CLINICAS DEL CAMINO REAL, INC.
Specialist Care Professional Services Agreement
AMENDMENT 7

This Seventh Amendment (the "Amendment") to the Specialist Care Professional Services Agreement dated July 1, 2019 ("Agreement") between Clinicas del Camino Real, Inc. ("Clinicas"), a California Corporation, with its main offices located at 1040 Flynn Road, Camarillo, California 93012, and the County of Ventura, a political subdivision of the State of California, including its Ventura County Health Care Agency ("Provider"), effective June 30, 2024, as follows:

1. The Agreement will remain in effect through December 31, 2024, unless earlier terminated as set forth in the Agreement. Thereafter, the Agreement may be extended, by mutual written agreement of the parties, for successive one-year terms.

2. Exhibit A-2, Compensation shall replace in its entirety Exhibit A-1 of the Agreement effective June 30, 2024. All claims for services provided on or after June 30, 2024 shall be paid under the terms of Exhibit A-2.

3. Clinicas shall pay Provider the rates listed in Exhibit A-2 for any and all services rendered on or after June 30, 2024. Any adjustments to previously billed claims shall be jointly reconciled and paid through a lump-sum payment, which shall be made to Provider no later than August 31, 2024.

4. Except as expressly amended herein, all other terms and conditions of the Agreement shall remain unchanged. In the event there is any inconsistency between the terms of the Agreement and this Amendment, this Amendment shall control.

[SIGNATURE PAGE TO FOLLOW]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the date set forth below each signature.

"Clinicas" Clinicas del Camino Real, Inc.	"Provider" County of Ventura
By: DocuSigned by: Gagan Pawar, M.D C6690AED5E4B4D4...	By:
Name: Gagan Pawar, MD, MBA	Name: Barry Zimmerman
Title: Chief Executive Officer	Title: HCA Director
Date: 7/1/2024	Date: 6.24.24

EXHIBIT A-2
Compensation
Effective June 30, 2024

1. PROVIDER Name of Provider: County of Ventura

2. COVERED SPECIALTY SERVICES

Specialty: Multispecialty and Ancillary Services

3. COMPENSATION

a. Payment for Covered Medical Services rendered by Provider to Clinicas Members and pre-approved by Clinicas will be made at Provider's billed charges or the fee schedule rates provided below as of the date of service, whichever is less. The following fees shall apply to Ancillary Medical Services and professional services, including Hospital Services and Outpatient Hospital Services rendered as Covered Services applicable to the terms of this Agreement for eligible Clinicas Members when Clinicas is financially responsible:

Services	Medi-Cal [1]	Medicare [2]	Commercial [2]
Professional Services (Physician and Mid-Level Providers)			
Consults (OP), Including all office visits,	$322	$322	$322
Consults (IP)	120% Medi-Cal	114% Medicare	130% Medicare
Surgical/Treatment (OP)	$322	$322	$322
Surgical / Treatment (IP)	120% Medi-Cal	114% Medicare	130% Medicare
Telehealth	$322	$322	$322
Urgent Care	$322	$322	$322
Emergency Room	125% Medi-Cal	114% Medicare	130% Medicare
Non-Professional Services - Hospital OP Department and Hospital Based Clinics			
Diagnostics, Ancillary, and Technical Fees	125% Medi-Cal	114% Medicare	130% Medicare fee schedule
Urgent Care	125% Medi-Cal	114% Medicare	
Drugs and Medication Administration Fees [3] [4]	35% Billed Charges	35% Billed Charges	
Non-Professional Services-FQHC and Other Non- Hospital Based Clinics*			
Diagnostics, Ancillary, and Technical Fees	120% Medi-Cal	114% Medicare	130% Medicare Fee Schedule
Drugs and Medication Administration Fees [3] [4]	35% Billed Charges	35% Billed Charges	130% Medicare fee schedule

[1] Rates based on Medi-Cal shall refer to the prevailing Medi-Cal fee schedule as of the date relevant services were rendered, as published by the California Department of Health Care Services, including any additional or supplemental payment(s) that are otherwise payable to Provider under the Medi-Cal Fee-for-Service Program.

[2] Rates based on Medicare shall refer to the prevailing Medicare fee schedule as of the date relevant services were rendered, as published by the Center for Medicaid and Medicare Services, including but not limited to the Medicare Physician Fee Schedule and the Medicare prospective payment system rates, that are otherwise payable to Provider under the traditional Medicare Program.

[3] "Billed Charges" shall refer to Provider's applicable charges as shown in Provider's Charge Description Master in effect as of the date the relevant services were rendered ("Charges").

[4] Rates apply to FDA-approved covered pharmaceuticals as part of an outpatient visit and when CLINICAS has financial responsibility.

b. For oncology services: The initial consultation and three (3) follow-up visits will be authorized. All subsequent visits will require prior authorization. All radiology and laboratory services performed at Provider while patients are receiving treatment do not require authorization.

c. For all Medical Services with a Relative Value Non-Established (RVNE) procedure and/or unlisted or incompatible CPT/RVRBS, or HCPCS codes, reimbursement shall be paid at thirty-five percent (35%) of Billed Charges or one hundred percent (100%) of payor(s) Fee Schedule identified in this Agreement, whichever is less.

d. Provider is required to accept payment for services through electronic funds transfer (EFT).

e. Claims for services rendered shall-be submitted within the following timeframes:

- Medi-Cal: Three hundred sixty-five (365) days from the date of service.
- Medicare: Three hundred sixty-five (365) days from the date of service.
- Commercial: One hundred-eighty (180) days from the date of service

These timeframes are subject to change based upon State and Federal regulatory requirements. These timeframes may be subject to change if required under State and/or Federal regulation(s).

f. In the event that Provider identifies an overpayment, duplicate payment or other excess payment ("Overpayment"), Provider shall report within sixty (60) calendar days of the data of identification of the Overpayment as outlined in the Provider Manual. The report shall include the amount of the Overpayment identified and the reason for the Overpayment. Provider shall also make repayment to CLINICAS within sixty (60) calendar days of the date of identification of such Overpayment.

g. All clean claims will be paid in accordance with Upstream Contractors and Regulatory Agencies.

h. Prior Authorization Required. Provider recognizes and acknowledges that that except for Emergency Care or as identified above, Prior Authorization by CLINICAS must be obtained on specialty, hospital and certain ancillary services, and that all referrals must be made to CLINICAS contracted providers, unless other arrangements are made prior to services being rendered.

i. Notwithstanding anything to the contrary, providers have three hundred and sixty-five days (365) after the date of service, date of the explanations of benefits (EOB) or Remittance Advice (RA) delineating specific claims payment, or other claim event to file a claim or claim dispute with CLINICAS. Thereafter, all claims actions will be denied.