other Participating Providers. Notwithstanding the above, in the event Plan provides notice of termination as the result of a breach by Provider and the Plan reasonably determines the health and safety of Members is

endangered by the actions of Provider, Plan shall have the right to terminate the Agreement immediately.

5.3. Automatic Termination Upon Revocation of License or Certificate. This Agreement shall automatically terminate upon the revocation, suspension or restriction of any license, certificate or other authority required to be maintained by Provider or Plan in order to perform the services required under this Agreement or upon the Provider's or Plan's failure to obtain such license, certificate or authority. In addition, this Agreement shall automatically be terminated if: (i) Provider is excluded from participation in the Medicare program or is subjected to sanctions imposed by the Medicare program or the Medicaid program; (ii) Provider's professional liability insurance or any other Provider insurance required under this Agreement is cancelled, non-renewed, or is no longer in effect; (iii) Provider fails to comply with Section 2.3 of this Agreement; or (iv) Provider dies or becomes incapacitated (as reasonably determined by Plan).

5.4. Termination of Member Group Contract. If any Member Group Contract terminates, this Agreement shall automatically terminate with respect to Members covered under the Member Group Contract on the date the Member Group Contract and any continuing care obligations under the Member Group Contract terminate.

5.5. Termination Without Cause. Either party may terminate this Agreement without cause at any time by giving the other party at least one hundred twenty (120) days prior written notice.

5.6. Termination if No Agreement on Provider Manual Modifications or Material Changes to Agreement. This Agreement may be terminated pursuant to the terms specified in Sections 6.8.2 and 6.8.3.

5.7. Transfer of Medical Records. Following termination of this Agreement, at Plan's request, Provider shall copy all requested Member medical records in the possession of Provider and forward such records to another provider of Covered Services designated by Plan, provided such copying and forwarding is not otherwise objected to by such Members. The cost of copying the Members' medical records shall be borne by Provider. Provider shall maintain the confidentiality of such Member medical records at all times.

5.8. Repayment Upon Termination. Within one hundred eighty (180) calendar days of the effective date of termination of this Agreement, an accounting shall be made by Plan of the monies due and owing either party and payment shall be forthcoming by the appropriate party to settle such balance within thirty (30) calendar days of such accounting.

5.9. Termination Not an Exclusive Remedy. Any termination by either party pursuant to this Article V is not meant as an exclusive remedy and such terminating party may seek whatever action in law or equity as may be necessary to enforce its rights under this Agreement. Notwithstanding the foregoing, the parties agree to waive any and all rights they may have to assert claims for or recover exemplary or punitive damages against the other party.

5.10. Continuing Care Obligations of Provider. If this Agreement is terminated for any reason, Provider shall continue to provide Covered Services, including Referral Services, to Members, including any Members who become eligible during the termination notice period, beginning on the effective date of termination and continuing until the first to occur of (i) a period of one hundred and twenty (120) days following termination of this Agreement or such longer period required for any Member as required by Law, or (ii) the date Plan provides written notice to Provider that it has made arrangements for all Members to receive services from another Participating Provider of Referral Services. In addition, Provider will continue to provide Covered Services, including Referral Services, to any Members who cannot be transferred within the time period specified above for Members who are hospitalized upon the expiration of the continuing care period, for Members who are entitled to continuing care as the result of their condition pursuant to Law, and otherwise in accordance with Plan's legal and contractual obligations to ensure continuity of care for its Members.

5.11. Fair Hearing. Notwithstanding the time periods for termination set forth in Sections 5.2 through 5.5 of this Agreement, in all cases in which Plan terminates this Agreement and Provider is entitled to a fair hearing under Plan's applicable notification and hearing procedures set forth in the Provider Manual, the termination will be final thirty (30) days from notice of the right to request a hearing, unless Provider 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, upon the request of Plan, Provider shall not thereafter provide Covered Services to Members until a decision is rendered and Plan reserves the right to transfer Members to other Participating Providers in its reasonable discretion.

ARTICLE VI.
GENERAL PROVISIONS

6.1. Independent Contractor Relationship. The relationship between Plan and Provider is an independent contractor relationship. Neither Provider nor its employees or agents are employees or agents of Plan. Neither Plan nor its employees or agents are partners, employees or agents of Provider.

6.2. Indemnification. Provider shall indemnify and hold harmless Plan and its directors, officers, employees, affiliates and agents against any claim, loss, damage, cost, expense or liability (including reasonable costs of defense) arising out of or related to the performance or nonperformance by Provider, its employees or agents of any Referral Services or other services to be performed or arranged by Provider under this Agreement; provided, however, that Provider shall not be responsible for indemnifying Plan for Plan's own acts or omissions.

6.3. Member Grievances. Plan shall be responsible for resolving Member claims for benefits under the Programs and all other claims against Plan. Provider will immediately refer Members to contact Plan or deliver any written complaint to Plan for handling pursuant to Plan's Member Grievance Procedures. Provider shall comply with all final determinations made by Plan through the Member Grievance Procedures.

6.4. Disputes Between Provider and Member. Any controversies or claims between Provider and a Member arising out of the performance of this Agreement by Provider, other than claims for benefits under the Program, are not governed by this Agreement. Provider and the Member may seek any appropriate legal action to resolve such controversy or claim deemed necessary. Provider will provide written notice to Plan of any dispute between Provider and Member.

6.5. Disputes Between Plan and Provider. Any claim, dispute, or other matter arising out of, relating to, or in any way connected with this Agreement, shall be addressed through the Plan's provider dispute resolution procedure as set forth in the Provider Manual. Provider will be informed of any changes to the provider dispute procedures including any changes to the procedures for processing and resolving disputes and the location and telephone number where information regarding disputes may be submitted. If the procedure set forth in this Section 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, Monterey or Merced County. Plan retains all immunities applicable to public entities to which it is entitled by law.

6.6. Notice. All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission. The addresses or facsimile number specified on the signature page shall be the addresses for delivery or mailing of notice. The parties may change the names, addresses, and facsimile numbers noted above through written notice in compliance with this Section. Notices shall be effective upon receipt.

6.7. Assignment. Neither this Agreement nor any portion of this Agreement shall be assigned, transferred or pledged in any way by Provider and shall not be subject to execution, attachment or similar process without

the prior written consent of Plan. A change of ownership through the sale of Provider's stock or assets shall be deemed an assignment requiring consent pursuant to this Section.

6.8. Amendments. Except as provided herein, no amendments or modifications to this Agreement shall be valid unless made in writing and signed by both Provider and Plan, and unless any required regulatory approvals are obtained.

6.8.1. Legally Required Modifications. The Plan may amend this Agreement at any time in order to comply with Law or any requirements of a private sector Accreditation Organization, as reasonably interpreted by the Plan. Plan shall notify Provider of such legally required modification. Such amendment shall be effective upon written notice to Provider, and shall not require the written consent of Provider.

6.8.2. Provider Manual Modifications. If Plan materially amends a manual, policy or procedure document referenced in the Agreement ("Provider Manual Modification"), Plan will provide at least forty five (45) business days' notice to Provider, and Provider will have the right to negotiate and agree to the change. If the parties cannot agree to the Provider Manual Modification, Provider will have the right to terminate the Agreement prior to the implementation of the Provider Manual Modification.

6.8.3. Material Changes to Agreement. For Providers compensated on a fee-for-service basis, Plan may amend a material term to the Agreement by providing a minimum of ninety (90) business days' notice of its intent to change a material term of the Agreement ("Material Change Notice"). Provider shall have the right to negotiate and agree to the change within thirty (30) business days of Provider's receipt of the Material Change Notice ("Right to Negotiate") by providing written notice of such intent within the thirty (30) business day period. Provider shall have the right to terminate the Agreement effective ninety (90) business days following the receipt of the Material Change Notice if Provider does not exercise Provider's Right to Negotiate or no agreement is reached during the ninety (90) business day period and if Provider provides notice of its intent to terminate prior to the expiration of the ninety (90) business day period. The material change shall become effective ninety (90) business days following the Material Change Notice if Provider does not exercise its Right to Negotiate or does not provide timely notice of its intent to terminate as described above. The parties may agree to the material change at any time during the ninety (90) business day period by mutual written agreement.

6.8.4. Non-Material Amendments to Agreement. The Plan may notify Provider of amendments to non-material terms of this Agreement. Such amendments shall be effective upon written notice to Provider, and shall not require the written consent of Provider.

6.8.5. Program Benefit Changes. Program benefit changes shall be effective upon implementation, following receipt of any required regulatory approvals.

6.9. Confidential and Proprietary Information.

6.9.1. Information Confidential and Proprietary to Plan. Provider shall maintain confidential all information designated in this Section. The information which Provider shall maintain confidential (the "Confidential Information") consists of: (i) any information containing the names, addresses and telephone numbers of Members which has been compiled by Plan; (ii) the financial arrangements between Plan and any of Plan's Participating Providers, including Provider; and (iii) any other information compiled or created by Plan which is proprietary to Plan and which Plan identifies in writing to Provider.

6.9.2. Non-Disclosure of Confidential Information. Neither party shall disclose or use the Confidential Information for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement. The parties may use the Confidential Information to the extent

necessary to perform its duties under this Agreement or upon express prior written permission of the other party. Upon the effective date of termination of this Agreement, Provider shall provide and return to Plan the Confidential Information in their possession in the manner specified by Plan.

6.9.3. Plan Names, Logos and Service Marks. Each party shall obtain the written consent of the other party prior to using the party's name, product names, logos and service marks in any promotional, marketing or advertising materials or for any other reason.

6.10. Solicitation of Plan Members. Provider shall not engage in solicitation of Members without Plan's prior written consent. Solicitation shall mean conduct by an officer, agent, employee or contractor of Provider or their respective assignees or successors during the term of this Agreement, and during the twelve (12) months immediately following the effective date of termination of this Agreement which may be reasonably interpreted as designed to persuade Members to disenroll from the Program or discontinue their relationship with Plan. Provider agrees that Plan shall, in addition to any other remedies provided for under this Agreement, have the right to seek a judicial temporary restraining order, preliminary injunction, or other equitable relief against Provider to enforce its rights under this Section in a manner consistent with and to the extent permitted by California law.

6.11. No Restrictions on Discussing a Member's Health Care. Nothing in this Agreement shall be interpreted to discourage or prohibit Provider or its Provider Professionals from discussing a Member's health care including, without limitation, communications regarding treatment options, alternative health plans or other coverage arrangements, unless such communications are for the primary purpose of securing financial gain.

6.12. Invalidity of Sections of Agreement. The unenforceability or invalidity of any paragraph or subparagraph of any section or subsection of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

6.13. Survival. The following provisions of this Agreement shall survive the termination of this Agreement: Sections 2.7, 2.8, 2.11, 2.13, 3.6, Article IV, Sections 5.6, 5.7, 5.8, 5.9, 5.10, 6.2, 6.4, 6.5, 6.10, 6.11 and any other section where survival of termination is required by Law.

6.14. Waiver of Breach. The waiver by either party to this Agreement of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

6.15. Entire Agreement. This Agreement, including all exhibits, attachments, addenda, and amendments hereto and the Provider Manual contains all the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement are null and void and of no further force or effect.

6.16. Incorporation of Exhibits and Attachments. The schedules, exhibits, addenda, and attachments to this Agreement and the Provider Manual are integral parts of this Agreement and are incorporated in full herein by this reference.

6.17. Authority to Bind. Each signatory of this Agreement represents and warrants individually on behalf of himself or herself, and the party on whose behalf he or she executes this Agreement, that he or she is duly authorized to execute this Agreement.

ARTICLE VII.
GOVERNING LAW AND REGULATORY REQUIREMENTS

7.1. Governing Law. This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of California, except where preempted by federal law, and the laws of the United States of America.

7.2. Americans with Disabilities Act of 1990. Provider's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled which includes, but is not limited to ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

7.3. Civil Rights Act of 1964. Provider will comply with Title VI of the Civil Rights Act of 1964 and any implementing regulations that prohibits recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

7.4. Language Assistance. Provider agrees to comply with the Plan's Language Assistance Program as detailed in the Plan's Policies and Procedures and Provider Manual.

7.5. Certification. As required by Title 31 U.S.C. Section 1352, if payments under this Agreement are $100,000 or more, Provider certifies to the best of Provider's knowledge and belief that no Federally appropriated funds have been paid or will be paid, by or on behalf of Provider, 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 payments under this Agreement are $100,000 or more, Provider shall submit to Plan the "Certification Regarding Lobbying" set forth in the Provider Manual. 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, Provider shall complete and submit to Plan standard form LLL, "Disclosure of Lobbying Activities", in accordance with its instructions. Provider shall file such disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by Provider. Provider 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. All such disclosure forms of subcontractors shall be forwarded to Plan.

7.6. Antifraud Plan. Provider agrees to comply with Plan's antifraud plan, as detailed in the Provider Manual. Provider will immediately notify Plan of (i) investigations of Provider or Provider's employees in which there are allegations relating to fraud, waste or abuse, and (ii) suspected cases where there is reason to believe that an incident of fraud, waste or abuse has occurred.

7.7. No Inducement for Referrals. The parties acknowledge and agree that: (1) they intend to comply with the safe harbor requirements set forth in 42 C.F.R. §1001.952(t); (2) in establishing the terms of the Agreement, including the exhibits, addenda and attachments hereto, neither party gave or received remuneration in return for or to induce the provision or acceptance of business (other than business covered by the Agreement) for which payment may be made in whole or in part by a federal health care program on a fee-for-service or cost basis; and (3) neither party will shift the financial burden of the Agreement to the extent that increased payments are claimed from a federal health care program. Plan represents and agrees that it is an eligible managed care organization, as defined in 42 C.F.R. §1001.952(t). Provider represents and agrees that (a) Provider is a first tier contractor under the Agreement, defined as an individual or entity that has a direct contract with Plan, as the managed care organization, to provide or arrange for items or services; and (b) Provider cannot and will not claim payment in any form, directly or indirectly, from a federal health care program for items or services covered under the Agreement for Members enrolled in the Plan, except as provided in 42 C.F.R. §1001.952(t).

7.8. Compliance with Law. Provider and any subcontractor to Provider shall comply with the Program Requirements set forth in the exhibits hereto. Any provisions required to be included in the Agreement by applicable Law, including the Knox-Keene Health Care Service Plan Act of 1975 (Cal. Health & Safety Code Section 1340 et seq.) and the regulations promulgated thereunder, shall be binding upon and enforceable against the parties to the Agreement and shall be deemed incorporated herein whether or not expressly set forth in the Agreement, including the exhibits hereto.

IN WITNESS WHEREOF, the undersigned have executed this Agreement effective as of the Commencement Date.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

By: Jane Parker

Print: Jane Parker

Title: Chair, CCAH

Date: July 29, 2011

PROVIDER

By: [signature]

Print: HARRY WEIS

Title: CEO

Date: 06/13/11

Provider Address and Facsimile Number for Notices:

Street: 1441 CONSTITUTION BLVD

City, State ZIP: SALINAS, CA 93906

Facsimile Number: (831) 755-6254

EXHIBIT A

SCHEDULE OF PROGRAMS

Provider has been approved to provide Covered Services, including Referral Services, under the Programs defined below and pursuant to the applicable terms and conditions of the Agreement. The Plan may amend the counties in which each Program operates from time to time, by providing Provider with written notice of such changes.

Medi-Cal Program: is a state- and federally-funded Program pursuant to a contract between the Plan and DHCS for coverage of Members who meet Medi-Cal eligibility requirements, as determined by DHCS. The Medi-Cal Program is, as of the Commencement Date, offered in Merced, Monterey, and Santa Cruz Counties.

Healthy Families Program: is a state- and federally-funded Program pursuant to a contract between the Plan and the California Managed Risk Medical Insurance Board ("MRMIB") for coverage of Members who meet Healthy Families Program eligibility requirements, as determined by MRMIB. The Healthy Families Program is, as of the Commencement Date, offered in Monterey and Santa Cruz Counties.

Alliance Care IHSS Health Program: is a state- and federally-funded Program pursuant to a contract between the Plan and the County of Monterey for coverage of Members who meet Alliance Care IHSS Health Program eligibility requirements, as determined by the County of Monterey. As of the Commencement Date, the Alliance Care IHSS Health Program is offered in Monterey County.

Healthy Kids Program: is a county-funded Program pursuant to contracts between the Plan and First 5 Santa Cruz County, the County of Santa Cruz, the Community Foundation of Santa Cruz County, and the Pajaro Valley Community Health Trust for coverage of Members who meet Healthy Kids Program eligibility requirements, as determined by Santa Cruz County. As of the Commencement Date, the Healthy Kids Program is offered in Santa Cruz County.

Alliance Care Access for Infants and Mothers (AIM) Program: is a state-funded Program pursuant to a contract between the Plan and the California Managed Risk Medical Insurance Board ("MRMIB") for coverage of Members who meet AIM Program eligibility requirements as determined by MRMIB. As of the Commencement Date, the AIM Program is offered in Monterey County.

Alliance Care Individual Conversion Program: is a Program offered by the Plan to the Plan's Alliance Care IHSS Members when IHSS Members are no longer eligible to continue participation in the Plan's Alliance Care IHSS Program through COBRA or Cal-COBRA. As of the Commencement Date, the Alliance Care Individual Conversion Program is offered in Monterey County.

EXHIBIT B

MEDI-CAL PROGRAM ATTACHMENT

This Exhibit B sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Medi-Cal Program.

1. With respect to the Medi-Cal Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the Medi-Cal Member Group Contract and Medi-Cal Member Handbook. Covered Services, including Referral Services, for Medi-Cal Members are set forth in Title 22 of the California Code of Regulations Section 51301 et seq., and Title 17 of the California Code of Regulations Section 6840 et seq. Information regarding Referral Services, excluded services, and certain health screening and preventive services for Medi-Cal Members is set forth in the Provider Manual.

2. With respect to the Medi-Cal Program, the term "Medi-Cal Member" shall mean an individual who is enrolled in Medi-Cal and who is determined to be eligible for membership in the Medi-Cal Program. A newborn of a 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 Medi-Cal Member is covered under the mother's membership during the mother's first month of enrollment.

3. Provider agrees to make all of its books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination or copying: (A) By the California Department of Health Care Services ("DHCS"), the United States Department of Health and Human Services, the California Department of Corporations, the United States Department of Justice, and the California Department of Managed Health Care; (B) At all reasonable times at the Provider's place of business, or at such other mutually agreeable location in California; (C) In a form maintained in accordance with the general standards applicable to such book or record keeping; (D) For a term of at least five years from the close of the Fiscal Year in which this Agreement was in effect; five years from the close of the current Fiscal Year in which the date of service occurred; five years from the date that the record or data was created or applied, and for which the financial record was created, or such longer period as required by Law; and (E) including all Covered Services Documentation for a period of at least 5 years, or such longer period as required by Law.

4. Member Payments are not permitted under the Medi-Cal Program. Provider shall not seek reimbursement of any such payments from Medi-Cal Members for any Covered Services provided under this Agreement.

5. Provider agrees to submit reports as required by Plan.

6. Plan shall conduct site reviews on all Referral Services sites according to Medi-Cal Managed Care Division Policy Letter 02-02.

7. If this Agreement terminates for any reason, Provider will assist the Plan in the transfer of care. Additionally, Provider will assist in the orderly transfer of necessary data and records to the Plan, a successor Plan, or DHCS. Provider will assist in the transition of Members, and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Provider will make available to Plan or DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Members, as determined by the Director of DHCS. In no circumstances will a Medi-Cal Member be billed for this activity.

8. Provider shall notify DHCS in the event the Agreement is terminated. Notice to the Department is considered given when properly addressed and deposited in the United States Postal Service as first-class

registered mail, postage attached. Notice should be mailed to the Department of Health Care Services, Medi-Cal Managed Care Division, County Organized Health Systems MS 4408, P.O. Box 997413, Sacramento, CA 95899.

9. Provider agrees that the assignment or delegation of any part of this Agreement shall be void unless prior written approval is obtained from DHCS in those instances where prior approval is required.

10. Provider agrees to 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.

11. Prior to commencing services under the Agreement, Provider shall provide Plan with any necessary disclosure statements, including the statement set forth in Title 22 of the California Code of Regulations, Section 51000.35.

12. If Provider provides Covered Services through nurse practitioners, physician assistants, or nurse midwives ("Non-Physician Medical Practitioners"), the ratio of one physician to Non-Physician Medical Practitioners may not exceed the following: (i) four (4) nurse practitioners; (ii) three (3) nurse midwives; (iii) four (4) physician assistants; or (iv) four (4) of the above individuals in any combination which does not exceed three (3) nurse midwives or two (2) physician assistants. Each individual Non-Physician Medical Practitioner shall maintain a full-time equivalent provider to patient caseload of no more than one thousand (1,000).

13. Provider shall ensure that Members are informed of the full array of covered contraceptive methods when appropriate and that informed consent is obtained from Members for sterilization consistent with requirements of applicable Law.

14. Provider will comply with the Medi-Cal Minor Consent Services program. Minors do not need parental consent in order to access services related to sexual assault, including rape, drug or alcohol abuse (for children 12 years of age or older), pregnancy, family planning, and STDs and HIV/AIDS (in children 12 years of age or older).

15. For Medi-Cal Members under the age of 21, the term "Medically Necessary" includes those standards set forth in Title 22 of the California Code of Regulations Sections 51340 and 51340.1.

16. When Provider provides Emergency Services to a Medi-Cal Member and such Member's treatment requires the use of drugs, Provider shall provide to the Member at least a 72-hour supply of Medically Necessary drugs, which may include an initial dose and a prescription for additional drugs.

17. Provider will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of payment and other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state the Provider's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

18. Provider will, in all solicitations or advancements for employees placed by or on behalf of Provider, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

19. Provider will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Provider's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

20. Provider will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

21. Provider will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

22. In the event of the Provider's noncompliance with the requirements of the provisions herein or with any Federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Provider may be declared ineligible for further Federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

23. By signing this Agreement, Provider agrees that if any performance under this Agreement or any subcontract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC Section 263a (CLIA) and the regulations thereto.

24. Provider shall comply with all applicable Federal requirements in Section 504 of the Rehabilitation Act of 1973 (29 USC Section 794) Nondiscrimination under Federal grants and programs; Title 45 CFR Part 84 Nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance; Title 28 CFR Part 36 Nondiscrimination on the basis of disability by public accommodations and in commercial facilities; Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 the Age Discrimination Act of 1975; and all other laws regarding privacy and confidentiality.

25. Provider shall comply with Plan's policies and procedures as described in the Provider Manual relating to the identification of Members that may be eligible for other Programs.

26. Provider 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 or Workers Compensation liability of a third party, casualty liability coverage, or any other third-party liability which could result in recovery by the Medi-Cal Member of funds for which DHCS has lien rights under Welfare and Institutions Code Section 14124.70. Provider shall identify and notify Plan of cases in which such an action could result in recovery by the Member. Provider shall notify Plan immediately upon the discovery of such cases and shall provide any requested information promptly to Plan. DHCS retains the right to such third-party tort and Workers Compensation liability, and casualty liability recoveries with respect to Medi-Cal Members as set forth in Welfare and Institutions Code Section 14124.70 and following.

EXHIBIT C

HEALTHY FAMILIES PROGRAM ATTACHMENT

This Exhibit C sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Healthy Families Program.

1. With respect to the Healthy Families Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the Healthy Families Member Group Contract. Covered Services, including Referral Services, for Healthy Families Members are set forth in Sections 2699.6700 through 2699.6707 of Title 10 of the California Code of Regulations, and are also described in the Healthy Families Evidence of Coverage and the Plan's Provider Manual.

2. Provider will comply with Plan's policies and procedures as described in the Provider Manual for the identification and referral of Members that have a serious emotional disturbance or serious mental disorder to the County Mental Health Department Programs.

3. Provider will provide extended payment plans for Members utilizing a significant number of health services for which Member Payments are required. When feasible, Provider shall offer an extended payment plan when a Member's Payment exceeds twenty-five dollars ($25) in one month.

4. Provider agrees that the awarding department ("the State"), the Department of Managed Health Care and the Bureau of State Audits, or their designated representatives, shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Provider agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated or required by Law. Provider agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, Provider agrees to include the same right of the State to audit records and interview staff in any subcontract related to performance of this Agreement.

5. During the performance of this Agreement, Provider, 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. Provider, 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. Provider, its employees and agents, shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 (a-f), 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. Provider shall give written notice of its obligations under this clause to labor organizations with which it has a collective bargaining or other agreement.

6. Provider 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 Commencement Date, on an annual basis, upon any change in information, and upon request, if required by law or by Plan's Member Group Contracts.

Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. Provider 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 Member Group Contracts. Such Debarment Certification and its instructions are set forth in the Provider Manual.

EXHIBIT D

ALLIANCE CARE IHSS HEALTH PROGRAM ATTACHMENT

This Exhibit D sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Alliance Care IHSS Health Program.

1. With respect to the Alliance Care IHSS Health Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the IHSS Member Group Contract. Covered Services, including Referral Services for IHSS Members are set forth in Sections 2699.6700 through 2699.6707 of Title 10 of the California Code of Regulations, and are also described in the Alliance Care IHSS Health Program Evidence of Coverage and the Plan's Provider Manual.

2. The County of Monterey and the Department of Managed Health Care may examine, monitor, and audit all records, documents, conditions, and activities of Provider related to the provision of Alliance Care IHSS Health Program Covered Services. Provider agrees to submit to an examination and audit of the State Auditor pertaining to matters connected with the performance of the IHSS Member Group Contract or provision of Alliance Care IHSS Health Program Covered Services for a period of three years after the final payment under the IHSS Member Group Contract.

3. Discrimination: The term "discrimination" as used in this Exhibit D, means the illegal denial of equal employment opportunity, harassment (including sexual harassment and violent harassment), disparate treatment, favoritism, subjection to unfair or unequal working conditions, and/or other discriminatory practice by any Monterey County official, employee or agent, due to an individual's race, color, ethnic group, national origin, ancestry, religious creed, sex, sexual orientation, age, veteran's status, cancer-related medical condition, physical handicap (including AIDS) or disability. The term also includes any act of retaliation.

4. Plan shall establish and follow its own written procedures for the prompt and fair resolution of discrimination complaints made against Plan by Provider.

5. During the performance of this Agreement, Plan and Provider shall comply with all Laws which prohibit discrimination, including but not limited to the following:

   i. California Fair Employment and Housing Act;

   ii. California Government Code Sections 11135-11139.5 and 22 CCR Sections 98000-98413;

   iii. Federal Civil Rights Acts of 1964 and 1991;

   iv. The Rehabilitation Act of 1973, and all guidelines and interpretations issued pursuant thereto;

   v. 7 Code of Federal Regulations (CFR) Part 15 and 28 CFR Part 42;

   vi. Title II of the Americans with Disabilities Act of 1990 (P.L. 101-336), 42 U.S.C. Sections 12101 et seq. and 47 U.S.C. Sections 225 and 611, and any federal regulations issued pursuant thereto (see 24 CFR Chapter I; 28 CFR Parts 35 and 36; 29 CFR Parts 1602, 1627, and 1630; and 36 CFR Part 1191);

   vii. Unruh Civil Rights Act, California Civil Code Section 51 et seq., as amended;

   viii. Chapter 2.80 of the Monterey County Code;

ix. Age Discrimination in Employment Act 1975, as amended (ADEA), 29 U.S.C. Sections 621 et seq.;

x. Equal Pay Act of 1963, 29 U.S.C. Section 206(d);

xi. California Equal Pay Act, Labor Code Section 1197.5;

xii. California Government Code Section 4450;

xiii. The Dymally-Alatorre Bilingual Services Act; California Government Code Section 7290 et seq.;

xiv. The Food Stamp Act of 1977, as amended and in particular Section 272.6.;

xv. California Code of Regulations, Title 24, Section 3105A (e); and

xvi. Removal of Barriers to Inter-Ethnic Adoption Act of 1996, Section 1808

6. Upon request by the County of Monterey, Provider will give any written assurances of compliance with the Civil Rights Act of 1964 and 1991, the Rehabilitation Act of 1973 and/or the Americans with Disabilities Act of 1990, as may be required by the federal government in connection with the IHSS Member Group Contract as may be required by Law.

7. Provider agrees to comply with the Elder Abuse and Dependent Adult Civil Protection Act, and will comply with its provisions which define a mandated reporter, and requires that reports of abuse or neglect be made by a mandated reporter when, in his or her professional capacity, or within the scope of his or her employment, he/she observes or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, isolation, financial abuse, or neglect. Provider will require any Participating Provider, employee, consultant, and agent performing services under the Agreement and this Exhibit D, who are mandated reporters under the Elder Abuse and Dependent Adult Civil Protection Act, to sign statements indicating that they know of and will comply with the reporting requirements of the Act.

EXHIBIT E

HEALTHY KIDS PROGRAM ATTACHMENT

This Exhibit E sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Healthy Kids Program.

1. With respect to the Healthy Kids Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the Healthy Kids Member Group Contract. Covered Services, including Referral Services, for Healthy Kids Members are set forth in Sections 2699.6700 through 2699.6707 of Title 10 of the California Code of Regulations, and are also described in the Healthy Kids Evidence of Coverage and the Plan's Provider Manual.

2. Provider's records, books, reports, and documentation related to the provision of Covered Services under this Program, shall be open for inspection and audit by federal, state, and county officials upon demand at reasonable times. All Provider financial records related to the payment of Covered Services pursuant to this Program shall be maintained during the term of this Agreement, and for a period of, at least three (3) years from the date of termination unless a longer period is required by Law, or until all claims, if any, have been resolved, whichever period is longer if otherwise required under the provisions of this Agreement.

3. In addition to the other regulatory requirements addressed in this Agreement, Provider agrees to comply with the Individuals with Disabilities Education Act (IDEA) and Executive Order 13166 issued on August 11, 2000.

EXHIBIT F

ALLIANCE CARE ACCESS FOR INFANTS AND MOTHERS PROGRAM ATTACHMENT

This Exhibit F sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Alliance Care Access for Infants and Mothers (AIM) Program.

1. With respect to the Alliance Care AIM Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the AIM Member Group Contract and are included in Section 2699.300 of Title 10 of the California Code of Regulations. Any services listed in Section 2699.301 of Title 10 of the California Code of regulations shall not be considered Covered Services. Covered Services for AIM Members, including Referral Services, are set forth in the Alliance Care AIM Program Evidence of Coverage, and are also described in the Plan's Provider Manual.

2. With respect to the Alliance Care AIM Program, the term "Emergency Services" shall mean health care services furnished by a qualified provider and needed to evaluate or stabilize a medical condition, including a psychiatric emergency medical condition (as defined in California Health and Safety Code Section 1317.1(k)(1)), which is manifested by acute symptoms of sufficient severity, active labor or 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.

3. Provider agrees that the Managed Risk Medical Insurance Board, the Department of Managed Health Care and the Bureau of State Audits, or their designated representatives, shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Provider agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated or required by Law. Provider agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records.

4. During the performance of this Agreement, Provider as well as its agents and employees, shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, sexual orientation, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (over 40), marital status, and use of family and medical care leave pursuant to state or federal law. Provider, as well as its agents and employees, shall ensure that the evaluation and treatment of its employees and applicants for employment are free from such discrimination and harassment. Provider, as well as its agents and employees, will comply with the provisions of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (Title 2, California Code of Regulations, Section 7285 et seq.). 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. Provider will give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

5. Provider shall keep accurate books and records connected with the performance of this Agreement during and for three (3) years after the term of this Agreement, or until the final payment under this Agreement, whichever is later. If an audit, review, examination or evaluation is commenced during the time specified herein for the maintenance of books and records, Provider shall continue to maintain all relevant books and records until the audit, review, examination or evaluation is completed.

6. Provider 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 Commencement Date, on an annual basis, upon any change in information, and upon request, if required by law or by Plan's Member Group Contracts. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. Provider 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 Member Group Contracts. Such Debarment Certification and its instructions are set forth in the Provider Manual.

EXHIBIT G

ALLIANCE CARE INDIVIDUAL CONVERSION PROGRAM ATTACHMENT

This Exhibit G sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Alliance Care Individual Conversion Program.

1. With respect to the Alliance Care Individual Conversion Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under California Health and Safety Code Sections 1345(b), 1366.35, and 1373.6 and the Alliance Care Individual Conversion Program Evidence of Coverage and the Plan's Provider Manual.

EXHIBIT H

COMPENSATION SCHEDULE

1. Payment in Full. Provider agrees to accept payment rendered pursuant to this Exhibit H, and any applicable Member Payment, as payment in full for any Covered Services provided by Provider to a Member, as well as any necessary administrative services. Payment may be subject to adjustment as described in Section 4.3 of this Agreement, and is subject to the Coordination of Benefits rules set forth in Section 4.4 of this Agreement.

2. Definitions. The following definitions are applicable to this Exhibit H:

   a. "Medi-Cal Rate" shall mean the current applicable Medi-Cal rate, as published by the California Department of Health Care Services in effect at the time Covered Services are rendered.

   b. "Monterey Medicare Rate" shall mean the schedule of Medicare maximum fee-for-service allowances and rates of payment for health care services in effect for the federal Medicare Program in Monterey County at the time when the Covered Services are rendered.

   c. "Outpatient Clinical Laboratory Services" shall mean clinical laboratory testing for Members not provided or ordered as part of an inpatient hospitalization that provides information for the diagnosis, prevention, or treatment of disease, or the assessment of medical condition and includes, but is not limited to, microbiological, serological, chemical, hematological, cytological, immunohematology, and pathological examinations performed on materials derived from the human body. Outpatient Clinical Laboratory Services also include consulting services for all tests performed or arranged by Provider, all necessary and required supplies, requisition forms, and the collection, preparation, and storage of specimens.

   d. "Santa Clara Medicare Rate" shall mean the schedule of Medicare maximum fee-for-service allowances and rates of payment for health care services in effect for the federal Medicare Program in Santa Clara County at the time when the Covered Services are rendered.

3. Payment for Covered Services Provided to Medi-Cal Members.

   a. Fee-for-Service Payment. Plan shall pay Provider for Covered Services provided to Medi-Cal Members as set forth below in subsections i., ii., iii., iv., and v.

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not durable medical equipment and medical supplies, physician-administered drugs, or Outpatient Clinical Laboratory Services) provided to Medi-Cal Members.

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4. Payment for Covered Services Provided to Healthy Families Members.

a. Fee-For-Service Payment. Plan will pay Provider for Covered Services (that are not durable
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5. Payment for Covered Services Provided to IHSS Members.

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6. Payment for Covered Services Provided to Healthy Kids Members.

a. Fee-For-Service Payment. Plan will pay Provider for Covered Services (that are not durable me Outpatient Clinical Laboratory Services) provided to He . Rate in ate for e Me

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7. Payment for Covered Services Provided to AIM Members.

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i. Providers with a CLIA certificate of waiver. Plan shall pay Providers granted waived

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8. Payment for Covered Services Provided to Conversion Members.

a. Fee-For-Service Payment. Plan will pay Provider for Covered Services (that are not durable

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outpatient clinical laboratory services are excluded from this Agreement and shall be referred to a clinical laboratory contracted with Plan.

ADDENDUM 1

REFERRAL PHYSICIAN UTILIZATION MANAGEMENT INCENTIVE PROGRAM

A. **Definitions.** For the purposes of this Addendum, the following definitions are applicable. Additional terms are defined in other sections to this Addendum and in Article I to the Agreement.

"Inpatient Hospital Services" are Covered Services provided to a Member who is admitted as a registered bed patient in a hospital, excluding physician services, unless such services are listed as inclusions in the hospital's agreement with Plan.

"Other Services" are Covered Services that are not Primary Care Physician Services, Referral Services or Inpatient Hospital Services.

B. **Risk Sharing.**

1. Budgeting

Plan shall periodically determine in its sole discretion amounts representing the average budgeted expenditures for Covered Services for Medi-Cal Members and Healthy Families Members. Health care costs shall be budgeted by three service categories: 1) Primary Care Physician Services, 2) Referral Physician and Other Services, and 3) Inpatient Hospital Services. Account totals will consist of the sum of the balances in the Accounts for these three service categories. Amounts equal to health care expenditures for Covered Services made on behalf of each Medi-Cal Member and each Healthy Families Member shall be allocated against the budgeted amounts. Health care expenditures for Covered Services include, but are not limited to, fee-for-service claims; the incurred cost of Inpatient Hospital Services, including any amounts paid and held in reserve; Primary Care Physician payment, including any amounts paid and held in reserve; other capitation payments; and estimated costs for services incurred but not yet reported (IBNR). Budgeting and allocations will occur separately for Santa Cruz Medi-Cal Members, Santa Cruz Healthy Families Members, Monterey Medi-Cal Members, Monterey Healthy Families Members, and Merced Medi-Cal Members.

2. Accounting

An account of the transactions and operations of health care expenditures for Covered Services shall be rendered by Plan annually four (4) months after the conclusion of the Fiscal Year and shall be certified by its financial officer. Such annual accounting shall be based on the Fiscal Year of Plan. Distributions are made to Providers 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 is subject to the approval of Plan. Plan shall have the sole discretion to establish binding policies regarding determination of balances.

3. Deficit Funding

Any risk sharing account that is in surplus shall be used to fund deficits in other Plan risk sharing accounts. Provider amounts held in reserve shall then be used to fund deficits in the accounts. After the funding of deficits, Provider amounts held in reserve shall be distributed to the extent that the applicable accounts are in surplus. Deficit accounting and funding shall occur separately for Santa Cruz Medi-Cal risk sharing accounts, Santa Cruz Healthy Families risk sharing accounts, Monterey Medi-Cal risk sharing accounts, Monterey Healthy Families risk sharing accounts and Merced Medi-Cal risk sharing accounts.

4. Surplus Balance

(a) If a Referral Physician and Other Services Account is in surplus after all applicable amounts held in reserve have been distributed to Providers, Provider will receive a portion of the surplus according to the following formula:

Acceptances for a Member course of treatment (regardless of the number of visits) by Provider / Total acceptances for a Member course of treatment by all Referral Physicians	X	ten percent (10%) of the total surplus balance in the Referral Physician and Other Services Account

and

(b) If an Inpatient Hospital Services Account is in surplus after all applicable amounts held in reserve have been distributed to Providers, Provider will receive a portion of the surplus according to the following formula:

Acceptances for a Member course of treatment (regardless of the number of visits) by Provider / Total acceptances for a Member course of treatment by all Referral Physicians	X	six and two thirds percent (6 2/3%) of the total surplus balance in the Inpatient Hospital Services Account

Plan shall determine in its sole discretion what constitutes an acceptance for a Member course of treatment, which shall be determined separately for Santa Cruz Medi-Cal Members, Santa Cruz Healthy Families Members, Monterey Medi-Cal Members, Monterey Healthy Families Members and Merced Medi-Cal Members. Surplus accounting and sharing shall occur separately for Santa Cruz Medi-Cal risk sharing accounts, Santa Cruz Healthy Families risk sharing accounts, Monterey Medi-Cal risk sharing accounts, Monterey Healthy Families risk sharing accounts and Merced Medi-Cal risk sharing accounts.

C. **Distribution of Amounts Held in Reserve and Surplus Sharing in Event of Termination.**

If this Agreement is terminated before the end of Plan's Fiscal Year by Provider or by Plan, Provider will be eligible for distribution of amounts held in reserve at the next annual accounting, but not for surplus sharing described in this Addendum 1 Section B.4.

D. **Term of Referral Physician Medi-Cal Utilization Management Incentive Program.**

The term of this Referral Physician Medi-Cal Utilization Management Incentive Program, as described in this Addendum 1, shall begin on January 1, 2011 and end on December 31, 2011 (the "UMIP Term").

E. **UMIP Programs for Future Periods.**

Plan, in its sole and absolute discretion, may implement utilization management incentive programs for periods after completion of the UMIP Term. Any such programs shall be on terms determined by Plan. Until Plan and Provider enter into a written agreement with respect to any such new program extending beyond the UMIP Term, no such program shall be binding upon Plan.