MEDI-CAL PHYSICIAN SERVICES PROVIDER AGREEMENT,
FEDERALLY QUALIFIED HEALTH CENTER OR RURAL HEALTH CLINIC

THIS AGREEMENT ("Agreement"), executed by and between **County of Santa Barbara**, an organization approved by the State Department of Health Services as a Federally Qualified Health Center (FQHC) (hereafter "County," as defined below") and made effective on the first day of January 2006 ("Effective Date"), and **Santa Barbara Regional Health Authority**, a body corporate and politic ("Authority") (County and Authority are jointly the "parties").

RECITALS

A. Authority and County have previously entered into contracts, which have been amended from time to time. This Agreement will amend and restate the relationship between the parties and will replace all prior Medi-Cal contracts and agreements.

B. Authority offers or directly administers one or more health benefit products and wishes to arrange for the provision of medical services to Members of products specified in this Agreement.

C. County employs or contracts with one or more Physicians capable of meeting the credentialing criteria of Authority.

D. Authority desires to engage County to deliver or arrange for the delivery of medical services to the Members of its Plans.

E. County is willing to deliver or arrange for the delivery of such services on the terms specified herein.

F. For administrative purposes, Authority requires an "Effective Date" that is the same for FQHC or RHC Providers regardless of the actual execution date of this Agreement by County.

G. The parties agree and understand that while the County, as an FQHC, is legally required to be offered the same terms and condition as other Authority providers, because the County is a governmental entity, certain terms and conditions applicable to other providers are not appropriate or applicable to the County.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, the parties hereby agree as follows:

1. DEFINITIONS

As used in this Agreement, the following terms shall have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended. Additional definitions applicable to this Agreement are set forth in the contract definitions section of the overview section of Authority's Provider Manual ("Provider Manual").

"Allied Health Provider" shall mean any qualified health care provider who has: (i) executed an agreement with Authority to provide health care services to Members, (ii) who is not a Physician, Hospital, skilled nursing facility or intermediate care facility; (iii) accepts the compensation set forth in Allied Health Provider's Agreement with Authority; and (iv) who has been credentialed, if required.

"Attending Physician" shall mean: (i) any physician who is rendering medical services to meet the medical needs of the Member; or (ii) any physician who is, through delegation from the Member's PCP, actively engaged in the treatment or evaluation of a Member's condition.

"Authority Referral" shall mean a referral authorization issued by Authority's Member Services, Provider Services, or Health Services Departments when PCP authorization is not possible due to administrative problems, or as specified in Authority's Referral, Authorization, and Utilization Review Process Policy and Procedure. Said Policy is summarized in the Provider Manual.

"Board of Directors" shall mean the Board of Directors of Authority.

"California Children Services Program" or "CCS" shall mean a public health program, which assures delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS eligible conditions, as defined in Title 22, California Code of Regulations (CCR), § 41800, et sec. Additional information about CCS is set forth in the Provider Manual.

"Capitation" shall mean a monthly payment in the form of a per capita (or per person) amount. Authority is paid capitation by Department of Health Services (DHS) for Medi-Cal patients and Authority pays its contracted SBHI PCPs, County and others who have executed capitated agreements using the capitation methodology. Whenever this term is used in the Agreement or in the Exhibits, it, or a portion of the full capitation rate, pertains only to payment for PCP's or County's Case Managed Class l SBHI Members.

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

"CHDP" shall mean California's version of the federal Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program. The CHDP Program provides for the payment of well child visits, screening procedures, and immunizations for children (to age 21), which are also Authority covered services. Authority currently does not administer the CHDP Program. Additional information regarding the CHDP Program and CHDP Providers is set forth in the Provider Manual.

"Claim" shall mean a statement of services submitted to Authority by Providers following the provision of Covered Services to a Member that shall include diagnoses and an itemization of services and treatment provided to Member. A Claim may be paper or electronic. A Claim is considered a "Clean" Claim if it is properly completed with complete CPT-4, ICD-9 coding or HCPCS coding where applicable, and which contains all the information specifically required in the Provider Manual.

"Clinic" shall mean County's FQHC Clinics, which provide Covered Services to Authority Members. Services may be rendered by County's Health Professionals and/or County's Physician Specialists. The parties agree that some services may be rendered outside of the clinic site, however for purposes of this Agreement, services are presumed to be provided at the Clinic.

"Clinical Privileges" shall mean permission to provide medical or other patient care services in the granting institution, within well-defined limits, based on the individual's professional license and experience, competence, ability and judgment.

"Committees of Authority" are described as well as their program responsibilities in the Provider Manual.

"Confidential Information" shall mean specific facts or documents identified as "confidential" by law, regulations, or contract language.

"Copayment" shall mean a charge, if any, that may be collected directly by a Provider or its designee from a Member in accordance with the requirements of the Medi-Cal program administered by Authority.

"County" shall mean the County of Santa Barbara. County's Public Health Department oversees the FQHC Clinics and provides medical, administrative and utilization management services.

"County Health Professional" shall mean an FQHC physician, Comprehensive Perinatal Services Program (CPSP) Practitioner, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker or visiting nurse. May also be referred to as Health Professional.

"County Physician Specialist" shall mean a Physician who is a specialist and contracts with County to provide services within its FQHC Clinics and outside of its FQHC Clinics. When a County Physician Specialist delivers services outside of County's FQHC Clinics, that physician's services are Referral Physician services which require Referral Authorization Forms and which are billed using County's Physician Medical Group (PMG) provider number.

"Covered Services" shall mean the Medically Necessary health care services and benefits that Members are entitled to receive, provided by and through Providers contracted with the Authority. Currently, Covered Services for Medi-Cal Members as set forth in the State Medi-Cal contract ("State Contract") are all Medically Necessary services covered under the California Medi-Cal Program set forth in Chapters 3 and 4 of Subdivision 1 of Title 22 CCR, and certain health assessment and health screening services set forth in the Provider Manual, subject to the excluded services set forth in Section 2.3. Covered Services shall also include those FQHC services that are included in the EDS manual, as follows:

- Physician Services (includes acupuncturist services when the acupuncturist is a doctor of medicine)
- Nurse practitioner services
- Physician assistant services
- Certified nurse midwife services
- Visiting nurse services
- CPSP practitioner services
- Preventive Health Services (as defined in Exhibit A)

"Days" shall mean calendar days, unless otherwise noted.

"EDS" shall mean Electronic Data Systems, which is the current Medi-Cal fiscal intermediary that has a contract with the State to process claims for State Medi-Cal beneficiaries. In the event EDS is no longer the fiscal intermediary, the references to EDS shall apply equally to any such successor fiscal intermediary. State Medi-Cal manuals, which include all aspects of the Medi-Cal program for each Provider type, are referred to as the EDS manual in this Agreement. County shall follow the EDS manual that is applicable to the type of services provided by the County, unless specifically superseded by Authority's Provider Manual.

"Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity, (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that 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 function; or (iii) serious dysfunction of any bodily organ or part.

"Emergency Services" shall mean: (i) those health services needed to evaluate or stabilize an Emergency Medical Condition, or (ii) situations in which the Member has attempted to contact the Member's PCP and has found that no provisions for the prompt and proper rendition of Covered Services has been made on his/or her behalf and this is verified by the Attending Physician.

"Encounter(s)" shall mean: (i) Covered Services rendered to Members Case Managed by County; (ii) Covered Services rendered to Members not Case Managed by County; (iii) non capitated Covered Services rendered to County's Case Managed Members; and (iv) County Physician Specialist Covered Services when provided in County FQHC Clinics. PCP capitated services are identified by select procedure codes included in Attachment A-1 of the Agreement. County submits Encounter information on a Claim form, indicating the capitated service(s) provided by inserting the appropriate procedure code(s), as set forth in Exhibit C, Encounter Billing Procedures, to this Agreement. Encounters with more than one County Health Professional and multiple Encounters with the same County Health Professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first Encounter, suffers an illness or injury requiring additional diagnosis or treatment. Encounters are for tracking of Covered Services only and County receives no fee-for-service reimbursement for these services. Encounters will also be submitted for Covered Services provided by County Physician Specialists and rendered in County's Clinics.

"Family Planning Services" shall mean all services and supplies rendered by any Provider to an individual of childbearing age during a visit to said Provider for the purpose of family planning, including but not limited to contraceptive services, breast and cervical cancer screening, testing and treatment of sexually transmitted diseases and sterilization procedures. Family Planning Services do not include abortions and visits only for breast and/or cervical cancer screening or related ongoing treatment.

"Federally Qualified Health Center" or "FQHC" shall mean an entity that has been approved and its Prospective Payment System ("PPS") rates have been established by DHS, pursuant to the Federal OBRA of 1989 and 1990, as amended by the Federal Beneficiary Improvement and Protection Act (BIPA) of 2000. An additional definition may be found in 42 USC 1396d(L)(2)(B). FQHCs were added as a Medi-Cal provider type in response to the Federal Omnibus Budget Reconciliation Act (OBRA) of 1989. Each FQHC Clinic is assigned a provider number for all physicians located in one site. When the term FQHC appears in this Agreement it is intended to also apply to a Rural Health Clinic (RHC) unless specifically excepted.

"Fiscal Year of Authority" shall mean the twelve-month period beginning July 1, and ending June 30. This may also be referred to as "Fiscal Year" or FY.

"FQHC Physician" shall mean that the following practitioners are defined as "physicians":

- A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license;
- A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license;
- A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license;

- A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license;
- A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license.

"Hospital" shall mean any licensed acute general hospital or limited service hospital that has a service agreement with the Authority.

"Limited Services" shall mean those services rendered by certain Allied Health Providers in accordance with the limitations and restrictions of the California Medi-Cal program and stated policy of the Board of Directors. Such SBHI Allied Health Providers include but are not limited to acupuncturists, audiologists, chiropractors, occupational therapists and speech pathologists. Refer to the Provider Manual for specific information on authorization and payment for Limited Services providers.

"Medi-Cal Rates" shall mean the schedule of Medi-Cal maximum fee-for-service allowances and rates of payment for health care services in effect for the State's Medi-Cal fee-for-service program at the time the services were rendered.

"Medical Director" shall mean the Medical Director employed by Authority, or the Medical Director's designee, who must be a licensed physician unless otherwise indicated.

"Medically Necessary" shall mean health care services or products that a prudent physician would provide to a Member for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is: (i) in accordance with nationally accepted standards of medical practice; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and (iii) not primarily for convenience of the Member, Physician, or other health care provider. This is also sometimes referred to as "Medical Necessity."

"Medicare" shall mean the federally-administered program, begun in 1965 that covers basic medical and hospital services (but as currently administered, not extended long term institutional care) for the elderly and disabled. Part A covers inpatient costs, Part B covers outpatient costs, and Part D covers most prescription medication costs.

"Medi/Medi Member" shall mean SBHI Members who are also eligible to receive Medicare.

"Member" shall mean a general term used in this Agreement, to describe an SBHI Class 1 Member

"NCQA" shall mean the National Committee for Quality Assurance. Authority may elect to abide by NCQA standards in connection with this Agreement, and County agrees to comply by such requirement of Authority.

"Notice" shall mean a communication by Authority to County informing County of the terms of or modification to the Medi-Cal program, and any other information relevant to the provision of Covered Services pursuant to this Agreement made in accordance with the provisions of §15.9.

"Physician" shall mean a Primary Care Physician, an Attending Physician, a Referral Physician, or a County Physician Specialist.

"Primary Care Physician" or "PCP" shall mean a physician, group or clinic: responsible for: (i) case managing, supervising, coordinating and providing initial and primary care to Members; (ii) processing initial referrals for Referral Physician care; and (iii) maintaining the continuity of Member care. A PCP is a

physician who has limited his/her practice of medicine to primary care, and who has executed a medical service agreement with Authority, a group, a clinic, or with County, agreeing to provide said services. Primary Care Physicians include general practitioners, family practitioners, internists and pediatricians.

"Primary Care Services" shall mean those services provided by a PCP or by County's PCPs to Members who are case-managed by that PCP or by County's PCPs or any physician with whom nighttime, weekend, or relief service has been arranged by the PCP or by County.

"Provider" shall mean a health professional or any other entity or institutional health provider who has: (i) agreed in writing, either through this Agreement or through another written instrument, to provide Covered Services to Members; (ii) accepted the compensation set forth in applicable Exhibits attached to this Agreement; and (iii) who has been credentialed, if required. Credentialing shall be done by the Authority or duly appointed and authorized agent to which such responsibility has been delegated, pursuant to Authority rules and procedures.

"Provider Information Form" or "PIF" shall mean an attachment that is included with this Agreement on which County indicates information pertinent to County's practice. Such information includes but is not limited to office and billing addresses, liability insurance coverage, handicapped accessibility, office hours, and practice coverage by other qualified practitioners, and the access levels, maximum number of Members, and Peer Pool designation as described in Exhibit A hereto. If subsequent changes to information on a PIF are necessary an amendment to this Agreement is not required, but these changes must be submitted in writing by County to Authority in a timely manner.

"Provider Manual" shall mean Authority's manual which sets forth operational documents including but not limited to Provider obligations, authorizations; claims and billing; Member services; quality of care, grievance system and Authority policies and procedures pertinent to Providers. The Provider Manual may also contain sections for: overview materials; Provider's Agreement; Provider Bulletins; and the Contracted Provider List. The Provider Manual, titled "Santa Barbara Regional Health Authority Provider Manual" prepared by Authority's Provider Services staff, may contain provisions of the EDS manual as specifically modified by Authority. The information set forth in the Provider Manual is part of this Agreement and may, in Authority's sole discretion, be amended from time to time and is incorporated by reference into the Agreement as if set out herein in full. Authority will give County advance notice and time to adjust to major changes to the Provider Manual. Notifications can be made through Provider Bulletins, substitution of pages, or other communications.

"Quality Assessment and Improvement Program" or "QAIP" shall mean a document that defines Authority's organizational structure and clinical and non-clinical processes vital to implementation of continuous quality improvement in health care. The QAIP encompasses the quality of acute, chronic and preventive clinical care and service provided in both the inpatient and outpatient setting by primary care and specialty Physicians, ancillary providers and Hospitals. The QAIP also encompasses Authority's processes for monitoring and improving the quality of non-health care administrative services provided to Members by Authority and its contracted Provider network as may be set forth in Authority's Provider Manual.

The QAIP is an evolving document adopted by Authority's Board of Directors and approved by appropriate State agencies pursuant to contractual and regulatory requirements. Authority may, in its sole discretion, elect to include NCQA standards in the QAIP. Notice of any material changes to the QAIP shall be given to County no less than thirty (30) Days prior to the date the change is to take effect. The current QAIP is available on the Authority's website: www.sbrha.org/Ensuring Quality/Quality Assessment and Improvement Program or upon request to Authority's Health Services Department.

"Referral Authorization Form" or "RAF" shall mean the required referral authorization form, or number, evidencing a referral by a PCP, the PCP's designee, County or the Medical Director or his/her physician or non-physician designee, to render services. Selected services that do not require RAFs (including but not limited to Emergency Services, Sensitive Services, Medi/Medi Members, and most Self Referral Services) are set forth in the Provider Manual. RAFs are not required prior to rendering services to SBHI Special Class Members, and any reference to RAF requirements for Members shall be deemed to exclude such requirement for SBHI Special Class Members. Additionally, County is not required to complete a RAF for services to be rendered within County's Clinics, including, County Physician Specialists.

"Referral Physician" shall mean any qualified physician or duly licensed group of physicians providing specialty services duly licensed in California and certified by the Medi-Cal program and who has/have executed an agreement with Authority to provide specialist physician services, and to whom a Primary Care Physician may refer any Member for consultation or treatment. Referral Physicians are also associated with County (County Physician Specialist) and unless otherwise specified, the term Referral Physician as used in the Agreement shall also apply to County Physician Specialist. See Exhibit B for Protocols for Referral Physicians.

"Referral Services" shall mean any services that are not Primary Care Services and that are provided on referral from the PCP or County.

"Rural Health Clinic" or "RHC" shall mean an organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services (DHHS). RHCs receive State issued provider numbers with the prefix RHM. Any services provided in an RHC will be deemed a service under this Agreement, and the general term "FQHC clinic" or "FQHC" will be deemed to include an RHC.

"SBHI" shall mean the Santa Barbara Health Initiative, the Medi-Cal program administered by Authority.

"SBHI Member" shall mean any person who has been determined to be eligible to receive Medi-Cal benefits by the County Social Services Department, the State, or the Social Security Administration and who is a resident of the County. SBHI Members are of two classes, as follows:

Class I Members shall include all SBHI Members who are case-managed by a Primary Care Physician and Special Class Members shall mean those SBHI Members who: (i) are eligible for Medi-Cal on a retroactive basis; or (ii) have been identified as non-case-manageable. Special Class Members' case management is assigned to Authority for the purposes of this Agreement. Special Class Members include, but are not limited, to those SBHI Members who are with CCS, for whom chronic renal dialysis services are verified as Medically Necessary by Authority, those with a confirmed diagnosis of acquired immune deficiency syndrome (AIDS), and those residing in skilled nursing facilities or outside the County. Additional information on eligibility and membership is contained in the Provider Manual.

"Self-Referral Services" shall mean the services in addition to Emergency Services that Members are allowed to access without authorization, as set forth in State Contracts or in Authority's processes. Self-Referral Services currently include, but are not limited to, most obstetric services, Limited Services and Sensitive Services. Self-Referral Services are subject to utilization controls as specified under the Medi-Cal program and may change from time-to-time.

"Sensitive Services" shall mean services related to Family Planning Services, sexually transmitted disease, abortion and human immunodeficiency virus (HIV) testing.

"Service Area" shall mean Santa Barbara County. Santa Barbara County is designated as County 42 by the State Medi-Cal program.

"State" shall mean the State of California.

"Subcontract" shall mean a written agreement entered into by County with: (i) a qualified person who provides health care services and who agrees to furnish Covered Services to Members; and/or (ii) any other organization or person(s) that agree(s) to perform any administrative function or service for County specifically related to fulfilling County's obligations to Authority under the terms of this Agreement.

"Subcontractor" shall mean a person or any organization that has entered into a Subcontract with County. Subcontractors shall meet specified requirements as set forth in this Agreement. Notwithstanding the above, County Health Professionals who are under contract to provide medical care in County's FQHC Clinics or through the County's Physician's Medical Group (as further addressed in subsection 4.1.3 of this Agreement) act as Providers of the FQHC and are thereby bound by this Agreement due to that status.

"Treatment Authorization Request" or "TAR" shall mean the document used by County to request authorization for coverage of services. The TAR is submitted to Authority, and is reviewed by the Authority's Health Services Department. TARs are approved, denied, or deferred based on Medical Necessity.

"Utilization Management" or "UM" shall mean the process by which Authority, or duly appointed and authorized entity to which such responsibility has been delegated, determines on a prospective, concurrent, or retrospective basis the medical appropriateness of Covered Services furnished to Members.

2. SERVICE OBLIGATIONS

2.1 Case Management. The Member may select or be assigned to one of County's FQHC Clinic sites. County's PCPs at the selected site shall be the sole source of primary medical contact and advice for the Member and shall provide or authorize the referral for all health care services, except for Emergency Services, Self-Referral Services and excluded services. This concept of Case Managed Members is such that the Clinic is the medical home of the Member, and is where the Member receives the majority of care and where the Member's overall health status, need for care and services and wellness are assessed, evaluated, monitored, managed, enhanced and/or maintained. The PCP at the Clinic site shall coordinate Members' needs for Covered Services and provide other services, or provide referral to other services, to assure Members receive all Medically Necessary care and services without regard to the party financially responsible for care and services. County shall be responsible for the Member's Case Management until the time such Member's PCP is changed in accordance with Authority's policies.

2.2 Case Management Services. County's PCPs or Physicians providing services at the request of County, shall:

2.2.1 Develop, implement and maintain an adequate system for tracking all referrals and follow-up care.

2.2.2 Maintain procedures for monitoring and measuring the coordination of care provided to the Members in all settings, including, but not limited to, coordination of discharge

planning from inpatient facilities and coordination of all Medically Necessary services both within and outside of the Service Area.

2.2.3 Implement and maintain polices and procedures to follow-up on missed/broken appointments.

2.2.4 Ensure continuity of care from the ambulatory care setting to the inpatient care setting and all other care settings as needed.

Additional information on Case Management is in the Provider Manual.

2.3 SBHI Covered Services and Excluded Services. SBHI Covered Services are those services covered under the California Medi-Cal program as specified in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, Article 4, beginning with § 51301 (unless they are an Authority-only benefit), which are included as Covered Services in the State Contract, and are Medically Necessary services, including anesthesia for dental services. For purposes of this Agreement, Covered Services do not include services listed in the State Contract as excluded services.

Excluded services include, but are not limited to, the following:

Specialty Mental Health Services; Short-Doyle/Medi-Cal Mental Health Services; Alcohol and drug treatment services and outpatient heroin detoxification; Dental services, as defined in Title 22, CCR, § 51307; Adult Day Health Care, pursuant to Title 22, CCR, § 54001; services rendered in any federal or State governmental hospital; and childhood lead poisoning case management services provided by the local health department.

2.4 Provision of Covered Services to Members. County shall provide Covered Services that are set forth in Exhibits A- and B to Members and County agrees as follows:

2.4.1 County shall make medical services available to Members in the same manner, in accordance with the same standards, and with the same availability, as to Countys' other patients;

2.4.2 County shall ensure that medical services provided under this Agreement are readily available and accessible, provided in a prompt and efficient manner without delays in terms of wait times or scheduling of appointments, and consistent with professionally recognized standards of practice;

2.4.3 County shall provide medical services to Members in a culturally and linguistically appropriate manner, as set forth in this Agreement or in the Provider Manual;

2.4.4 County shall be available to provide to Members or arrange for Members to receive prompt urgent services within 24 hours when Medically Necessary;

2.4.5 County shall be available to provide or case manage services that are Emergency Services twenty-four (24 hours) per day, seven (7) days per week;

2.4.6 County shall provide all Covered Services to Members that are the financial responsibility of County, consistent with the terms and provisions of this Agreement, any letters or bulletins from the State, Provider Manual, and Authority policies;

2.4.7 County shall be liable for the provision of all Covered Services notwithstanding a delay in payment of any Capitation payment to County;

2.4.8 Without amending this Agreement, Authority may incorporate any change in Covered Services mandated by federal or State law or regulation into the Agreement effective the date the change goes into effect. Whenever possible, Authority shall give County thirty (30) Days prior notice of any such change. Authority shall determine the effective date of the change in Covered Services;

2.4.9 The actual provision of any Covered Service is subject to the professional judgment of County as to the Medical Necessity of the service, except that County shall provide assessment and evaluation services ordered by a court or legal mandate;

2.4.10 Decisions concerning whether to provide or authorize Covered Services shall be based solely on Medical Necessity. County agrees and understands that all disputes between the respective Provider and Members about Medical Necessity can be appealed pursuant to Authority policies; and

2.4.11 In no event, including but not limited to, non-payment by Authority, Authority's insolvency, or breach of this Agreement by County or Authority, shall County or Subcontractors bill, charge, collect a deposit from, or to seek compensation, remuneration or reimbursement from, or have any recourse against the State (except as permitted by FQHC regulations governing payment), a Member or persons acting on the behalf of a Member for Covered Services provided pursuant to this Agreement. This provision does not prohibit County or Subcontractors from collecting Copayments and deductibles, if any, as specifically provided for in this Agreement or as set forth in the EDS manual, or for billing the Member and collecting fees for non-Covered Services from the Member if the Member agrees to the fees prior to the actual delivery of non-Covered Services. County further agrees that:

2.4.11.1 This sub-section 2.4.11 shall survive the termination of this Agreement for those Covered Services rendered prior to the termination of this Agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members;

2.4.11.2 This sub-section 2.4.11 shall supersede any oral or written contrary agreement now existing or hereafter entered into between County or Subcontractors;

2.4.11.3 This subsection 2.4.11 shall prevent County Subcontractors from pursuing compensation from Members.; and

2.4.11.4 No change or amendment to this sub-section 2.4.11 or to similar section(s) in Subcontracts between County and Subcontractors shall be made without the prior written approval of Authority.

2.5 Referral to Additional Providers. County's PCP shall have the right to refer Member to any Referral Physician, including County Physician Specialists, or other referral Provider practicing within the Service Area who, prior to referral, has expressed a willingness to serve Members and to undertake care in accordance with the provisions of this Agreement and the practices of Authority, and who has executed an Agreement with Authority, or with an entity contracted with Authority. Referrals may be made outside the Service Area to contracted or non-contracted State Medi-Cal referral Providers when services requested are not available or not sufficient for the Member population in the Service Area, on an as-needed basis for long term care facilities, for Member continuity of care and/or in cases of Medical Necessity. Most referrals, other than referrals to County Physician Specialists, require prior authorization.

2.6 Copies of Clinical Information. If County's PCP renders service to Members not assigned to County, or is providing Referral Services, County will promptly forward the copies of initial consultation reports upon completion of the consultation, and summaries of Member care or Member results upon completion of Member care or discharge to the Member's PCP. County shall provide copies of such clinical information to the Member's PCP at no charge. Release of this information shall be in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations and requirements**.**

2.7 Prior Authorization. Except for Emergency and Self-Referral Services, up to two total Limited Services per month for SBHI Members, and for services indicated on "When RAFs are Not Required" in the Provider Manual, County shall obtain the following authorization prior to providing services to Members: (i) a Referral Authorization Form ("RAF") from the Member's PCP or his or her designee; and (ii) a Treatment Authorization Form ("TAR") approved by Authority (if required); (iii) a prescription if required, i. e. for durable medical equipment, and (iv) a Medical Request Form (MRF), when required, for pharmaceutical services and prescribed drugs. The RAF and TAR outline the scope of such medical services to be provided, and the MRF allows a prescribing provider to request non-formulary drugs. Any such services, including tests, procedures, consulting services, supplies, drugs and hospital services not specifically described in the prescription, MRF, RAF and TAR (if required), must be authorized in advance. Except when services are those excepted services indicated above, compensation for services provided to Members is payable by Authority only if such services are Covered Services and have been authorized. County shall verify a Member's eligibility prior to rendering non-Emergency Services. Referral authorization from a PCP is not a guarantee of eligibility. Authorization procedures are further described in the Provider Manual. Notwithstanding the above, because of its FQHC status, County is not required to submit TARs but has chosen to do so, and encounters will not be denied based on the absence of a TAR. Additionally, County is not required to issue a RAF for Covered Services rendered within County's Clinics.

Should the non County PCP refuse to authorize a service deemed by County to be Medically Necessary, County may contact Authority's Health Services or Provider Services Department to request that an Authority Referral be issued.

2.8 Pharmaceutical Services and Prescribed Drugs. Providers who are authorized to issue prescriptions, shall provide pharmaceutical services and prescribed drugs, either directly or through Subcontracts, in accordance with all laws and regulations regarding the provisions of pharmaceutical services and prescription drugs to Members. At a minimum, such pharmaceutical services and drugs shall be available to Members during normal business hours. Said Providers contracted with Authority shall provide a sufficient quantity of drugs to a Member to last until the Member can reasonably be expected to have a prescription filled when drugs are provided to a Member under emergency circumstances. Further information about Pharmaceuticals is set forth in §5.3 (Formulary), of this Agreement and in the Provider Manual.

County will use best efforts to cooperate with Authority's cost saving programs related to pharmacy services, prescribed drugs, diabetic supplies, specified injectable drugs and medications, etc. in effect now or during the term of this Agreement as they may be amended from time to time.

2.9 Subcontracts. If County arranges for the provision of some medical services from other health care providers, County shall require its Subcontractors to (i) seek payment only from County, not from Authority and not from the Member as set forth in §2.4.11; (ii) maintain and disclose records and other information as set forth in §8.1; (iii) abide by the nondiscrimination and Confidential Information provisions set forth in §§5.4 and 8.5, respectively; (iv) maintain

insurance as set forth in §7.1; (v) comply with credentialing requirements, if required, as set forth in §3.1.2; (vi) comply with the grievance resolution provisions as set forth in §5.2 and in the Provider Manual; and (vii) comply with all other applicable provisions of this Agreement. Upon termination of this Agreement, such Subcontracts shall terminate with respect to Covered Services provided to Members. Upon request, County shall make such Subcontracts available to Authority and government officials for review and approval.

2.10 Coordination Regarding Non-Covered Services.

2.10.1 SBHI Members who may have a possible CCS eligible condition may be referred by the Member's PCP to the local CCS program. Such services must be authorized by the local program in order for payment to be made. Procedures for referral of said Members assigned to CCS, or not, and payment of Claims for these services are set forth in the Provider Manual.

2.10.2 Members who may need specialty mental health services may be referred by the Member's PCP to the County Department of Alcohol, Drug, and Mental Health Services (ADHMS). If ADHMS does not cover said Member's diagnosis, the PCP shall refer Member to other appropriate community resources and/or shall coordinate services with the mental health provider, as appropriate. See Provider Manual for additional information on mental health coverage and specialty mental health providers.

2.10.3 County, when applicable, shall assist Members in obtaining services that are not Covered Services, including but not limited to, referring Members to public programs for which the Member may be eligible.

2.11 Fraud and Abuse Reporting. County shall report to Authority all cases of suspected fraud and/or abuse, as defined in Title 42, CFR, § 455.2, relating to the rendering of Covered Services by County's Subcontractors, out of network Providers, Members, or County's employees. Said report shall be made within ten (10) business days of the date when County first becomes aware of or is on notice of such activity.

3. OBLIGATIONS OF COUNTY

3.1 Licensed and in Good Standing.

3.1.1 County represents that its FQHC Physicians shall remain licensed or registered, as applicable, to provide or arrange for the provision of those applicable Covered Services that are identified in Exhibits A and B, attached hereto and made part of this Agreement by this reference. County further represents that it has, and will maintain and keep current all legally required licenses.

3.1.2 County agrees to cooperate in credentialing and recredentialing in accordance with the process set forth in the Provider Manual. County agrees that its FQHC Physicians who are required to be credentialed must be approved by appropriate Committees of Authority prior to rendering Covered Services to Members. Additionally, County shall ensure that all Subcontractors who furnish items and/or services to Members and/or submit Claims and/or receive reimbursement for Covered Services furnished to Members shall be qualified to provide Covered Services. County shall ensure that any Subcontractor who is required to meet these standards, but fails to do so, does not furnish items and/or services and/or receive reimbursement for any Covered Services furnished to Members.

3.1.3 County's FQHC Physicians who admit Members into the Hospital, must maintain, at one of Authority's Hospitals, active medical staff privileges and all Clinical Privileges necessary to perform required services, or have executed a formal agreement with another Physician to admit and follow Members in said Hospital. Such arrangement must be acceptable to Authority, acting reasonably.

3.1.4 County has received certification as a CHDP program provider in order to be assigned Members under nineteen (19) years of age. However, CHDP provider status is not required for each FQHC Clinic in the network if County chooses not to offer CHDP services at a Clinic site. Nothing in this section will preclude non-CHDP County Clinics from being reimbursed for specialty care provided to Members under 19.

3.1.5 Covered Services that are provided by or arranged for by County shall be delivered by professional personnel qualified by licensure, training, or experience to discharge their responsibilities and operate their facilities in a manner that complies with generally accepted standards in the industry. All Covered Services are to be provided at a place appropriate for the proper rendition thereof, within the constraints of the State Medi-Cal program regulations.

3.1.6 Staff Qualifications. It must be documented that County's medical assistant staff is qualified and trained for assigned responsibilities and are competent to perform the duties described in Title 16, CCR, Division 13, Chapter 3, Article 2, §1366(a). Further, County's FQHC Physician, if acting as a supervising Physician, must assure that each members of the medical assistant staff is certified by an accredited school, or must instead prepare a written and signed letter or statement that certifies the date, location, content, duration of training and demonstrated proficiency of the medical assistant to perform the current assigned scope of work. The medical assistant must have completed at least the minimum amount of training hours established in Title 16 above, §1366.1. However, when the provisions of this §3.1.6 conflict with the civil service system which governs County classifications, the civil service system will prevail.

3.2 Laboratories. County shall require that each laboratory used by its Clinics or by its Subcontractors(s) to provide services comply with federal and State laws. County may also use a laboratory that has been issued a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration, and that has a CLIA identification number. CLIA waived laboratories shall provide only the types of tests permitted.

Any laboratory that does not comply with the appropriate federal and State law is not eligible for participation in, or reimbursement from, the Medicare or Medi-Cal programs.

3.3 Patient Load. County shall designate on the PIF the maximum number of Members each Clinic ("each site") shall serve, provided, however, that the maximum number of Members does not exceed the limits as set forth in the Case Management Protocols of the Provider Manual.

County may request that only previous Members wishing to be re-assigned to a Clinic be accepted (established patients only), or that the Clinic is open to new patients. Unless County has indicated an established patients only or closed status on the PIF, County agrees to accept as patients all Members who have selected or been assigned to each site, up to the maximum number of Members designated by County on the PIF, without regard to the health status or health care needs of such Members. In addition, County may not request Member assignment changes due to a Member's medical condition requiring increased care. Additional information on designating access and Member reassignment is in the Provider Manual.

3.4 Non-Physician Medical Practitioner Limits. Because Clinics provide medical services through non-physician medical practitioners, the number of the non-physician medical practitioners who may be supervised by a single Physician shall be limited as set forth in the Case Management Protocols in the Provider Manual.

3.5 Notification of Changes. If County decides to cease providing or suspend any Covered Service or reduce the hours at any of its sites, County shall notify Authority in writing at least forty-five (45) Days prior to any such cessation, suspension or reduction, or shall so notify Authority upon notification by Subcontractor of change(s). County will notify Authority immediately of any changes in operation, Clinical Privileges, emergency conditions, or factors such as limited capacity that may significantly affect Covered Services provided to any Member or that may impair County's ability to perform its obligations under this Agreement. County shall notify Authority promptly of any change in name, location, tax identification number, Medicare or Medi-Cal number.

3.6 Provider Responsibility.

3.6.1 County's PCPs, and any Provider to whom the it's PCPs have delegated the authority to proceed with treatment or the use of resources, shall be responsible for all medical advice and Covered Services performed or prescribed through them for the Member. The Authority allows and encourages open communication between Providers and Members regarding appropriate treatment or treatment alternatives, and does not penalize Providers for discussing Medically Necessary or appropriate care with or for the Member, regardless of benefit coverage limitations.

County Health Professionals shall also be responsible for providing information to Members on the proper use of health care services, and for providing health education, and preventive health information. Such educational offerings shall be noted in the Member's medical record and shall be documented in accordance with Authority's standards for medical record keeping as set forth in Authority's current "Chart Quality Guidelines", if applicable.

3.6.2 Authority will notify Members of their right to an initial health assessment to be performed within 120 Days of enrollment. County agrees to develop, implement and maintain procedures for the performance of an initial health assessment for each new Member upon request for an appointment by Member, unless it is determined that the Member's medical record is adequate, as described in the Provider Manual.

County shall take all reasonable steps to ensure that Preventive Health Services, as more particularly defined in Exhibit A hereto, (well infant, well child, well adolescent visits and adult initial and periodic preventive medicine evaluations) are performed in accordance with requirements as may be set forth in the Provider Manual.

3.6.3 Nothing expressed or implied herein shall require the County's FQHC Physicians to provide to the Member, or order on behalf of the Member, Covered Services which, in the professional opinion of the said Provider, are not required for the control of present or future health impairment or are more costly and which are not of sufficient likelihood of being more effective in achieving these ends and/or seem inadvisable.

3.6.4 County agrees to cooperate with Authority's quality improvement activities and to provide access to medical, financial and administrative information: (i) as may be necessary for compliance by Authority with State and federal law; and (ii) for Authority's program management purposes including, as appropriate: Utilization Management, grievance process, peer review, credentialing, Health Employer Data Information Set ("HEDIS")

reporting, medical chart review and facility audits, as may be set forth in this Agreement or the Provider Manual.

3.6.5 County agrees within reason to comply with all final recommendations and determinations rendered by Committees of Authority appropriate to the issue in question.

3.6.6 County and/or its office staff is/are responsible to understand and adhere to the requirements of the Medi-Cal program as set forth in the EDS manual and Authority's Provider Manual, as respectively amended from time to time by the State and Authority.

3.7 Encounter Reporting. County shall submit Encounter data pursuant to standards defined by Authority policies, or as set forth in this Agreement, in Exhibit C to this Agreement, or in the Provider Manual. Since County participates in the SBHI PCP Incentive Program, (as defined in Exhibit A hereto), County's payout is subject to reduction if Encounter data does not meet the standards required pursuant to the Incentive Program. Additional information about the SBHI PCP Incentive Program is in the Provider Manual.

3.8 Other Reporting. County shall also supply Authority with other periodic reports and information pertaining to: (i) Covered Services provided to Members by County's FQHC Physicians, Health Professionals or County's Subcontractors; and (ii) County's financial resources, on such forms and within such times as requested by Authority, and which will enable Authority to meet all federal and State legal and contractual reporting requirements. County shall complete and return with this Agreement Attachment 1, Disclosure Form, attached hereto.

3.9 Access to Care. County shall be held to the standards established by Authority for accessibility to care. At least annually, Authority will measure for compliance against applicable access to care standards that are contained in the Provider Manual.

3.10 Cultural and Linguistic Services. Authority and County have joint responsibility in meeting cultural and linguistic services as may be required by the State. Such services include, but are not limited to: (i) twenty-four (24) hour access to interpreter services, which may include face-to face encounters with County's FQHC Physicians, Health Professionals or staff, telephone language services, or the use of urgent care telephone lines, for all limited English proficient Members seeking health services from a Provider; (ii) referrals to culturally and linguistically appropriate community services programs; and (iii) use of translated signage and written translated materials appropriate for County's Members. As County has indicated bilingual language capabilities it shall ensure those providing such interpreter services are bilingually proficient at both medical and non-medical points of contact.

Authority may provide training for County and its staff on the cultural and linguistic needs of Members. Additionally, materials on cultural and linguistic services are contained in the Provider Manual. Authority may assess the cultural competence of County and its staff from time to time, and provide tools to assist County in cultural or linguistic competency.

3.11 Participation on Committees. County's staff and/or Physicians, if requested by Authority, shall serve on a specified Committees of Authority for a two year term, unless excepted. A description of the membership and responsibilities of Authority's Committees is set forth in the QAIP and/or Provider Manual.

3.12 Utilization Management. County hereby acknowledges that: (i) Authority conducts UM programs regarding the care provided to Members; and (ii) has indicated in the quality of care section of the Provider Manual affirmative statements regarding UM decisions and financial reward. County shall participate in and cooperate and comply with the provisions of Authority's UM programs and its policies and procedures, including prospective, concurrent and retrospective review by Authority's UM committees and staff. Upon reasonable notification, County shall allow Authority UM personnel, or their designees, physical and telephone access to review, observe, and monitor Member care and County's performance of its obligations under this Agreement. Additional information on UM is set forth in the Provider Manual.

4. PAYMENT AND BILLING

4.1 Payment of Compensation

4.1.1 Case Managed Members. In accordance with the provisions of this Section 4 "Payment and Billing" and Exhibits A, B and C as may be provided with this Agreement, Authority shall pay County on a capitated basis for Covered Services that are capitated services as indicated on Attachment A-1 rendered to County's Case Managed Members. County will receive the Case Management list electronically as agreed to by the parties.

4.1.2 Non Case Managed Members/Case Managed Members who receive non-PCP Defined Procedures ("Non-Case Managed Services"). Authority shall reimburse County, as negotiated and agreed to by the parties, for the following type of services when rendered in its Clinics: (i) Covered Services rendered to Members not Case Managed by County; or (ii) non capitated Covered Services rendered to County's Case Managed Members; (iii) County Physician Specialist services; and (iv) non-PCP defined procedures rendered to County's Case Managed Members that may not be included in (ii) or (iii) of this subsection 4.1.2. Covered Services that are provided to Members normally require RAFs from providers outside of County's Clinics, but not TARs as a condition for payment.

4.1.3 Services Provided Outside of County's Clinics by County Physician Specialists and County Health Professionals. For non capitated Covered Services rendered by County Physician Specialists and County Health Professionals outside of County's FQHC Clinic ("Physician Medical Group services", as defined in Exhibit B), County shall submit Claim forms, bill electronically, or enter Claims on Authority's website. Payment for these Covered Services is set forth in Exhibit B to this Agreement.

4.2 Payment.

4.2.1 Regular Compensation. County's compensation for services to Members shall be paid as indicated when all requirements have been met in accordance with the appropriate EDS manual and Authority's Provider Manual.

4.2.2 County PCPs. For those Members Case Managed under the SBHI program County shall receive monthly Capitation as set forth in Attachment A-2.

4.2.3 Non Case Managed Services. For Members receiving Non-Case Managed Services, compensation for these Non Case Managed Services rendered after authorization, if required, by County's PCP shall be as follows:

4.2.3.1 For the period January 1, 2006 through December 31, 2006, Authority shall pay County in equal quarterly installments of $153,250 on February 15th, May 15th, August 15th, and November 15th 2006;

4.2.3.2 In December 2006, Authority will calculate the value of medical care ("Value") that County provided for Non-Case Managed Services during the preceding period of

January 1 through September 30, 2006 based on the Authority's prevailing reimbursement rate(s) to its contracted Medi-Cal Referral Physician network; and

4.2.3.3 If the Value is an increase or decrease by ten percent (10%) from the sum of the February, May, and August quarterly installment payments, then quarterly installment payments commencing on the subsequent February 2007 payment date will reflect one-quarter (1/4) of the Value. Otherwise, the amount of the quarterly installment payments will remain unchanged for the subsequent annual period.

4.2.3.4 Calculations as indicated above for 2006 shall occur in subsequent years during the term of this Agreement, unless amended by the parties.

4.3 Copayments. When Members are required to make Copayments, County may collect such Copayments from the Member at the time of service, or as arranged with Member.

4.4 Payment to County. County agrees to accept the Capitation paid by Authority, for Primary Care Services and quarterly installments for Non Case Managed Services for services rendered in County's Clinics as payment in full from Authority. County reserves the right to obtain additional revenue up to its full FQHC PPS per visit rate from the State.

4.5 Claims and Encounters. County shall submit to Authority all Claims and Encounters for Covered Services provided to Authority Members. Claims and Encounters shall be submitted on the currently accepted Claim form in use in the Medi-Cal program, and shall be submitted within one (1) year of the date of service, or as indicated in attached Exhibits, in accordance with the laws, regulations and billing procedures set forth in the EDS manual and in accordance with Authority's Provider Manual and policies. Authority will process Encounters for Covered Services billed under County's FHC provider numbers as set forth in Exhibit C to this Agreement. County agrees to submit most Claims and Encounters in an electronic format using industry standards as specified by the DHS and/or HIPAA as agreed by the parties, or to enter Claims and Encounters on Authority's website at www.sbrha.org. Additional information and requirements regarding submission of Claims and Encounters is set forth in the EDS manual and in the Provider Manual.

4.6 Uncashed Checks. When checks issued to County remain uncashed beyond three (3) years of issuance, Authority will make reasonable attempts to contact County. If such contacts have failed, the Authority will void the check and the funds will be returned to the Authority's general fund.

4.7 Repayment. Authority hereby agrees that Claims and Encounters submitted for Covered Services rendered by County shall be presumed to be coded correctly. Authority may rebut such presumption with evidence that a Claim form fails to satisfy the standards set forth in the EDS manual or in the Provider Manual. If an audit conducted by Authority concludes that County owes monies to Authority, Authority reserves the right to require repayment or to deduct monies that may be due to County from subsequent payable Claims. Authority also reserves the right to take such action if: (i) County fails to meet its participation requirements; (ii) County fails to report services rendered in the manner specified herein; or (iii) the quality or timeliness of care and services rendered to Members is found to be unacceptable, as determined in the Authority's sole and absolute discretion, but acting reasonably.

Should Authority seek repayment or elect to deduct money from subsequent Claims, it shall take steps to do so in accordance with the Authority's established policies and procedures, and shall notify County in writing as soon as practical. If County wishes to dispute such action, it shall do so in accordance with the processes set forth in Authority's grievance system policies and procedures set forth in the Provider Manual.

4.8 Billing Other Sources. County may bill the Member in the following circumstances:

(i) For Copayments that are payable, if any.

(ii) Other Coverage. If a Member is entitled to benefits under other health benefits coverage and such coverage is primary, County will coordinate benefits as set forth in the Provider Manual.

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

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

4.10 Medicare and Certain Other Recoveries. The EDS manuals specify that certain other health programs (including Medicare and the Healthy Families program) for Members must be billed and recoveries made prior to billing the Medi-Cal program. Such rules shall also apply to the Authority's administration of the Medi-Cal program. Authority shall process such Claims and reduce payment or deny Claims as appropriate, and notice of such reduction or denial will appear on an explanation of benefits (EOB) that County receives.

County's Capitation rate for Class I Members covered by Medicare assumes that County will recover directly from Medicare for County's PCP's services. Such Medicare recoveries belong to County. Most services billed initially to Medicare will be reported to Authority as a Medi-Medi crossover, as set forth in the Provider Manual. County may also qualify for Medicare recoveries.

County's Encounters for Covered Services rendered to Medi/Medi Members (crossovers) shall be processed as set forth in Exhibit C to this Agreement.

For determination of the PCP Incentive Physician Services, Authority will calculate the value of a crossover claim by taking the difference between the flat rate that County receives from Medicare and the Authority's fee-for-service rate for the given HCPCS/CPT code. This difference will represent the amount the Authority would have paid the County were the service billed as a fee-for-service crossover claim. This difference will be known as the fee-for-service equivalent amount. The fee-for-service equivalent amounts for specialty services will be calculated under the Utilization measures of the Authority's PCP Incentives Program.

The Authority may use similar methodology (though not based on the value of a crossover claim) to calculate a fee-for-service equivalent for other services, and the resulting equivalent amounts for all services will be used by the Authority to calculate Covered Services during the Fiscal Year of Authority, to make projections for future fiscal years, and to perform other ad-hoc costs analysis.

4.11 Notification of Member's Potential Tort, Casualty, or Workers Compensation Awards. Since Authority is under a contractual obligation to the State to notify the State of any potential tort, casualty insurance, Workers' Compensation award and uninsured motorists coverage for the value of Covered Services provided to any Member, Authority must rely on its Providers to

inform Authority of such potential awards. Therefore, County agrees to notify Authority that a potential tort, casualty insurance, Workers' Compensation award, or uninsured motorists coverage may cover any Covered Services provided by County whenever County discovers such potential awards.

4.12 No Reimbursement from State or Members. Except as specifically allowed as a direct result of County's status as an FQHC Provider, County shall hold harmless the State and Members in the event that Authority cannot or will not pay for Covered Services performed by County pursuant to this Agreement.

4.13 Payment Option. Should the State, through an Operating Instruction Letter (OIL) or otherwise, require Authority to implement benefit changes that could result in reimbursement to County at a rate different than the rate indicated in any and all attachments, Authority reserves the right, but does not have the obligation, to make said adjustments. In the event Authority does elect to make such an adjustment, Authority shall be obliged only to do so back to the beginning of the current Fiscal Year of Authority.

4.14 Incentive Payments. Authority, in its sole and absolute discretion and if it is financially feasible, may elect to pay Incentive Payments (as described on Exhibit A), to some Providers based on specific criteria. No Provider shall be entitled to any such Incentive Payment. Incentive Payment shall **not** be deemed to be: (i) compensation for Covered Services under this Agreement; or (ii) a program in which any change requires an amendment to this Agreement.

5. ADMINISTRATIVE PROCEDURES

5.1 Deemed Notice of Provider Manuals, Rules, Policies and Procedures. County will comply with the EDS manual and with Authority's Provider Manuals and the policies and procedures established by Authority and will be deemed to have accepted same, to the extent County has been provided Notice thereof. As of the effective date hereof, the policies, rules, and procedures applicable to County are set forth in Authority's Provider Manuals and other Exhibits attached hereto and incorporated by this reference. County is hereby notified that the Provider Manuals are available, as they may be updated and revised from time to time, on the Authority's web site: www.sbrha.org, and on the Medi-Cal web site: www.medi-cal.ca.gov. Changes to the SBHI language in the above referenced documents and directions for acceptance of said changes will be indicated in a cover letter accompanying such proposed SBHI changes. County may provide specific names and addresses of those who should receive notification of changes.

5.2 Grievance System. County and any Subcontractors shall comply with Authority's grievance system policy and procedures, and Authority shall provide County a reasonable system for the resolution of disputes between County and Authority. Additionally, County shall cooperate with Authority in identifying, processing, and resolving all Member concerns and complaints pursuant to Authority's Member grievance procedures. Authority's grievance system polices are set out in full in the Provider Manual.

5.3 Formulary. County shall comply with Authority's formulary and any associated drug utilization and disease management guidelines and protocols in effect now or that may become effective during the term of this Agreement. When required, the prescribing Physician shall be responsible for obtaining authorization through the MRF process, and shall provide Authority or its pharmacy benefit management company all information necessary to process MRFs.

Prescribing Physicians shall prescribe generic drugs if available instead of the brand name drugs whenever a therapeutically equivalent generic drug exists. See also Pharmaceutical Services and Prescribed Drugs, Section 2.8.

5.4 Non-Discrimination. During the performance of this Agreement, neither County nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including HIV and AIDS, AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. County and Subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. County and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, §12900, et seq.) and the applicable regulations promulgated thereunder (Title 2, CCR, §7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, §12990, set forth in Chapter 5 of Division 4 of Title 2, CCR are incorporated into this Agreement by reference and made a part hereof as if set forth in full. County and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. County shall include the non-discrimination and compliance provisions of this clause in all Subcontracts to perform work under this Agreement.

Neither County nor Subcontractors shall discriminate against Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC, § 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code §11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code § 51 (all types of arbitrary discrimination); rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

For the purpose of this Agreement, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a facility; (ii) providing to a Member any Covered Service which is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Agreement, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating a Member differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions which individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

County shall take steps to ensure that all Members are provided Medically Necessary Covered Services without unlawful discrimination. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait and X-linked hemophilia.

County shall act upon all complaints alleging discrimination against Members in accordance with Authority's Member grievance system and shall forward copies of all such grievances to Authority within five (5) Days of receipt of same.

5.5 Notification. County will notify affected Members in writing of any substantial changes in the availability or location of Covered Services as may be provided by its Clinics at least thirty (30) Days prior to the effective date of such changes, or within fourteen (14) Days prior to the change in cases of unforeseeable circumstances. Authority shall notify Members immediately if County's FQHC clinic site is terminated or closes so that the Member may choose a new PCP as soon as practicable.

Authority will notify contracted County should a Provider who is either an individual or a member of a group no longer provide services to Members.

6. AUTHORITY OBLIGATIONS

6.1 Products and Benefit Information. Authority shall include in the Provider Manual a brief description of the SBHI program and shall promptly update the Provider Manual upon material changes to the program. Authority shall advise and counsel its Members and Providers on the type, scope and duration of benefits and Covered Services to which Members are entitled pursuant to agreement between Authority, County and Members.

6.2 Provider Network. County shall permit Authority to include County in a list of Providers distributed to Members and Providers; provided however, that such rights shall not extend to listing County in any newspaper, radio, or television advertising without the prior written consent of County. County shall notify Authority of address changes pursuant to Section 15.9 of this Agreement, and such changes will be reflected in the contracted Provider lists distributed to Providers and Members as set forth in Section 8.7.

6.3 Consultation with Medical Director. County may at any time seek consultation with Authority's Medical Director or designee, on any matter concerning the treatment of a Member.

6.4 Noninterference with Medical Care. Nothing in this Agreement is intended to create (nor shall be construed or deemed to create) any right of Authority to intervene in any manner in the methods or means by which County renders health care services or provides health care supplies to Members. Nothing herein shall be construed to require County to take any action inconsistent with professional judgment concerning the medical care and treatment to be rendered to Members.

6.5 Reports. Authority shall continue to provide already designed Information Technology ("IT") reports to County. Authority will allow up to fifty (50) hours per year of additional data analysis, reporting and general IT support without charge, with charges of one hundred dollars ($100) per hour thereafter. This provision does not include troubleshooting claims issues that are due to Authority mistakes.

7. INSURANCE AND INDEMNIFICATION

7.1 Insurance

7.1.1 County shall carry at County's sole expense professional liability insurance, or provide and maintain a self-insurance program. Insurance is against professional errors and

omissions (malpractice) in providing services under the terms of this Agreement and for the protection of the interests and property of County, its said employees, Authority Members, and Authority. If applicable, each of County's drivers shall be insured with automobile liability insurance. County shall also carry appropriate Workers' Compensation Insurance. Insurance may be provided in a form of blanket policy. All insurance shall be at limits reasonably required by Authority.

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

7.2 Indemnification. Each party to this Agreement agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all claims, costs, damages and expenses, including reasonable attorneys' fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Agreement. Neither termination of this Agreement nor completion of the acts to be performed under this Agreement shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action are based shall have occurred prior to the effective date of termination or completion.

8. RECORDS AND CONFIDENTIALITY

8.1 Medical and Administrative Records. County shall establish and maintain a legible medical record for each Member who has received Covered Services from County's FQHC Physicians or Health Professionals. Such medical record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of County, its qualified employees, or County's Subcontractor. Such medical record shall be in such a form as to allow trained health professionals, other than County, its employees, or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The medical record shall be kept in a detail consistent with good medical and professional practice in accordance with Title 22, CCR, § 53284, and which permits effective professional review and facilitates a system of follow-up treatment.

8.2 Maintenance of Records. County, its employees, and any Subcontractors shall maintain books, charts, documents, papers, reports and records (including, but not limited to: financial records; books of account; working papers; administrative records; patient medical records; laboratory results; prescription files; Subcontracts; management information systems and procedures; copies of current licenses and certifications for personnel legally required to be licensed or certified; and other documentation pertaining to medical and non-medical services

for Members) related to medical services provided hereunder to Members, to the cost thereof, to payment received from Members or others on their behalf, and to the financial condition of County ("Records"). Records also include those that are customarily maintained by County for purposes of verifying Claims information and reviewing appropriate utilization requirements, including privacy and confidentiality requirements and in accord with the general standards applicable to that book or record keeping. Records shall be legible, kept in detail: (i) consistent with appropriate medical and professional practice and prevailing community standards; (ii) which permits effective internal professional review and external medical audit process; and (iii) which facilitates an adequate system for follow-up treatment. The Member's medical record shall reflect whether the Member has executed an advance directive. County shall be fully bound by the requirements in Title 42, CFR, 2.1 et seq., relating to the maintenance and disclosure of Member records received or acquired by federally assisted alcohol or drug programs. County shall preserve Records for the longer of: (i) five (5) years after the close of the Authority's State Contract; or (ii) the period of time required by State and federal law, and by the Medicare and Medi-Cal programs, as applicable. Upon request, at any time during the period of this Agreement, County shall furnish any such Record, or copy thereof, to the Authority, which shall pay the cost of reproduction at the rate Authority has in effect at the time of the request and mailing costs.

8.3 Records Retention. In order to comply with Authority's obligations under the State Contract, County shall retain, preserve and make available upon request all Records relating to the performance of its obligations under this Agreement, including Claim forms, for a period of not less than five (5) years from the date of the State's fiscal year in which the applicable Agreement between Authority and County expires or terminates, except that, in the event County has been duly notified that the State, DHS, DHHS, the Department of Justice or Comptroller General of the United States, or their duly authorized representative, or any other government entity (collectively "Government Officials") have commenced an audit or investigation of the Agreement or any Subcontract until such time as the matter under audit or investigation has been resolved, whichever is later. Records involving matters that are the subject of litigation shall be retained for a period of not less than five (5) years following the termination of litigation. Such provisions shall also apply to County's Subcontractors.

8.4 Inspection Rights. County shall allow Government Officials statutorily authorized to have oversight responsibilities over the Authority and its contracts and the successors and duly authorized representatives of the Government Officials, including DHS' external quality review organization contractor, to inspect, monitor, or otherwise evaluate the quality, appropriateness and timeliness of services performed under this Agreement and applicable federal and State laws and regulations, and to inspect, evaluate and audit any and all books, records and facilities maintained by County and any and all of its Subcontractors pertaining to these services at any time during normal business hours at the County's normal place of business, or at such other mutually-agreeable location in California.

County shall provide, at Authority's request, reasonable facilities, cooperation and assistance to State and/or Authority representatives in the performance of their duties. When permitted by law, and including but not limited to HIPAA regulations, to conduct health care operations, County shall promptly provide copies of requested records to allow Authority's inspection, monitoring, or evaluation of medical records without patient consent.

8.5 Confidentiality of Information. Not withstanding any other provision of this Agreement, the name of persons receiving public social services is Confidential Information and protected from unauthorized disclosure in accordance with Title 42, CFR, §§ 14100, 431.300 et seq., and

14100.2, California Welfare and Institutions Code, and regulations adopted thereunder. Additionally, Authority, County and any Subcontractors shall protect all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to individual Members from unauthorized disclosure. Authority may release medical records in accordance with applicable law pertaining to the release of this type of Confidential Information.

With respect to any personally identifiable information concerning a Medi-Cal Member that is obtained by County, County's FQHC Physicians and its Health Professionals and any Subcontractors will: (i) not use any such Confidential Information for any purpose other than carrying out the express terms of this Agreement; (ii) promptly transmit to Authority all requests for disclosure of such Confidential Information; (iii) not disclose except as specifically permitted by this Agreement, any such Confidential Information to any party other than Authority, without prior written authorization specifying that the information is releasable under Title 42, CFR, § 431.300 and following, California Welfare and Institutions Code §14100.2, and regulations adopted thereunder; and (iv) at the expiration or termination of this Agreement, return all such Confidential Information to Authority or maintain it according to written procedures sent to Authority by DHS for this purpose.

8.6 Member Request for Medical Records. County and it's Subcontractors shall furnish a copy of a Member's medical records to another treating or consulting Provider regardless of whether the requesting Provider is a participating Provider or an out of network provider, at no cost to Authority or to the Member when: (i) such a transfer of records facilitates the continuity of that Member's care; (ii) the Member is transferring from one Provider to another for treatment; or (iii) the Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

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

9. AGREEMENT TERM AND TERMINATION

9.1 Term. This Agreement shall be effective between Authority and County as of the date it has been executed by both parties, but payments, depending on circumstances, may be made to County for those Covered Services provided to Authority's Member prior to that date. The Agreement shall be for three years subject to renewal upon mutual agreement, unless terminated or amended as hereinafter provided.

9.2 Without Cause Termination. County may terminate this Agreement at any time for any reason or for no reason with at least sixty (60) Days prior written Notice to Authority. Authority may terminate this Agreement at any time for any reason or for no reason with at least thirty (30) Days prior written Notice to County.

9.3 With Cause Termination. If a party materially breaches this Agreement and fails to cure the material breach to the satisfaction of the non-breaching party within fourteen (14) Days after the non-breaching party gives written Notice of the material breach, the non-breaching party may

terminate this Agreement immediately upon written Notice to the other party. Notwithstanding the above, Authority may immediately suspend this Agreement pending completion of applicable termination procedures, if Authority makes a reasonable determination, supported by written findings, that the health and welfare of Members is jeopardized by continuation of the Agreement.

9.4 Immediate Suspension and Termination.

9.4.1 County shall immediately notify Authority and Authority may immediately suspend this Agreement in the event there is a material adverse change in County's insurance coverage, or County's FQHC Physician license(s), Medicare or Medi-Cal certification, accreditation (if applicable) or the credentialing status with Authority is suspended or limited. If County does not provide adequate insurance coverage within thirty (30) Days of the material adverse change, or if County's FQHC Physician's license(s), certification, accreditation (if applicable) or the credentialing status is not fully reinstated within thirty (30) Days of such suspension or limitation, Authority may terminate this Agreement immediately. County shall immediately notify Authority and this Agreement will terminate without further action of the parties if County's insurance coverage is canceled, not renewed or expires, or if County fails to obtain insurance coverage as required by this Agreement, or if County's FQHC Physician license(s), Medicare or Medi-Cal certification, accreditation (if applicable) or credentialing status with Authority is revoked, not renewed or expires, if County's licensure or certification is not obtained as required by this Agreement, or if County is excluded from participation in the Medicare or Medi-Cal programs. If this Agreement terminates without further action of the parties, the effective date of termination shall be the date of the occurrence of such event or, at Authority's option, such other date determined by Authority in its sole discretion.

9.4.2 Authority may immediately suspend this Agreement in whole or in part in the event Authority does not receive funds from the State for health care services or the State determines that Authority is no longer responsible to arrange for the provision of health care services to Members due to a catastrophic occurrence. In any event, this Agreement will automatically terminate at the termination of the Authority's State Contract.

9.4.3 County shall notify Authority and Authority may terminate this Agreement immediately upon written Notice to County if County files a petition in or for bankruptcy, reorganization or an arrangement with creditors or has a case or proceeding commenced against it under any bankruptcy or insolvency law. County must notify Authority, within twenty-four (24) hours, if County's FQHC Physician Clinical Privileges, membership, contractual participation or employment by any medical organization is denied, suspended, restricted, reduced, revoked, is subject to probationary conditions, or is not renewed for possible incompetence, improper professional conduct or breach of contract, or if any such action is pending. Authority will review the issues and may terminate this Agreement immediately upon notification to County.

9.4.4 County shall notify Authority and Authority may terminate this Agreement immediately upon written Notice to County if County provides services to Members through a Subcontractor and: (i) such Subcontractor's license to practice medicine in any state is suspended, revoked, expired or not renewed; (ii) such Subcontractor's staff privileges at any Hospital is revoked, suspended, not renewed or significantly (in the judgment of Authority) reduced for any medical disciplinary cause or reason (if Subcontractor is a physician); (iii) such Subcontractor is not or ceases to be covered by professional liability coverage as required under this Agreement; (iv) such Subcontractor is criminally charged with any act involving moral turpitude; (v) the credentialing information, if required, provided to Authority with respect to

such Subcontractor was materially false; or (vi) such Subcontractor no longer satisfies the credentialing standards, if required, of Authority.

9.4.5 Authority may terminate this Agreement immediately upon written Notice to County if: (i) County surcharges the Members; (ii) County fails to comply with Authority's UM procedures; (iii) County fails to abide by Authority's grievance or quality assurance procedures; (iv) County rejects a modification pursuant to §12; or (v) there is any change to the composition of FQHC Physicians, County Health Professionals and other health care providers providing Covered Services on behalf of County and such Providers have not been credentialed, if required, by Authority.

9.5 Fair Hearing. Notwithstanding time periods for termination set forth in §§ 9.2 through 9.4 above, in all cases in which Authority terminates this Agreement and County is entitled to a fair hearing under Authority's applicable notification and hearing procedures, as amended from time to time, the termination will be final thirty (30) Days from Notice of the right to request a hearing, unless County 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: (i) this Agreement may be terminated for other reasons or without cause; and (ii) upon the request of Authority, County shall not thereafter render Covered Services to Members until a decision is rendered.

9.6 Practice Closure. In the event County ceases to be a Provider, this Agreement shall be of no further effect, except insofar as moneys owed either party shall remain a liability for the applicable party.

9.7 Assignment. Except as provided in § 3.5 of this Agreement, this Agreement may not be transferred or assigned to any other person or entity.

10. RESPONSIBILITY UPON TERMINATION

10.1 Continuation of Covered Services. Upon termination of this Agreement, County shall continue to provide Covered Services to Members under the care of County at the time of termination, and shall accept as compensation for such Covered Services the rates set forth in this Agreement and/or in the applicable attached Exhibit(s) until County or Authority has made reasonable and medically appropriate provision for the assumption of such Covered Services by a new Provider. County or Authority shall use best efforts to make such alternate arrangements within ninety (90) Days of the termination of this Agreement. The terms and conditions of this Agreement will continue to apply to Covered Services provided to each such Member until completion or until transfer to a new Provider. County shall act in such a manner as to facilitate any new Provider's assumption of Covered Services.

10.2 Turnover Requirements. Upon request by the Member, County shall assist the Member in the orderly transfer of the Member’s medical care. In doing this, County shall make available to the subsequent Provider copies of medical records, patient files and any other pertinent information necessary for efficient medical case management of Members. In no circumstances shall a Member be billed for this service.

10.3 Provisions Surviving Termination. Provisions of this Agreement including, but not limited to, §3.12 (Utilization Management), §5.2 (Grievance System), §7 (Insurance and Indemnification), and §8 (Records and Confidentiality) that are not fully performed or are not capable of being fully performed as of the date of termination will survive termination of this Agreement.

County further agrees that § 2.4.11 shall: (i) survive the termination of this Agreement regardless of the cause giving rise to termination; (ii) be construed to be for the benefit of the Members; and (iii) supersede any oral or written contrary agreement now existing or hereafter entered into by the parties. Any modification to this §10.3 shall become effective only after proper State and federal regulatory authorities have received written notification of the proposed change.

10.4 Return of Funds. Upon termination of this Agreement, County shall, within thirty (30) Days, return to Authority the pro rata portion of money paid to County which corresponds to the unexpired period for which payment has been received, if any.

11. HIPAA COMPLIANCE

County and Authority shall make any and all efforts and take any and all actions necessary to comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

County shall comply with HIPAA requirements as currently established in Authority's Provider Manual. County shall also take actions and develop capabilities as required to support Authority compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats. County and Authority agree and acknowledge that County and Authority are covered entities who may disclose personal health information to carry out essential health care functions for treatment, payment and health care operations, as those terms are defined in HIPAA, in accordance with 45 CFR §§164.502(a) and 164.506.

12. AMENDMENT

Authority may amend this Agreement by providing written Notice to County. The amendment shall become effective on the date stated in the Notice, which date shall be at least thirty (30) Days after Notice is given to County, unless County objects in writing within thirty (30) Days of receipt of said Notice of amendment. In that event, authorized County and Authority representatives shall meet and confer to resolve any such objections. In the event they are unable to do so within a reasonable amount of time, County has the right to terminate this Agreement within five (5) Days of the inability of the parties to resolve their differences. Notwithstanding the forgoing, amendments required due to legislative, regulatory or other legal authority do not require prior approval of County and shall be deemed effective immediately upon County's receipt of Notice.

13. AUTHORITY

All parties to this Agreement warrant and represent that they have the power and authority to enter into this Agreement: (i) in the names, titles and capacities herein stated; (ii) on behalf of any entities, persons, or firms represented or purported to be represented by such entity(ies), person(s), or firm(s); (iii) without the need for approval or agreement by any other person or entity. Each party further represents and warrants that it has complied with all formal requirements necessary or required by any State and/or federal law in order to enter into this Agreement.

14. DISPUTE RESOLUTION

14.1 Good Faith Efforts. Except for the right of either party to apply to a court of competent jurisdiction for a temporary restraining order or other provisional remedy to preserve the status quo or prevent irreparable harm, County and Authority agree to attempt in good faith to promptly resolve any dispute, controversy or claim arising out of or relating to this Agreement, including but not limited to payment disputes, through negotiations between senior management of the parties and their designees. If the dispute cannot be resolved within fifteen (15) Days of initiating such negotiations or such other time period mutually agreed to by the parties in writing, either party may pursue its available legal and equitable remedies.

14.2 Continued Performance. County and Authority agree that, the existence of a dispute notwithstanding, they will continue without delay to carry out all their respective responsibilities under this Agreement.

15. MISCELLANEOUS

15.1 Independent Contractor. None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, the employee, or the representative of the other.

15.2 Compliance with State and Federal Program. County shall comply with requirements established by State and/or federal programs relating to its performance under this Agreement. Compliance shall include but not be limited to provisions of the State Contract requirements for Authority to maintain its Center for Medicare and Medicaid Services (CMS) waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and State and/or federal regulations regarding FQHCs.

15.3 Obligations Under Prior Agreement. County acknowledges and agrees that certain of its obligations and duties under the prior agreement as described in Recital A hereof, survive the expiration of the prior agreement and/or are measured following the expiration of the prior agreement (including, without limitation, financial requirements, corrective action plans, quality improvement and credentialing functions). County agrees to perform all such obligations and duties.

15.4 Approval by DHS. This Agreement and any amendments hereto are subject to approval by DHS. Authority shall notify DHS of any amendments to this Agreement.

15.5 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Agreement which such party believes is essential to the successful performance of this Agreement, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Agreement.

15.6 Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon non-compliance or default by the other party with respect to any of the terms of this Agreement shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

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

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

15.9 Notices. Any Notice or other communication required or permitted in this Agreement shall be in writing and shall be deemed to have been duly given on the day of service if served personally or by facsimile transmission with confirmation, or three (3) Days after mailing if mailed by registered or certified mail, or two (2) Days after delivery to a nationally recognized overnight courier, to the person and address noted below or to such other person or address as a party may designate in writing from time to time. The addresses for Notice shall be changed in the manner provided for in this §15.9.

If served on Authority, it should be addressed to Director of Provider Services, 110 Castilian Drive, Goleta, CA 93117-3028

If served on County, it shall be addressed to County at the address that appears on the Agreement, the PIF, or to the most recent address on file with Authority.

County shall provide notice of amendment or termination of this Agreement to DHS, by first class certified mail, postage prepaid at the following address:

Chief, COHS, GMC and Other Contracts Section
California Department of Health Services
Medi-Cal Managed Care Division
MS # 4408
POB 997413Sacramento, CA 95899-7413

15.10 Billing and Procedure Codes. Any billing or procedure codes ("Codes") referred to in this Physician Services Provider Agreement or any Exhibits hereto are for the convenience of the parties only. The parties agree and understand that the Codes may change from time to time and such Code changes shall not require any amendment to this Agreement.

15.11 Governing Law. This Agreement shall be governed by and construed in accordance with all laws and regulations applicable to the Authority and all contractual obligations of the Authority. Any provision required by State or federal laws, or by regulatory agencies to be in this Agreement shall bind the parties whether or not provided in this Agreement. Any reference to any law, regulation, rule, program or plan promulgated by any governmental entity having authority over the Authority or the subject matter of this Agreement shall be deemed to refer equally to any amendment, modification, revision or restatement thereof.

16. ENTIRE AGREEMENT

This Agreement in its entirety is comprised of the Agreement, any and/or all of Exhibits A, B and C applicable to County, Attachment 1, and Authority's Provider Manual. This Agreement, as described in the preceding sentence, contains the entire agreement of the parties and as of the Effective Date supersedes any prior negotiations, proposals or understandings relating to the subject matter of this Agreement. It is agreed by the parties that this Agreement may not be modified, altered or changed in any manner, except in accordance with §12 hereof. *In addition, County is receiving the PIF to complete and return concurrently with this Agreement.*

By signing **on the next page,** County agrees to participate in the following Plans administered by Authority as indicated by receipt of the applicable Exhibits below.

County has received the following Exhibits/Attachments with this Agreement:

__X___Exhibit A--Protocols for Primary Care Physicians (incl. Attachments A-1, A-2, and A-3) *(Pages 1-16)*
__X___Exhibit B--Protocols for Referral (Specialist) Physicians *(Pages 1-5)*
__X___Exhibit C--Encounter Billing Procedures *(Pages 1-2)*
__X___Attachment 1--Disclosure Form--Officers and Owners, Stockholders Owning more than 10% Stock, and Major Creditors *(Page 1)*

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective on the date executed by COUNTY.

SANTA BARBARA REGIONAL
HEALTH AUTHORITY

By: _____
ROBERT S. FREEMAN,
Deputy Executive Director
Tax ID Number: 95-3865941

APPROVED AS TO FORM:

_____
Renée de Jong
Director of Legal Affairs

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective on the date executed by COUNTY

ATTEST:
MICHAEL F. BROWN
CLERK OF THE BOARD

By: _____
Deputy

COUNTY OF SANTA BARBARA

By: _____
Chair, Board of Supervisors

Date:_____

APPROVED AS TO FORM:
STEPHEN SHANE STARK
COUNTY COUNSEL

By: _____
Deputy County Counsel

APPROVED AS TO ACCOUNTING FORM:
ROBERT W GEIS, CPA
AUDITOR-CONTROLLER

By: _____
Deputy

APPROVED AS TO INSURANCE FORM:
RAY AROMATARIO,
RISK MANAGER

By:_____
Risk Manager

ATTACHMENT 1

DISCLOSURE FORM

PLEASE COMPLETE AND RETURN

Please complete the following information:

1) Names of the officers and owners *(i.e. if the provider is Dr. John Doe and he is the sole owner of the practice he should be listed in this section):*

_____ _____

_____ _____

_____ _____

_____ _____

If the following questions 2) and 3) are not applicable to County, please check here ☐

2) Stockholders owning more than 10 percent of the stock issued by County:

_____ _____

_____ _____

_____ _____

3) Major creditors holding more than five percent of the debt of County:

_____ _____

_____ _____