SPECIALIST CARE PROFESSIONAL SERVICES AGREEMENT
BETWEEN
CLINICAS DEL CAMINO REAL, INC. AND COUNTY OF VENTURA

This Specialist Care Professional Services Agreement ("**Agreement**") is made and entered into effective July 1, 2019 ("Effective Date") by and between **Clinicas del Camino Real, Inc.,** a California not-for-profit corporation, located at **1040 Flynn Road, Camarillo, CA 93012 ("CLINICAS")** and **County of Ventura,** with administrative offices located at **800 South Victoria Ave., Ventura, CA 93009**, **("Provider")**, with reference to the following:

RECITALS

WHEREAS, CLINICAS is a not for profit, comprehensive Federally Qualified Health Center that contracts with primary care Physicians, specialty Physicians, and Ancillary Medical Services providers to provide medical services to the population of Ventura County. This population includes patients of health plans with Medi-Cal, Medicare Advantage and commercial managed care Members (collectively, "Plans"); and

WHEREAS, CLINICAS has executed or will execute contracts with the Ventura County Medi-Cal Managed Care Commission ("COHS"), a public entity, doing business as Gold Coast Health Plan, AmericasHealth Plan ("AHP") and other Managed Care Health Plans, to arrange for the provision of medical services to its Members on a prepaid (per Member per month capitation) or Fee For Service basis; and

WHEREAS, the parties desire to enter into this Agreement and acknowledge that it represents the foundation of responsibilities to successfully provide quality, cost effective, covered health services to Members on a continuing basis; that mutual cooperation, respect and communication are essential to the fulfillment of these responsibilities; and that the timely, accurate and good faith fulfillment of each party's responsibilities is necessary in order for the other to satisfy its responsibilities; and

WHEREAS, the parties resolve that by executing this Agreement, Provider agrees to participate in CLINICAS negotiated payor agreements, and to honor and fulfill all terms, conditions and obligations as a contracted provider.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, and for other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties agree as follows:

SECTION I
DEFINITIONS

1.1 **Affiliated Hospital** shall mean the Providers' hospitals identified in Exhibit "C," which is attached hereto and incorporated herein by this reference.

1.2 **Ancillary Medical Services** shall mean those Covered Services necessary to the diagnosis and treatment of Members, including, but not limited to ambulatory or day surgery, imaging services, laboratory, pharmacy, physical or occupational therapy, Urgently Needed or Emergency Services and other Covered Services customarily deemed ancillary.

1.3 **Authorization** means the approval by CLINICAS for a Member to be referred to a specialist Physician, to be prescribed pharmaceuticals not included in a Plan's drug formulary or for Covered Services.

1.4 **Benefit Agreement** shall mean the written agreements entered into between a Plan and employer or other groups, individuals or governmental agencies or other payors under which the Plan and CLINICAS provide or administer health benefits to persons enrolled in the Plan.

1.5 **Claim** shall mean a paper CMS Form 1500 or digital statement prepared by a Participating Provider for the purpose of identifying all diagnoses, and completely itemizing all services and treatments provided to a Member.

1.6 **CMS** shall mean the Centers for Medicare and Medicaid Services, which is the department of DHHS that oversees the Medi-Cal and Medicare programs as well as the health insurance exchange, including Plans Medicare Advantage Plan or its successor.

1.7 **COHS**. Shall mean the Ventura County Medi-Cal Managed Care Commission, a local agency created by the Ventura County Board of Supervisors to contract with the Medi-Cal program.

1.8 **Coordination of Benefits** ("**COB**") shall mean those provisions by which a Plan, CLINICAS, and Provider either together or separately, seek to recover costs of Covered Services provided to a Member for care that may be covered by another Plan, subject to limitations imposed by law, regulation or a contract limiting or preventing such recovery.

1.9 **Copayments** shall mean those charges, including deductibles, for Covered Services that are to be paid directly to Provider by a Member in accordance with the applicable Benefit Agreement.

1.10 **Covered Services** shall have the meaning ascribed in the relevant Plan agreement entered into by CLINICAS.

1.11 **DHCS** means the State of California Department of Health Care Services.

1.12 **DHHS** means the Department of Health and Human Services.

1.13 **DMHC** shall mean the California Department of Managed Health Care, the agency responsible for licensing and regulating healthcare service plans under the Knox-Keene Act.

1.14 **Effective Date** shall mean the date when this Agreement shall take effect and is represented in the first paragraph of this Agreement.

1.15 **Emergency Medical Condition** shall mean (a) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that a prudent layperson would reasonably have cause to believe constitutes a condition whereby the absence of immediate attention could reasonably be expected to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or the unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part; or (b) with respect to a pregnant woman who is having contractions, (i) a situation in which there is inadequate time to effect a safe transfer to a Hospital or another health care facility before delivery; or (ii) a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

1.16 **Emergency Services** shall mean those Medically Necessary medical and Hospital Services that are (i) furnished by a provider qualified to furnish Emergency Services; and (ii) needed to evaluate or stabilize an Emergency Medical Condition.

1.17 **Fee for Service** shall mean payment to Provider for services rendered by a Participating Provider for services rendered for an agreed upon fee.

1.18 **HMO** means a health maintenance organization or a health care service plan licensed by DMHC which has entered into a Benefit Agreement with DHCS, CMS, or any other health benefit program or Plan to provide or arrange for health care services to persons eligible to receive health care services within the Plan's service area under the applicable Benefit Agreement.

1.19 **Hospital** shall mean an acute care hospital licensed in California, approved by the Joint Commission or other accrediting agency and certified for participation under the Medi-Cal and Medicaid programs.

1.20 **Hospital Services** shall mean acute and sub-acute inpatient care and Hospital outpatient services and supplies that are both (a) covered by a Benefit Agreement, and (b) ordered or authorized by a Plan or CLINICAS, if delegated. Hospital Services do not include long-term non-acute care.

1.21 **Managed Care Health Plans** shall mean CMS, AHP, HMOs, preferred provider organizations, exclusive provider organizations, self-funded employers, insurance carriers, third party administrators, managed care plans, state or federal health benefits plans, Employee Retirement Income Security Act of 1974 trusts, or other Plans that contract with CLINICAS to provide patient care services to its Members or beneficiaries.

1.22 **Medically Necessary** shall mean medical or surgical treatment a Plan determines (i) is not experimental, (ii) is required and appropriate in accordance with acceptable standards of medical practice, (iii) has been established as safe and effective, and (iv) is furnished in accordance with generally accepted professional standards to treat an illness, injury, or medical condition. These services must be consistent with the Plan's medical policy, be consistent with the symptoms or diagnosis, be furnished at the most appropriate level and not be furnished primarily for the convenience of the Member, the attending Physician or any other provider.

1.23 **Medicare Advantage Plan** shall mean the Medicare managed care benefit plan a Plan offers to Medicare beneficiaries pursuant to the Plan's contract with CMS.

1.24 **Member** shall mean an individual who is entitled to receive Covered Services pursuant to the applicable Benefit Agreement.

1.25 **Non-Covered Services** shall mean those services that are not benefits under the applicable Benefit Agreement.

1.26 **Outpatient Hospital Services** shall mean services provided in a Plan Hospital to a Member who has not been admitted for an overnight stay. Outpatient Hospital Services includes, but is not limited to, the facility component of outpatient surgery, pre-admission testing, and laboratory and radiology services.

1.27 **Participating Provider** shall mean any duly licensed Physician, nurse practitioner, physician assistant, or other certified ancillary care provider who is contracted with Provider, and who shall provide services under this Agreement. The Participating Provider must be enrolled in the Medi-Cal program.

1.28 **Physician** shall mean an individual who holds an unrestricted license to practice medicine or osteopathy issued by the State of California.

1.29 **Provider Manual** shall mean the document, incorporated herein by this reference, that is created by CLINICAS to inform Providers of administrative policies, procedures and guidelines applicable to Provider's performance under this Agreement and to comply with the requirements and operational standards imposed by applicable laws and regulations and Plan contractual obligations. It may be formally compiled in a single manual, or set forth in a series of manuals, bulletins or guidelines, which may in some cases refer to

Plans, DHCS, DMHC, CMS or other publications that are available to Provider, and may be printed or made available on the CLINICAS or Plan website.

1.30 **Provider Practice Area** shall mean the geographic area in which Provider shall provide Physician services to Members. The designation of a particular geographic area as the Provider Practice Area shall not be construed as giving Provider any particular rights to that geographic area.

1.31 **Regulatory Agencies** shall mean all applicable federal, state and local laws, and all related rules and regulations promulgated by all federal, state and local regulatory entities and their designees who have either jurisdiction or responsibility for oversight of various aspects of this Agreement. Such Regulatory Agencies may include but not be limited to the DHHS, Department of Justice, and CMS. California agencies include the DHCS, Department of Corporations, Department of Insurance, and DMHC.

1.32 **Self-Referred Urgently Needed Services** shall mean those Urgently Needed Services obtained by a Member who accesses such services on his/her own volition absent any form of prior Authorization or referral by a Plan or any Participating Provider.

1.33 **Upstream Contractors** shall mean those signatories in the chain of agreements leading back to the ultimate source of payment for a particular patient population. As an example, the immediate Upstream Contractor to this Agreement is a Plan that contracts with CLINICAS.

1.34 **Urgently Needed Services** shall mean those Covered Services (other than Emergency Services) that are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness or injury with respect to which treatment cannot reasonably be delayed.

1.35 **Utilization Management** shall mean the programs and process standards to authorize and monitor the utilization of Covered Services provided to Members.

1.36 **Utilization Review** shall mean the process by which a Payor 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.

Section II
RESPONSIBILITIES OF CLINICAS

2.1. **CLINICAS Responsibilities**. CLINICAS shall be responsible to provide or arrange all administration, financial management and control, Claims processing, Claims payment, provider credentialing and the operation of comprehensive quality assurance and

Utilization Management consistent with the requirements of Regulatory Agencies and its managed care contracts. CLINICAS shall maintain, and provide to Provider, written policies and procedures relating to such activities.

2.2. **Identification Card**. CLINICAS is responsible for providing copies of all identification cards used by CLINICAS Members to Provider. The cards shall be prepared by each Plan contracted with CLINICAS and will bear the name and symbols of the Plan as well as the name and symbol of CLINICAS, and contain: a) Member name and identification number, b) Member's primary care physician, and c) other identifying data.

2.3. **Provider Manual.** CLINICAS shall provide or make available to Providers all Provider Manuals applicable to services provided under this Agreement.

2.4. **Financial Responsibility.** If CLINICAS denies payment for a Claim submitted by Provider, CLINICAS shall provide a reason code for all denials; said denials shall be consistent with those defined by regulatory agencies or Plan benefits. Additionally, CLINICAS will work with Plan(s) to ensure that if services are covered, Provider will be paid either by Plan or CLINICAS based on which organization has financial responsibility for the service(s) provided.

SECTION III
RESPONSIBILITIES OF PROVIDER

3.1. **Licensure**. Provider warrants that each Participating Provider has, and will continue to have as long as this Agreement remains in effect, a currently valid unrestricted license to practice medicine or osteopathy in the State of California to provide Covered Services under the terms of this Agreement; that each Participating Provider has the personal capacity to perform pursuant to the terms of this Agreement; and that each Participating Provider will satisfy any continuing professional education requirements prescribed by state licensure and/or certification regulations, and will continue to do so as long as this Agreement remains in effect.

3.2. **Credentialing.** Provider agrees to aid in procuring all credentialing requirements in accordance with the guidelines established by the National Committee on Quality Assurance.

3.3. **Record-Keeping and Access.** Provider shall make all of its premises, facilities, equipment, books, and records, contracts, computers, and other electronic systems, pertaining to the services furnished under the terms of this Agreement, available for purpose of audit, inspection, evaluation, examination or copying by DHCS, CMS, DHHS office of the Inspector General, the Comptroller General, and the Department of Justice or their designees:

a. At all reasonable times, at Provider's place of business or at such other mutually agreeable location in California;
b. In a form maintained in accordance with the general standards applicable to such book or record keeping;
c. For a term of at least ten (10) years from the termination of this Agreement or from the date of completion of any audit, whichever is later.

If DHCS, CMS, or the DHHS office of the Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS office of the Inspector General may inspect, evaluate, and audit Provider or a subcontractor at any time. Upon resolution of a full investigation of fraud, DHCS shall have the right to suspend or terminate Provider from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan and direct CLINICAS to terminate its contract with Provider due to fraud. Through the end of the records retention period, Provider shall furnish any record or copy of it, upon request, to DHCS or any other federal or state or Plan entity at Provider's sole expense.

3.4. **Provision of Covered Services**. Provider shall provide Covered Services to Members consistent with the scope of Provider's license, certification or accreditation, and in accordance with professionally recognized standards in effect at the time services are rendered in a manner that ensures availability, timely access and continuity of care on a 24/7 basis. Covered Services shall be provided in accordance with, and shall otherwise comply with, all provisions of Regulatory Agencies and Plan agreements of CLINICAS as amended from time to time, as set forth in the Provider Manual. Provider further acknowledges that it is not restricted from advising Members about their health status, medical care, or treatment regardless of benefit coverage if the professional is acting within its scope of practice.

3.5. **Non-Payment; Hold Harmless; No Surcharges; Patient Waivers**.

a. Provider, for itself and each of its contracted Participating Providers, agrees that in no event, including but not limited to non-payment, insolvency or a breach of this Agreement, shall Provider or a Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons (other than a Plan or CLINICAS) acting on their behalf for Covered Services. This provision shall not prohibit the collection of any applicable Copayments, deductibles or coinsurance.

b. In the event of non-payment by a Plan to CLINICAS, or from CLINICAS to Provider, for any reason including the Plan's insolvency, CLINICAS' insolvency or breach of this Agreement, Provider and each Participating Provider shall continue to provide Covered Services (i) to all Members for the duration of the period for which payments are made to the Plan or CLINICAS, or (ii) for Members who are hospitalized as of the

date Plan or CLINICAS becomes insolvent, through discharge. Provider and each Participating Provider's sole recourse for payment shall be against the Plan if the Plan is in default or against CLINICAS if CLINICAS is in default.

c. Provider and all contracted Participating Providers agree that this provision shall survive termination of this Agreement, regardless of cause, and shall be construed to be for the benefit of the Member. This provision supersedes any oral or written agreements to the contrary now existing or hereafter entered into between the Provider, its Participating Providers, and a Member or persons acting on the Member's behalf.

d. No Surcharges. Provider and its Participating Providers shall not assess surcharges to Members for Covered Services. Provider will immediately refund any such monies as soon as Provider knows of the error. Provider acknowledges that, should a Plan or CLINICAS receive notice of any such surcharge and Provider fails to reimburse the Member within fifteen (15) calendar days of notice to do so, CLINICAS shall have the right to terminate this Agreement effective upon receipt by Provider of termination notice.

e. Patient Waivers. Provider shall not charge Members for services denied payment as not being Medically Necessary unless Provider has obtained a written waiver in advance from the Member clearly stating that the Member is responsible for payment and identifying the cost of those services.

3.6. **Insurance Coverage**. During the term of this Agreement, Provider shall maintain professional liability, general liability, and other insurance coverage of not less than one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) aggregate. Provider shall provide proof of coverage on request. CLINICAS shall be notified within ten (10) days of any reduction or cancellation of insurance coverage.

3.7. **Non-Discrimination**. Provider shall comply with all applicable Regulatory Agencies prohibiting discrimination against any Member, Provider, a Plan, and any current or prospective contracting party or person reasonably expected to benefit from any such contract, on the grounds of race, color, age, creed, sex, religion, ancestry, national origin, marital status, sexual orientation, income level, health status, plan membership, or physical or mental handicap, including but not limited to Title VI of the Civil Rights Act, 42 USC 200d; the Americans with Disabilities Act, 42 USC 12101 et seq; the 1975 Age Discrimination Act, as amended, 42 USC 6101 et seq; the 1974 Rehabilitation Act and Executive Order 11246 "Equal Employment Opportunity" as amended by Executive Order 11375, and all laws, rules and regulations issued pursuant to all of the above.

3.8. **Covenant Not To Solicit or Transfer Members**. The business and professional relationships between CLINICAS and its Members, and the business and professional relationships between CLINICAS and the Plans with whom it contracts, is CLINICAS property, including all Member lists accepted by Provider. During the term of this

Agreement and for two (2) years after its termination, Provider and its Participating Providers agree that they will not: interfere with CLINICAS contract and/or property rights; advise or counsel any Member or Plan to terminate its relationship with CLINICAS; solicit any Member to become enrolled with any other Plan; or disclose proprietary CLINICAS information. Provider acknowledges that such activity would constitute prohibited use of CLINICAS confidential information. In addition, during the term of this Agreement, Provider agrees to not move any CLINICAS affiliated membership to any other provider network in which Provider is contracted.

3.9. **Performance Standards**. Provider shall comply and cooperate with all standards, policies and procedures as may be adopted or amended from time to time by applicable Regulatory Agencies. Provider agrees to participate and comply with all the applicable requirements of the Medi-Cal program.

3.10. **Utilization Management Activities**. Provider agrees to abide by and incorporate the policies, procedures, standards and programs developed by Regulatory Agencies with respect to required referrals and linkage systems. To the extent that Provider is responsible for the coordination of care for Members, CLINICAS agrees to share with Provider any utilization data that DHCS has provided to CLINICAS, and Provider agrees to receive the utilization data provided and use it as it is able for the purpose of Member care coordination.

3.11. **Quality Management Activities**. Provider agrees to participate in, cooperate with, submit all required reports and records to, and abide by the policies, procedures, decisions, rules and regulations of Regulatory Agencies as they pertain to quality improvement, Utilization Review, peer review, credentialing, Member and Provider grievances and appeals, audits, statistical activities and encounter data submission. By this reference, Provider agrees to incorporate and abide by the content of such protocols, policies, procedures and committee formats, and to any updates as may occur and be distributed from time to time.

3.12. **HIPAA Compliance - Confidentiality of Medical Records.**

a. All Member medical information will be treated in a confidential manner in accord with applicable state and federal laws, including, without limitation, the regulations of DHHS concerning the privacy and security of health information. Providers' contractors, employees or other staff will not have access to or the right to review any medical record of any Member, except where necessary to provide Covered Services to Members and to meet the requirements of this Agreement.

b. Provider acknowledges that it is a "covered entity" as that term is defined under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and regulations issued thereunder (collectively, "HIPAA"). Provider agrees to comply with the applicable provisions of HIPAA, including but not limited to the HIPAA standards

for (i) privacy, (ii) code sets, (iii) data transmission standards, and (iv) security regarding physical storage, maintenance, transmission of and access to individual health information.

c. Provider acknowledges that it is a "business associate" of CLINICAS, as that term is defined under HIPAA, and shall enter into the HIPAA Business Associate Addendum attached hereto as Exhibit "D" which is attached hereto and incorporated herein by this reference, or another equivalent form approved by CLINICAS.

3.13. **Other Regulatory Compliance**. Provider and CLINICAS each agree to comply with all applicable federal, state, municipal and county ordinances and regulations, and all applicable state and federal laws and regulations as may be in effect now or hereafter, to the extent that they directly or indirectly bear upon the subject matter of this Agreement.

3.14. **Reciprocity**. For any Plan contract requiring a reciprocity provision for which CLINICAS is not financially responsible, Provider agrees to accept such reciprocal payments at the other Plan's standard rate or the rate in Schedule A, whichever is greater, from the applicable Plan as payment in full. This provision shall not prohibit the collection of any applicable Copayments, deductibles or coinsurance.

3.15. **Disciplinary Action**. Provider acknowledges that Upstream Contractors, under their respective contracts, have the right to require a Plan or CLINICAS to suspend assignment of new Members, to transfer Members from or to another Participating Provider, or to terminate a Participating Provider at any time, subject to such review or appeal rights as may be provided in accordance with, and subject to, policies and procedures as implemented from time to time.

3.16. **Provider Manual.** Provider shall comply with the standards and procedures set forth in the Provider Manual. A Plan may amend its Provider Manual from time to time. Changes to non-material terms of the Provider Manual shall be effective immediately upon notice to Provider. CLINICAS shall notify Provider in writing not less than forty-five (45) business days prior to a change in any material term set forth in the Provider Manual. Provider shall notify CLINICAS of its objections to such amendments or modifications within thirty (30) days after CLINICAS gives notice of the change. If CLINICAS or Provider so requests, the parties shall negotiate for Provider to accept the amendment or for a modified amendment. If Provider does not accept the amendment and the parties do not agree on a modified amendment by the end of the forty-five (45) business days' notice period, Provider and CLINICAS shall each have the right to terminate this Agreement effective on not less than thirty (30) days' notice or prior to the effective date of the amendment or modification to the Provider Manual, whichever is later. Nothing in this Section 3.16 limits the ability of the parties to mutually agree to the proposed change at any time after Provider has received notice of the proposed change.

3.17. **Member Grievances**. CLINICAS retains responsibility for grievance resolution for Members. Provider agrees to cooperate in resolving Member grievances related to CLINICAS. CLINICAS will bring all Member complaints involving Provider, and CLINICAS will, in accordance with its regular procedure, investigate such complaints and use its best efforts to resolve them in a fair and equitable manner. CLINICAS agrees to notify Provider promptly of any action taken or proposed with respect to the resolution of such complaints and CLINICAS will provide an action plan so that similar complaints in the future can be avoided. CLINICAS agrees to adhere to all state and federal regulations set forth in the Provider Manual regarding Member grievances.

3.18. **Submission of Encounter Data**. Provider agrees to furnish CLINICAS with complete encounter data for all Covered Services rendered to Members in the CMS Form 1500 format or a mutually acceptable alternate format as described in the Provider Manual. This encounter data will be furnished to CLINICAS through electronic data interchange and shall be received by CLINICAS within the required timelines as defined in Section 5.2 of this Agreement. Provider agrees to furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

SECTION IV
TERM AND TERMINATION

4.1 **Initial Term**. This Agreement shall be effective July 1, 2019 and shall remain in effect for a period of one (1) year ("Initial Term"). After the Initial Term, this Agreement will renew automatically for up to two (2) consecutive annual periods thereafter unless terminated as provided below. This Agreement will automatically expire on June 30, 2022 unless terminated sooner as provided below.

4.2 **Termination for Loss of Provider Qualifications**.

a. This Agreement shall automatically terminate if Provider is prohibited from participating in the Medicare or Medi-Cal programs.

b. CLINICAS may terminate this Agreement effective upon notice if Provider (i) fails to maintain professional liability insurance; (ii) has been convicted of, or pleads no contest to, a felony charge or charge of fraud, deceit, forgery, misrepresentation, moral turpitude or unprofessional conduct; or (iii) if, by allowing Provider to continue to provide Covered Services to Members under the circumstances, the health or safety of Members would be endangered, CLINICAS would be in violation of state licensure, federal qualification and/or accreditation standards and/or subject to sanction by Regulatory Agencies and/or CLINICAS' relationship with any Plan or reputation in the community would be damaged.

c. CLINICAS may terminate this agreement effective upon thirty (30) days' notice if any of the following events occur with respect to a Participating Provider, and Provider,

after having notice of the event, does not bar that individual from continuing to be a Participating Provider with respect to CLINICAS referrals or CLINICAS Members: the Physician (i) ceases for any reason to be a member in good standing of a Hospital's medical staff; (ii) the Physician's license to practice medicine is revoked or subject to disciplinary action by the Medical Board of California or Osteopathic Board, or other board as applicable; (iii) the Physician fails to maintain professional liability insurance; (iv) the Physician is prohibited in participating in the Medicare or Medicaid program; (v) the Physician has failed to meet CLINICAS' credentialing or recredentialing standards; (vi) the Physician has been convicted of, or pleads no contest to, a felony charge or charge of fraud, deceit, forgery, misrepresentation, moral turpitude or unprofessional conduct; (vii) COHS, AHP, or another Plan requests or demands that the Physician no longer provide services to its enrollees or be removed from its panel of participating providers; or (viii) if, by allowing the Physician to continue to provide Covered Services to Members under the circumstances, the health or safety of Members would be endangered, CLINICAS would be in violation of state licensure and/or accreditation standards and/or subject to sanction by Regulatory Agencies, and/or CLINICAS' relationship with any Plan or reputation in the community would be damaged.

4.3 **Voluntary Termination**. After the Initial Term, Provider may terminate this Agreement by giving CLINICAS ninety (90) days prior written notice of its intent to terminate. Conversely, after the Initial Term, CLINICAS may terminate this Agreement by giving Provider ninety (90) days prior written notice of its intent to terminate.

4.4. **Termination for Cause**. CLINICAS may terminate this Agreement for cause in the event that Provider breaches a material term of condition of this Agreement and fails to cure such breach within thirty (30) days after written notice of the breach. Cause may include, but is not limited to quality of care and accessibility considerations, or failure to provide credentialing or other required information.

4.5. **Provider Appeals of Termination Decisions**. Provider may appeal a termination decision by CLINICAS by providing a written appeal within thirty (30) days of the termination decision, to which CLINICAS must respond within thirty (30) days. Nothing in this Section 4.5 shall be construed to prevent a Participating Provider from having open clinical dialogue with a Member, including communicating medical advice and/or treatment options, regardless of cost or coverage of the options.

4.6. **Notification of Members**. Upon termination of this Agreement for any reason, Provider must notify affected Members of the termination. Affected Members are Members who have been under the ongoing care of Provider.

4.7. **Transfer of Patient Care Responsibility; Member Benefit Continuation**. The parties agree that nothing in this Agreement authorizes Provider to abandon any Member who

is a patient. Upon termination of this Agreement for any reason, Provider shall continue providing Covered Services to Members who retain eligibility and for whom premium is paid, or by operation of law, until such services are completed or until CLINICAS has made arrangements for treatment by another provider and the transfer of patient care responsibility is completed. Provider shall assist CLINICAS in the transfer of Members' patient care responsibility to other providers. For such activity, Provider shall continue to be compensated in accordance with the terms set forth in Schedule A.

4.8. **Continuation of Coverage When a Participating Provider is Terminated by Provider.**

a. At the request of a Member, and as required by Health and Safety Code Section 1373.96, Provider shall arrange for the continuation of Covered Services rendered by a terminated provider to a Member who is undergoing a course of treatment from a terminated provider for the following conditions, in accordance with and as described the Provider Manual.

(i) **Acute Conditions**. If the Member has an "acute condition," Provider will assign a new Participating Provider to provide completion of services for the duration of the acute condition. An "acute condition" is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

(ii) **Serious Chronic Conditions**. If the Member has a "serious chronic condition," Provider will assign a new Participating Provider to provide completion of services for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider. The length of time shall be determined by the Participating Provider in consultation with the Member, and shall be consistent with good professional practice. In no event, however, shall the period of time exceed twelve (12) months from the Agreement termination date. A "serious chronic condition" is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

(iii) **Pregnancies**. If the Member is pregnant, completion of services shall be provided for the duration of the pregnancy. "Pregnancy" is defined as the full term of the pregnancy and the immediate postpartum period (usually six weeks).

(iv) **Terminal Illnesses**. If the Member is terminally ill, Provider will assign a new Participating Provider to provide completion of services for the

duration of the terminal illness. "Terminal illness" means an incurable or irreversible condition that has a high probability of causing death within one (1) year or less.

(v) **Care of Newborns**. Completion of services for a newborn child between birth and age thirty-six (36) months will be provided for no more than twelve (12) months from the contract termination date.

(vi) **Authorized Surgeries/Other Procedures**. Provider will assign a new Participating Provider to provide for completion of services for surgeries or other procedures that CLINICAS or a Plan authorized as part of a documented course and treatment and has been recommended and documented by the Participating Provider to occur within one hundred eighty (180) days of the contract termination date.

SECTION V
COMPENSATION

5.1. **Compensation**. Unless otherwise provided in an applicable Plan contract, CLINICAS agrees to pay, and Provider agrees to accept, the amounts set forth in Exhibit A, and if applicable, less any deductibles, Copayments or dollars recovered through COB activities. CLINICAS agrees to pay Provider the amounts due under Exhibit A within thirty (30) business days for Medi-Cal patients and sixty (60) days for Medicare and commercial patients after CLINICAS has received a clean Claim from Provider. Such payment shall be considered payment in full. Payments to Provider shall be further subject to Exhibit E "CLAIMS SETTLEMENT PRACTICES AND PROVIDER DISPUTE RESOLUTION" attached hereto and incorporated herein by this reference, representing the standards and procedures governing claims payment and ensure that Claim processing and provider dispute resolution mechanisms are compliant with requirements established by state law. Provider acknowledges and agrees that by participating in this Agreement, there are no financial incentives acting directly or indirectly as an inducement to limit Medically Necessary services. Discrepancies in the amount billed or procedures performed may be appealed to the CLINICAS Utilization Management committee in writing. CLINICAS' obligation to pay Provider is conditioned upon receipt of payment from a Plan, unless the Plan is AHP or COHS (except if the cause of nonpayment from COHS to CLINICAS or from AHP to CLINICAS is wholly caused by nonpayment from the State of California to COHS). Provider acknowledges that prior Authorization may be required by certain programs before specific services are provided, and that not obtaining prior Authorization may result in denial of Claims.

5.2. **Billing.** Provider shall bill CLINICAS on CMS Form 1500, or its successor, within one hundred and eighty (180) days from the date of service for Medi-Cal Claims to avoid

timeliness submission reductions. For Medicare/commercial Claims, Provider shall bill within three hundred sixty five (365) days from the date of service. Claims submitted after three hundred and sixty five (365) days will be denied due to untimely filing. Such time frame shall be defined as the "Billing Deadline." Should Provider fail to submit Claims prior to the expiration of the Billing Deadline, CLINICAS shall reserve the right to deny such Claims, unless one or more of the following conditions apply:

a. A patient submits erroneous or outdated information to Provider regarding insurance coverage or Plan affiliation, and in reasonable reliance on such erroneous or outdated information, Provider bills the incorrect Plan or other health plan and/or an incorrect capitated medical group, as applicable, and such patient later enrolls with CLINICAS. In such cases, the Billing Deadline shall be ninety (90) days from the date the patient is determined to be a CLINICAS Member.

b. CLINICAS is determined to be a secondary payor. In such cases, the Billing Deadline shall be ninety (90) days from the date Provider receives the applicable payment and explanation of benefits from primary payor.

c. CLINICAS erroneously denies the Claim for not being submitted prior to the expiration of the Billing Deadline, and Provider can substantiate with written documentation that the billing was timely submitted.

d. A claim submitted after the expiration of the Billing Deadline constitutes a rebilling and the initial billing was submitted prior to expiration of the Billing Deadline.

5.3. **Verification of Enrollment; Authorization for Services.** The parties acknowledge that COHS or another Plan may provide or arrange for identification cards or other materials for Members, to enable Provider to identify Plan Members and, in particular, CLINICAS Members, who are eligible to receive Covered Services from or through Provider, and that the lists of eligible Members are initially prepared by DHCS, CMS or another health plan sponsor, which delivers them to COHS or another Plan, which in turn prepares a list of Plan Members which it delivers to the Plan, which in turns provides a list of CLINICAS Members to CLINICAS. CLINICAS relies upon such lists, which are sometimes inaccurate, and are subject to retroactive changes by the Plan or Upstream Contractor. Subject to the foregoing limitations, CLINICAS shall maintain either itself, or through reference to the Plans, a system of CLINICAS Member eligibility verification to enable Provider to determine whether, according to the information CLINICAS has received from the Plan, a purported Plan Member is a CLINICAS Member and is eligible to receive Covered Services. If a patient holds himself or herself out to be a CLINICAS Member, Provider shall attempt to verify eligibility as a CLINICAS Member by following the eligibility verification procedure. If Provider is unable to verify the purported Plan Member's eligibility, Provider shall render immediate, necessary Provider services on a good faith basis. At the first available opportunity, Provider shall verify eligibility and Authorization for specific

Covered Services. If CLINICAS or the Plan verifies eligibility and CLINICAS authorizes Covered Services, then Provider shall provide the authorized Covered Services. In the event of an erroneous verification of eligibility by the Plan, due to an error or a retroactive disenrollment by COHS or another Plan, or by DHCS, CMS or another health plan sponsor, Provider may bill the patient, the Plan, or other coverage to the extent permitted by applicable law and the terms of Provider's contract, if any, with that Plan or plan sponsor. The Plan shall only be responsible for compensating Provider in accordance with Section 5.1 in the event it verifies eligibility and authorizes services but the patient is determined not to have been eligible as a Plan Member at the time the Provider rendered care, if the following conditions are met:

a. Provider reasonably relies on the Plan's verification to provide Covered Services;

b. The verification was erroneous due to CLINICAS error (retroactive disenrollment by the Plan or plan sponsor shall not be deemed a CLINICAS error);

c. The verification or Authorization by CLINICAS was not based on a misrepresentation by the patient, a Physician, Provider staff, or another person not under CLINICAS' or the Plan's control; and

d. Provider is unable after two billing cycles to collect from any other responsible party.

5.4. **Third Party Liens.** Provider shall make reasonable efforts to recover the value of Covered Services rendered to Members whenever said Members are covered for the same services, either fully or partially, under any other contractual or legal entitlement including, but not limited to, a private group or indemnification program. Provider's pursuit and recovery under third party liens shall be conducted in strict accordance with the procedures set forth in the Provider Manual. All sums received must (i) be reported to CLINICAS within thirty (30) days of receipt, and (ii) not exceed the amounts permitted under Section 3040 of the Civil Code and as set forth more fully in the Provider Manual. However, notwithstanding anything to the contrary herein, Provider shall make no claims of recovery for the value of Covered Services rendered to a Medi-Cal Member when such recovery would result from an action involving the tort liability of a third party. Provider shall notify CLINICAS within five (5) working days of discovering any circumstances involving a Medi-Cal Member that may result in the Member recovering tort liability payments, casualty or other insurance payments or workers' compensation awards.

5.5. **Payment for Non-Covered Services**. Provider may seek payment from Members for Non-Covered Services at usual and customary charges, in accordance with the procedures set forth in the Provider Manual.

SECTION VI
MISCELLANEOUS

6.1. **Mutual Indemnification**. Each party agrees to indemnify, defend and hold harmless the other, its agents, employees, shareholders, directors and representatives from and against any and all liability or expense, including defense costs and legal fees, incurred in connection with claims for damages of any nature, including but not limited to bodily or personal injury, death, property damage, or other damages arising from the performance of or failure to perform under this Agreement, unless it is determined that the liability was the direct consequence of negligence or willful misconduct on the part of the other, its agents, employees, shareholders, directors and representatives. This provision shall survive termination of this Agreement.

6.2. **Arbitration**. The parties agree to meet and confer in good faith to resolve any problems or disputes that may arise. In the event it cannot be resolved in this way, the problem or dispute shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association, and judgment by the arbitrator(s) may be entered in any court having jurisdiction thereof. Such arbitration shall occur in Ventura County, California, unless it is mutually agreed to have such proceeding in some other locale. Either party may initiate arbitration by making a written demand for arbitration on the other. The arbitrator(s) may, in any such proceeding, award costs to the prevailing party. The arbitrator's decision shall be final and binding.

6.3. **Independent Contractor Status**. In the performance of the work, duties and obligations under this Agreement, it is mutually agreed and understood that Provider is at all times acting and performing as an independent contractor. CLINICAS shall neither have nor exercise control or direction over Provider's work or functions, except that the interest of CLINICAS is to assure that medical services are rendered in a competent, efficient and satisfactory manner. Provider shall not have any claim against CLINICAS for vacation, sick leave, retirement, pension, social security, disability, workers' compensation or unemployment benefits of any kind.

6.4. **Binding Agreement and Assignment**. This Agreement shall be binding upon and shall inure to the benefit of the parties hereto, and their respective successors, assigns, heirs and legal representatives. This Agreement is not assignable, in whole or in part, by any party without the prior written consent of the other. Such consent shall not be unreasonably withheld. CLINICAS shall, and hereby does, represent and warrant that it has authority to bind its contracted Physicians to the provisions hereof.

6.5. **Validity**. The invalidity and non-enforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision. The waiver by either party of a breach of any provision shall not operate as or be construed as a waiver of any subsequent breach thereof.

6.6 **Amendments**. This Agreement may be amended only by mutual written consent of the parties. Any amendment must be approved by the Ventura County Board of Supervisors before it can be effective.

6.7 **Other Plan Agreements**. As CLINICAS enters into new Plan agreements, notice shall be provided to Provider within forty-five (45) business days after execution of the new Plan agreement.

6.8. **Subcontracts**. CLINICAS acknowledges that Provider may from time to time terminate contracts with its Participating Providers and it may also from time to time employ or enter into agreements with new Participating Providers. Provider shall notify CLINICAS within thirty (30) business days of any termination of a previously credentialed Participating Provider. Provider shall promptly give notice to CLINICAS of any Physician it wishes to add as a Participating Provider and provide the requested credentialing information. Without credentialing approved by CLINICAS, the new Physician employee or contractor of Provider shall not be permitted to provide services to CLINICAS Members, except in an emergency. Except as set forth above, no subcontracts to this Agreement may be allowed without the express written permission of CLINICAS.

6.9. **MegaRule Exhibit Incorporated**. Exhibit F "Medi-Cal and Medicaid Program Provisions" is attached hereto and incorporated herein by this reference and represent the final rule entitled "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule at 81 Fed. Reg. 27497 on May 6, 2016" which amends the Medicaid managed care requirements at 42 C.F.R. Part 438, as further contained in the 42 C.F. R. Parts 430 to 481.

6.10. **Entire Agreement**. This Agreement and the exhibits, schedules and attachments hereto contains the entire agreement between the parties and supersedes all prior understandings, agreements and representations, written or oral, on the same subject matter. This Agreement shall be governed under the laws of California except as preempted by federal law.

6.11. **Agreement Confidentiality**. The terms and conditions of this Agreement shall be held strictly confidential, except to the extent that this Agreement is a public document under the laws governing Provider as a public agency. Before publishing or otherwise disclosing to the public or to third parties other than those who assist Provider in fulfilling the terms of this Agreement, the rates or other financial terms of this Agreement, or CLINICAS policies and procedures, standards, guidelines, forms, or other reporting and measurement tools, or those of its Plan or management services organization contractors, Provider shall confer with CLINICAS with regard to the reasons, timing, and nature of the disclosure. A breach of this Section 6.11 shall be

considered a material breach and a condition of immediate termination of this Agreement.

6.12. **Notice**. Any notice to be provided pursuant to the terms hereof shall be deemed given when deposited in postage prepaid, certified or registered mail, return receipt requested at the following address:

CLINICAS:
Clinicas del Camino Real, Inc.
Corporate Offices – Attn: CEO
1040 Flynn Road
Camarillo, CA 93012

Provider:
County of Ventura
800 South Victoria Ave.
L#4615
Ventura, CA 93009
Attention: HCA Director

6.13. **Free Exchange of Information**. No provision of this Agreement shall be construed to prohibit, nor shall any provision in any contract between CLINICAS and its employees or subcontractors prohibit, the free, open and unrestricted exchange of any and all information of any kind between health care providers and Members regarding the nature of the Member's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Member's Benefit Agreement, and the Member's right to appeal any adverse decision made by CLINICAS or a Plan regarding coverage of treatment which has been recommended or rendered. Moreover, CLINICAS agrees not to penalize or sanction any health care provider in any way for engaging in such free, open and unrestricted communication with a Member or for advocating for a particular service on a Member's behalf.

6.14. **Waiver**. The waiver by either party of one or more defaults, on the part of the other, shall not be construed as a waiver of any future default, under the same or different terms, conditions or covenants contained in this Agreement.

6.15 **Use of Names and Trademarks; Identification of Physicians**. CLINICAS and Provider each reserve the right to control the use of its name, symbols, trademarks or other marks currently existing or later established. Neither party may use the other party's name, symbols, trademarks or other marks without the prior written approval of the other party.

Provider agrees that Plans and CLINICAS may list the name, address, telephone number and hours of operation of Provider, and specialty, board status and curriculum vitae information on Participating Providers in publications furnished to current or potential Participating Providers or Members.

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IN WITNESS WHEREOF, the parties have caused this Agreement to be executed and effective as of this July 1, 2019.

Clinicas del Camino Real, Inc.	**County of Ventura**
Signature: _____	Signature: _____
Print Name: Roberto S. Juarez	Print Name: William T. Foley
Title: Chief Executive Officer	Title: HCA Director
Date: _____	Date: _____
	Phone #: (805) 677-5110
	TIN/EIN #: 95-6000944
	Medical State License #: 050000032
	DEA Number: FV 1677523
	NPI Number: 1629167457

EXHIBIT "A"
COMPENSATION

The following Fee for Service rates shall apply to Ancillary Medical Services and professional services, including Hospital Services and Outpatient Hospital Services rendered for Covered Services applicable to the terms of this Agreement for eligible CLINICAS Members:

CLINICAS (Professional Fees) - Specialty, UC, Ancillary (no PCP)				
	Medi-Cal	Commercial	Medicare	Notes
Consults				Hospital/Office Consults
Surgical / Treatment				Surgery, Intervention, Treatment, Infusion, etc.…
Diagnostics				DX Studies, Labs, etc.…
Other Evaluation & Management				Hospitalist rounds, office visits

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.

For all By Report (BR) and Relative Value Non Established (RVNE) procedures and/or incompatible CPT/ RVRBS codes, reimbursement shall be at billed charges less a forty percent (40%) discount or at the Medicare Fee Schedule identified in this agreement, whichever is less.

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

Exhibit "B "

LIST OF PARTICIPATING PROVIDERS

A monthly roster from Provider will be provided to CLINICAS identifying all specialty providers and the office location(s) for each provider.

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EXHIBIT "C"
AFFILIATED HOSPITAL
AND PROVIDER PRACTICE AREA

Affiliated Hospital:

Ventura County Medical Center and Santa Paula Hospital

Provider Practice Area:

Ventura County

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EXHIBIT "D"
HIPAA BUSINESS ASSOCIATE ADDENDUM

This HIPAA Business Associate Addendum ("Addendum") supplements and is made a part of the Specialist Care Profession Services Agreement, dated July 1, 2019 ("Agreement") by and between CLINICAS and Provider.

RECITALS

A. CLINICAS wishes to disclose certain information to Provider pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("PHI"), as that term is defined herein.

B. CLINICAS and Provider intend to protect the privacy and provide for the security of PHI disclosed to Provider pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and the regulations promulgated thereunder by the U.S. Department of Health and Human Services ("DHHS") (the "HIPAA Regulations") and other applicable laws.

C. The purpose of this Addendum is to satisfy certain standards and requirements of HIPAA and the HIPAA Regulations, including, but not limited to, Title 45, Sections 164.308(b), 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("C.F.R."), as such standards and requirements may be amended from time to time.

NOW, THEREFORE, Plan and Provider agree as follows:

1. Definitions. The following terms shall have the meaning ascribed to them in this Section. Other capitalized terms shall have the meaning ascribed to them in the context in which they first appear.

"**Designated Record Set**" shall have the meaning given to such term under the HIPAA Regulations at 45 C.F.R. Section 164.501.

a. "HIPAA Regulations" shall mean the regulations promulgated by DHHS and found at 45 C.F.R. Parts 160 and 164.

"**Protected Health Information**" or "PHI" means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA and the HIPAA Regulations at 45 C.F.R. Section 160.103.

"Security Incident" shall have the meaning given to such term under the HIPAA Regulations at 45 C.F.R. Section 164.304.

"PHI" shall mean personal health information provided by CLINICAS to Provider or created or received by CLINICAS on Plan's behalf.

2. Obligations of Provider.

Permitted Uses and Disclosures. Provider shall not use or disclose PHI except as allowed under the Agreement and this Addendum. CLINICAS shall not use or disclose PHI in any manner that would constitute a violation of the HIPAA Regulations if so used or disclosed by CLINICAS, except that CLINICAS may use PHI (i) for the proper management and administration of Plan and (ii) to carry out the legal responsibilities of CLINICAS.

Disclosures to Third Parties. To the extent that CLINICAS discloses PHI to a third party, CLINICAS must obtain, prior to making any such disclosure, (i) reasonable assurances from such third party that such PHI will be held confidential as provided pursuant to this Addendum and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (ii) an agreement from such third party to immediately notify Provider of any breaches of confidentiality of the PHI, to the extent it has obtained knowledge of such breaches.

Appropriate Safeguards. CLINICAS shall implement appropriate safeguards as are necessary to prevent the use or disclosure of PHI other than as permitted by this Addendum. CLINICAS shall maintain a comprehensive written information privacy and security program that includes administrative, physical and technical safeguards appropriate to the size and complexity of the CLINICAS operations and the nature and scope of its activities. CLINICAS further agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic PHI that Provider creates, receives, maintains, or transmits on behalf of Plan.

Reporting of Improper Use or Disclosure. CLINICAS shall report to Plan in writing of any use or disclosure of PHI not provided for or allowed by this Addendum or any Security Incident of which CLINICAS becomes aware within three (3) business days of the day in which Provider discovers such use or disclosure.

Medical Group's Agents. CLINICAS shall ensure that any agents, including subcontractors, to whom it provides PHI, agree to the same restrictions and conditions that apply to CLINICAS with respect to such PHI. CLINICAS shall implement and maintain sanctions against any agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation.

Access to PHI. CLINICAS shall make PHI maintained by CLINICAS or its subcontractors or agents in Designated Record Sets available to Plan for inspection and copying within ten (10) business days of a request by Plan to enable Plan to fulfill its obligations under the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 164.524. If any individual requests PHI directly from CLINICAS or its agents or subcontractors, CLINICAS must notify Plan in writing within five (5) business days of the request. Any denial of access to PHI maintained by CLINICAS or its agents or subcontractors in Designated Record Sets shall be the responsibility of Plan.

Amendment of PHI. Within ten (10) business days of receipt of a request from Plan for an amendment of PHI or a record relating to the individual in a Designated Record Set, CLINICAS or its agents or subcontractors shall make such PHI available to Plan for amendment and incorporate any such amendment to enable Plan to fulfill its obligations under the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 164.526. If any individual requests an amendment of PHI directly from Provider or its agents or subcontractors, Provider must notify CLINICAS in writing within five (5) business days of the request. Any denial of amendment of PHI maintained by Provider or its agents or subcontractors shall be the responsibility of Plan.

Accounting Rights. Within ten (10) business days of notice by Plan of a request for an accounting of disclosures of PHI, Provider and its agents or subcontractors shall make available to Plan the information required to provide an accounting of disclosures to enable Plan to fulfill its obligations under the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 164.528. As set forth in, and as limited by, 45 C.F.R. Section 164.528, medical group shall not provide an accounting to Plan of disclosures: (i) to carry out treatment, payment or health care operations, as set forth in 45 C.F.R. Section 164.506: (ii) to individuals of PHI about them, as set forth in 45 C.F.R. Section 164.502; (iii) to persons involved in the individual's care or other notification purposes as set forth in 45 C.F.R. Section 164.510; (iv) for national security or intelligence purposes as set forth in 45 C.F.R. Section 164.512(k)(2); or (v) to correctional institutions or law enforcement officials as set forth in 45 C.F.R. Section 164.512(k)(5). Provider agrees to implement a process that allows for an accounting to be collected and maintained by CLINICAS and its agents or subcontractors for at least six (6) years prior to the request, but not before the applicable compliance date of the HIPAA Regulations. At a minimum, such information shall include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. In the event that the request for an accounting is delivered directly to Provider or its agents or subcontractors, Provider shall within five (5) business days of a request forward it to Plan in writing. It shall be Plan's responsibility to prepare and deliver any such accounting requested. Provider shall not disclose any PHI except as set forth in Sections 3(a) and 3(b) of this Addendum.

Governmental Access to Books and Records. Provider shall make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. DHHS (the "Secretary") or the Secretary's designee for purposes of determining compliance with the HIPAA Regulations. Provider shall provide to CLINICAS a copy of any PHI that Provider provides to the Secretary concurrently with providing such PHI to the Secretary.

Minimum Necessary. CLINICAS (and its subcontractors or agents) shall only request, use and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure.

Data Ownership. CLINICAS acknowledges that CLINICAS has no ownership rights with respect to the PHI.

Retention of Protected Information. Notwithstanding Section 5(c) of this Addendum, CLINICAS and its subcontractors or agents shall retain all PHI for the term of the Agreement and shall continue to maintain the information required under Section 3(h) of this Addendum for a period of six (6) years after termination of the Agreement.

Audits, Inspection and Enforcement. Within ten (10) business days of a written request by Plan, CLINICAS and its agents or subcontractors shall allow Plan to inspect the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of PHI pursuant to this Addendum for the purpose of determining whether Provider has complied with this Addendum.

3. Plan's Obligations. Plan shall be responsible for using appropriate safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to Provider pursuant to this Addendum, in accordance with the standards and requirements of the HIPAA Regulations, until Provider receives such PHI.

4. Termination. **Material Breach.** A breach by Provider of any provision of this Addendum, as determined by Plan, shall constitute a material breach of the Agreement and shall provide grounds for immediate termination of the Agreement by CLINICAS.

Reasonable Steps to Cure Breach. If CLINICAS knows of a pattern of activity or practice of Provider that constitutes a material breach or violation of the Provider's obligations under the provisions of this Agreement or another arrangement and does not terminate this Agreement pursuant to Section 5(a), then CLINICAS shall take reasonable steps to cure such breach upon terms mutually agreeable to the parties. If such mutually agreeable terms cannot be reached within ten (10) business days of notice by Plan to Provider of the material breach, medical group must cure such material breach to the satisfaction of Plan, or Plan shall either: (i) terminate the Agreement, if feasible; or (ii) if termination of the Agreement is not feasible, report Provider's breach or violation to the Secretary.

Effect of Termination. Upon termination of this Agreement for any reason, Provider shall, if feasible, return or destroy all PHI received from CLINICAS that Provider or its subcontractors or agents still maintain in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, CLINICAS or its subcontractors or agents shall continue to extend the protections of this Addendum to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. If Provider elects to destroy the Protected Information, Provider shall certify to CLINICAS that the PHI has been destroyed.

5. Amendment(s) to this Agreement. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI. CLINICAS may terminate this Addendum upon thirty (30) calendar days written notice in the event: (i) Provider does not promptly enter into negotiations to amend this Addendum when requested by Plan pursuant to this Section or (ii) Provider does not enter into an amendment to this Addendum providing assurances regarding the safeguarding of PHI that CLINICAS, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA Regulations or other applicable laws.

6. Entire Agreement. This Addendum consists of this document, and constitutes the entire agreement between the parties. There are no understandings or agreements relating to this Addendum that are not fully expressed in this Addendum and no change, waiver or discharge of obligations arising under this Addendum shall be valid unless in writing and executed by the party against whom such change, waiver or discharge is sought to be enforced.

7. Assistance in Litigation or Administrative Proceedings. CLINICAS shall make itself, and any subcontractors, employees or agents assisting Provider in the performance of its obligations under this Addendum, available to CLINICAS, at no cost to CLINICAS, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Plan or CLINICAS, its directors, officers or employees based upon violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy, except where CLINICAS or its subcontractor, employee or agent is a named adverse party.

8. No Third Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Plan, CLINICAS, Provider and their respective successors or assigns, any rights, remedies obligations or liabilities whatsoever.

9. Disclaimer. CLINICAS makes no warranty or representation that compliance by Provider with this Addendum, HIPAA or the HIPAA Regulations will be adequate or satisfactory for

Provider's own purposes. Provider is solely responsible for all decisions made by Provider regarding the safeguarding of PHI.

10. Injunctive Relief. Notwithstanding any rights or remedies provided for in this Addendum, Plan or CLINICAS retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by Provider or any agent, contractor, subcontractor, or third party that received PHI from medical group.

12. Interpretation. The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and the HIPAA Regulations. The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Regulations.

EXHIBIT "E"
CLAIMS SETTLEMENT PRACTICES AND
PROVIDER DISPUTE RESOLUTION

1. CLINICAS Claims Payment Policies and Procedures. CLINICAS shall comply with the standards and procedures governing claims payment set forth in Plan's Provider Manual, including but not limited to the following: (i) payment of interest and other applicable amounts required under the Knox-Keene Act to a claimant if an uncontested Claim is not reimbursed within the time frame provided therein; (ii) those requirements regarding reimbursement of Claims initially denied by CLINICAS due to lack of medical necessity but later determined to be Medically Necessary pursuant to the independent medical review process set forth at Section 1374.32 et seq. of the Health & Safety Code; and (iii) CLINICAS shall reimburse emergency providers of emergency services regardless of whether the provider of service has an agreement with the Contractor and CLINICAS may not limit what constitutes an emergency medical condition based on diagnoses of symptoms or refuse to cover emergency services based on the emergency room provider, hospital or fiscal agent not notifying the Member's primary care provider, the contractor, DHCS, of the Member's screening and treatment within ten (10) calendar days of presentation for emergency services and Emergency Services shall not be subject to Prior Authorization by Provider.

2. Claims Adjudication. CLINICAS shall accept and adjudicate Claims for health care services provided to Members in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations. Notwithstanding the foregoing, CLINICAS shall pay Claims for Covered Services rendered to Plan Medicare Members within the time period required by law and Plan Medi-Cal Members within thirty (30) days.

3. **Dispute Resolution**. CLINICAS shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371. 4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations.

4. Reporting Requirements. CLINICAS shall submit a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to Plan within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose CLINICAS compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8 of the California Health & Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the California Code of Regulations. In the event that the California Department of Managed Health Care promulgates a required report

format for the Quarterly Claims Report, CLINICAS shall submit its Quarterly Claims Report in this format.

(a) CLINICAS shall ensure that each Quarterly Claims Report be signed by and include the written verification of a principal officer, as defined by Section 1300.45(o) of Title 28 of the California Code of Regulations, of CLINICAS, stating that the report is true and correct to the best knowledge and belief of the principal officer.

(b) CLINICAS Quarterly Claims Report shall include a tabulated record of each provider dispute it received, categorized by date of receipt, and including the identification of the provider, type of dispute, disposition and working days to resolution, as to each provider dispute received. Each individual dispute contained in a provider's bundled notice of provider dispute shall be reported separately to Plan.

CLINICAS shall make available to Plan and the California Department of Managed Health Care, all records, notes and documents regarding its provider dispute resolution mechanism and the resolution of its provider disputes.

5. Provider Right of Appeal. Any provider/medical group that submits a claim dispute to CLINICAS dispute resolution mechanism involving an issue of medical necessity or Utilization Review shall have an unconditional right of appeal for that claim dispute to Plan's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from CLINICAS Date of Determination. For purposes of this section, "Date of Determination" means the date of postmark or electronic mark on the written provider dispute determination or amended provider dispute determination that is delivered, by physical or electronic means, to the claimant's office or other address of record.

6. Plan's Right to Assume Responsibility for Claims Processing. Plan is authorized to assume responsibility for the processing and timely reimbursement of Provider Claims in the event that CLINICAS fails to timely and accurately reimburse its Claims (including the payment of interest and penalties). Such assumption by Plan shall be based upon: (1) a Demonstrable and Unjust Payment Pattern; (2) any reports required by this Agreement; (3) claim audits conducted by Plan or the California Department of Managed Health Care; and (4) shall be in accordance with the delegation provisions of the Agreement. Plan's assumption of responsibility for the processing and timely reimbursement of Provider Claims may be altered to the extent that medical group has established an approved corrective action plan consistent with §1375.4(b)(4) of the Health & Safety Code. For the purposes of this section, a "Demonstrable and Unjust Payment Pattern" means any practice, policy or procedure that result in repeated delays in the adjudication and correct reimbursement of Provider's Claims.

7. **Plan's Right to Assume Responsibility for Dispute Resolution.** Plan is authorized to assume responsibility for the administration of CLINICAS dispute resolution mechanism and for the timely resolution of provider disputes in the event that CLINICAS fails to timely resolve its provider disputes, including the issuance of a written decision. The terms of such assumption by Plan shall be based upon: (1) any reports required by this Agreement; (2) claim audits conducted by Plan or the California Department of Managed Health Care; and (3) shall be in accordance with the delegation provisions of the Agreement. Plan's assumption of responsibility for the processing and timely resolution of provider disputes may be altered to the extent that medical group has developed an appropriate corrective action plan, pursuant to Section 1300.71.38(k)(3) of Title 28 of the California Code of Regulations.

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EXIBIT "F"
MegaRule Agreements

1. **Non-Discrimination**. Provider shall not discriminate against Members or Eligible Beneficiaries, Providers, Plans, and any current or prospective contracting party or persons reasonably expected to benefit from any such contract because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, or physical or mental handicap gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56 in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, the Americans with Disabilities Act, 42 USC 12101 et seq; the 1975 Age Discrimination Act, as amended, 42 USC 6101 et seq; the 1974 Rehabilitation Act as amended, 29 USC 794; and Executive Order 11246 "Equal Employ-ment Opportunity' as amended by Executive Order 11375, and all laws, rules and regulations issued pursuant to all of the above. For the purpose of this Agreement, discrimination on the grounds of race, color, national origin, creed, ancestry, religion, ancestry language, age, marital status, sex, national origin, marital status, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other person or groups defined in Penal Code 422.56 or physical or mental handicap include, but are not limited to, the following:
    - Denying any Member any Covered Services or availability of a Facility;
    - Providing to a Member any Covered Services which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated;
    - Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Services;
    - Restricting a Member in anyway in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Services, treating a Member or Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any Covered Service;
    - The assignment of times or places for the provision of services on the basis of the race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, of the participants to be served.
    - 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 persona's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait,

thalassemia trait, and X-linked hemophilia. (Medi-Cal Agreement, Ex. E, Att. 2, § 28.A.)

2. Provider shall comply with all of the monitoring provisions of this Agreement, the monitoring provisions in the Medi-Cal Agreement (as applicable), and any monitoring requests of DHCS, including but not limited to, the following: (42 CFR § 438.3(h), Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(7).)

a. Through the end of the records retentions period, Provider shall allow DHCS to inspect, evaluate, and audit any and all premises, books, records, equipment, and facilities, contracts, computers, or other electronics systems maintained by Provider pertaining to these services at any time during normal business hours, pursuant to 42 CFR § 438.3(h).

b. Records and documents include, but are not limited to, all physical records originated or prepared by pursuant to the performance under this Agreement, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period Provider shall furnish any record, or copy of it, to DHCS or any other entity listed below at Provider's sole expense.

c.

d. If DHCS, the Centers for Medicare and Medicaid Services ("CMS"), or DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risks, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit a subcontractor at any time.

(i) DHCS shall conduct unannounced validation reviews on primary care sites, selected at the discretion of DHCS' to verify compliance of these sites with DHCS requirements.

(ii) Authorized state and federal agencies will have the right to monitor all aspects of the Provider's operations for compliance with the provisions of this Agreement and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Provider and subcontractors facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time during Provider's or other facility's normal business hours, pursuant to 42 CFR § 438.3(h). The monitoring activities will be either announced or unannounced. Staff designated by authorized State agencies will have access to all security areas and Provider will provide reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken

in such manner as to not unduly delay the work of the Provider. (42 CFR § 438.3(h), Medi-Cal Agreement, Ex. E, Att. 2, § 20.)

3. **Monitoring Provisions**. Provider shall comply with all of the monitoring provisions of this Agreement, the monitoring provisions in the Medi-Cal Agreement (as applicable), and any monitoring requests of DHCS, including but not limited to, the following: (42 CFR § 438.3(h), Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(7).)

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representative(s) in the performance of their duties. Access will be undertaken in such manner as to not unduly delay the work of the Provider. (42 CFR § 438.3(h), Medi-Cal Agreement, Ex. E, Att. 2, § 20.)

4. **Privileged Information**. Upon request by DHCS, Provider shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to lawful privileges, in Provider's possessions, related to threatened or pending litigation by or against DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify DHCS, Plan and CLINICAS of any subpoenas, documents production requests, or requests for records, received by Provider related to CLINICAS's contract with DHCS. Provider shall be reimbursed by DHCS for the services necessary to comply with this requirement under the reimbursement terms specified in Plan's contract with DHCS. (Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(16).)

5. **Regulatory Compliance.** This Agreement shall be governed by and construed in accordance with all laws, regulations, and contractual obligations incumbent upon CLINICAS under its agreement with Plan, including but not limited to, DHCS, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 19972 (regarding education programs and activities; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; the Americans with Disability Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act. Provider shall comply with the Medi-Cal Program and all applicable provisions of the Medi-Cal Agreement.

6. **Equal Opportunity Employer**. Provider shall, in all solicitations or advertisements for employees placed by or on behalf of Provider, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has collective bargaining agreement or other contracts or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of the Provider's commitment as an equal opportunity employer and will post copies of the notice in conspicuous places available to employees and applicants for employment.

7. **Disabled Veteran's Business Enterprises**. In addition to other obligations contained herein, Provider shall comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises commencing at Section 10115 of the Public Contract Code.

8. **Data Retention**. Provider shall retain, as applicable, the following information: enrollee grievance and appeal records in § 438.416, base data in § 438.5(c), Medical Loss Ratio reports in § 438.8(k), and the data, information, and documentation specified in §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years.

9. **DHCS Approval.** The Agreement's effective date shall be based upon approval from DHCS and shall be in writing, or by operation of law where the DHCS has acknowledged receipt of this Agreement and has failed to approve or disapprove the Agreement within sixty (60) days of receipt. Amendments to this Agreement shall be submitted to the DHCS, for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes which are neither approved nor disapproved by DHCS, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt of the amendment, or date specified in the amendment, whichever is later.

10. **Conflict of Interest**. Provider shall ensure that its personnel do not have conflicts of interest with respect to CLINICAS and the Services. "Conflict of Interests" includes activities or relationships with other persons or entities that may result in a person or entity being unable or potentially unable to render impartial assistance or advice to CLINICAS, or the person's objectivity in performing the contract work is or may be impaired, or a person has an unfair competitive advantage.

11. **Fraud, Waste and Abuse**. Provider shall report to CLINICAS's compliance officer all cases suspected fraud, waste, and/or abuse, as defined in 42 C.F.R. § 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employee within (48) hours of the time when Provider first becomes aware of, or is on notice of such activity. Provider shall immediately report to CLINICAS any notices of investigation of Provider relating to fraud, waste, or abuse. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud, waste, and/or abuse in the provision of health care services under the Medi-Cal program. Upon the request of CLINICAS and/or State, Provider shall consult with the appropriate State agency prior to and during the course of such investigations. Provider shall comply with CLINICAS's antifraud program, including its policies and procedures relating to the investigation, detection, and prevention of and corrective actions relating to fraud, waste, and abuse. Provider represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable State and federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse including, but not limited to, applicable provisions of the federal and State civil and criminal law, the program integrity requirements of 42 C.F.R. § 438.608, the Federal False Claim Act (31.S.C § 3729 *et seq*.), Employee Education About False Claims Recovery (U.S.C § 1396a(a)(68)), the California State False Claim Act (Cal. Gov't Code Section § 1650 *et seq*.), and the anti-kickback statute (Social Security Act §1128B(b).). Upon request by

DHCS, Provider shall demonstrate compliance with this provision, which may include providing DHCS with copies of Provider's applicable written policies and procedures and any relevant employee handbook excerpts. Provider shall comply with 42 C.F.R. §§ 438.608(a)(8) and 438.610.

Additionally, Provider is prohibited from employing, contracting or maintaining a contact with persons or entities for the provisions of services related to this Agreement that are excluded, suspended or terminated from participation in the Medicare or Medi-Ca/Medicaid programs. Provider shall notify CLINICAS immediately upon discovery of employment or contract with a person or entity that is excluded, suspended, or terminated. A list of suspended and ineligible providers is updated monthly and available on line and in print at the DHCS Medi-Cal website (http://medi-cal.ca.gov). Lists of excluded individuals and entities are also available through the DHHS, Office of Inspector General, List of Excluded Individuals and Entities (http//oig.hhs.gov), and the Federal System of Award Management (http://www.sam.gov). Provider is deemed to have knowledge of any persons or entities on these lists. Provider must notify CLINICAS within ten (10) working days of removing a suspended, excluded, or terminated provider from its employment or subcontract and confirm that the individual or entity is no longer receiving payments in connection with the Medicaid program.

12. **Prohibited Affiliations**. In accordance with 42 C.F.R. 438.608 ©, Provider agrees to:

a. Provide written disclosure of any prohibited affiliation under 42 C.F.R. 438.610.
b. Provide CLINICAS with the disclosure statement set forth in Title 22, California Code of Regulations Section 51000.35 (which incorporates the requirement of 42 C.F.R.455.104) prior to commencing services under this Agreement. Specifically, Provider shall disclose the names of the officers and owners of Provider Group, stockholders owning more than ten percent (10%) of the stock issued by the Provider, if any, and major creditors holding more than five (5%) of the debt of Provider. For that purpose, Provider shall use the Disclosure Form made available by CLINICAS.