AGREEMENT
Between
San Mateo Health Commission
And
County of San Mateo
For
Healthy Kids Program

This Agreement is made this day of February 12, 2005 by and between the San Mateo Health Commission, dba Health Plan of San Mateo (PLAN), and the County of San Mateo County (COUNTY).

RECITALS:

WHEREAS, the PLAN is authorized by state law and County Ordinance to arrange for the provision of health care services to individuals who are eligible for various publicly funded health care programs and to those who lack sufficient annual income to meet the cost of health care,

WHEREAS, the COUNTY receives public funds and has committed some of these funds to provide health care coverage for children through age 5 who do not have other health insurance; and

WHEREAS, both parties hereto desire to enter into this Agreement to provide health care coverage for qualified children;

NOW, THEREFORE, in consideration of the mutual promises and covenants hereinafter contained, the parties agree as follows:

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SECTION 1
DEFINITIONS

As used in this agreement, the following terms (listed alphabetically) shall have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended.

1.1 **"Actual Quarterly Premium Due"** shall mean the Premium due from COUNTY to PLAN to provide coverage for Members for a quarter, based on the number of actual member months of coverage per quarter.

1.2 **"Administrative Costs"** shall mean a percentage of all Premiums payable to PLAN under this Agreement not greater than the percentage that administrative expenses represent of the State capitation payments for the annual Medi-Cal budget approved by the San Mateo Health Commission at the beginning of each fiscal year.

1.3 **"First 5 San Mateo"** shall mean the organization created in San Mateo County in 1998 as a result of California Children and Families Act (Proposition 10).

1.4 **"Children's Health Initiative (CHI) Coalition"** shall mean the decision making body established by the San Mateo County Board of Supervisors for the planning and development of the Healthy Kids Program.

1.5 "**Commission**" shall mean the San Mateo Health Commission.

1.6 "**Copayment**" shall mean the portion of health care costs for covered services for which the Member's parent or guardian has financial responsibility under the Healthy Kids Program.

1.7 **"Cost of Health Services"** shall mean the total fiscal year costs of providing Covered Services to Members and shall include Administrative Costs and projections to pay the costs of incurred but not reported Covered Services.

1.8 "**Covered Services**" shall mean those health care services and supplies which a Member is entitled to receive under Healthy Kids and which are set forth in the Healthy Kids Evidence of Coverage (Attachment A, attached hereto and hereby incorporated by reference).

1.9 **"Estimated Quarterly Premium Due"** shall mean the amount of premium for the projection of member months to be covered in a quarter.

1.10 **"Evidence of Coverage"** shall mean the document issued by the PLAN to Members that describes Covered Services and Non-Covered Services in Healthy Kids (Attachment A, attached hereto and incorporated herein by reference).

1.11 **"Family Contribution"** shall mean the financial contribution made by the Responsible Party on behalf of a Member of Healthy Kids for either an annual or quarterly period.

1.12 **"Grievance Program"** shall mean a formalized set of activities designed to provide Members and Providers, exercising their rights under applicable state and federal law, to a fair and solution-oriented process to address a perceived problem with the operations of the PLAN, including delivery and access to care, in a reasonable amount of time. This Program includes provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers.

1.13 **"Health Plan of San Mateo"** shall mean the health plan governed by the San Mateo Health Commission

1.14 "**Healthy Kids**" shall mean the health insurance program created by the Children's Health Initiative Coalition for children through age 18 in families with incomes up to 400% of the federal poverty level residing in San Mateo County who are ineligible for Healthy Families and full scope Medi-Cal.

1.15 **"Hospital"** shall mean a licensed general acute care hospital.

1.16 **"Member"** shall mean a child from birth through age of eighteen (18) who has been determined to be eligible by the San Mateo County Human Services Agency to receive Covered Services under Healthy Kids

1.17 **"Membership Report"** shall mean a report summarizing Healthy Kids Program membership submitted by the PLAN to COUNTY each quarter to assist in the calculation of the Total Quarterly Premium Amount due from COUNTY to PLAN.

1.18 **"Participating Provider"** shall mean a provider who has entered into an agreement with the PLAN to provide Covered Services to Members. The terms "Participating Provider" and "Contracting Provider" may be used interchangeably.

1.19 **"PLAN"** shall mean the Health Plan of San Mateo, which is governed by the San Mateo Health Commission, and which provides health service coverage through Medi-Cal, Healthy Families, HealthWorx, and Healthy Kids lines of business.

1.20 **"Premium"** shall mean the amount paid by COUNTY per Member per month, to the PLAN for providing coverage to Members under this Agreement.

1.21 **"Protected Health Information"** shall mean individually identifiable health information.

1.22 **"Provider"** shall mean any health professional or institution certified to render Covered Services to Members.

1.23 **"Quality Assessment and Improvement Program"** means the set of formalized activities and structure developed by the PLAN to ensure the continuous review and evaluation of quality of care, performance of medical personnel, utilization of services and facilities, and trends in Grievances filed with the PLAN through quality of care studies and other health related activities in order to make improvements in the care provided to Members.

1.24 **"Quarter for Premium Due"** shall mean any one of the following fixed three-month periods: January 1 through March 31, April 1 through June 30, July 1 through September 30, or October 1 through Dec 31.

1.25 **"Responsible Party"** shall mean a parent, guardian, other adult, or emancipated minor of San Mateo County who has completed an application for a child for participation in and coverage by the Healthy Kids Program.

1.26 **"Retention Grant"** shall mean those activities conducted to increase membership retention, health navigation and utilization and which are set forth in the Retention Scope of Work (Attachment C, attached hereto and incorporated herein by reference).

1.27 **"San Mateo County Human Services Agency (HSA)"** shall mean the agency that is part of the County of San Mateo, which has undertaken a contractual responsibility for determining eligibility for Healthy Kids.

1.28 **"Total Quarterly Premium Amount"** shall mean the payment due each quarter to PLAN from COUNTY. The Quarterly Premium Amount is calculated using the Actual and Estimated Quarterly Premiums.

SECTION II
GENERAL CONTRACTUAL RELATIONSHIP

2.1 Healthy Kids will be funded by several sources which will pay premiums to PLAN on behalf of Members. These include but are not limited to: (1) the County of San Mateo acting on behalf of the First 5 San Mateo Commission, (2) the County of San Mateo acting on behalf of Peninsula Community Foundation, and (3) the County of San Mateo acting on its own behalf.

2.2 Funding sources shall pay the premiums for Members in the following order of priority: (1) First 5 San Mateo for Members up to the age of six (6) until all the Commission's allocated funds are committed; (2) the County of San Mateo acting on behalf of the Peninsula Community Foundation for Members meeting the qualifications or restrictions placed on the Foundation's funds, if any, until all the Foundation's allocated funds are committed; and (3) the County of San Mateo acting on its own behalf for Members not covered under (1) or (2) until all the County's allocated funds are committed.

2.3 The San Mateo County Human Services Agency will provide eligibility determination for Members.

2.4 In consideration of the Premiums paid and services provided by funding sources, PLAN will administer Healthy Kids and will make payments to Providers for Covered Services for Members according to the guidelines and policies and procedures established by PLAN.

2.5 In consideration of the PLAN's administration of the program and payment for health care services for Members:

2.5.1 The funding parties authorize PLAN to retain twenty percent (20%) of any positive remainder for PLAN's fiscal year after expenses from (1) the Cost of Health Services, (2) special projects related to retention, and (3) projects related to increasing health care utilization are subtracted from the total Premiums accrued by PLAN.

2.5.2 PLAN shall return eighty percent (80%) of any positive remainder to the COUNTY as determined in 2.5.1 within thirty days of the Commission's approval of its annual audit performed by an outside auditor provided COUNTY is current in making Premium payments to PLAN pursuant to sections 4.2, 4.3, and 4.4.

2.5.3 If an annual positive remainder is projected as of July 1st of a given calendar year, PLAN shall make an interim payment to COUNTY by July 31st of the calendar year equal to fifty percent (50%) of the amount to be returned pursuant to Subsection 2.5.2 provided County is current in making Premium payments to PLAN pursuant to Sections 4.2, 4.3, and 4.4.

2.6 In addition to Premiums paid by the funding parties, Responsible Parties will be required to make a Family Contribution. However, as set forth in this agreement, PLAN will not retain any portion of the Family Contributions, pursuant to Section 4.5.

SECTION III
ENROLLMENT

3.1 The San Mateo County Human Services Agency has agreed, in a separate contract, to be responsible for (1) determining the eligibility of children for whom Responsible Parties have applied to be covered under Healthy Kids and (2) forwarding completed enrollment information to PLAN for Members for whom the Human Services Agency has determined eligible.

3.2 In consideration of COUNTY's payment of Premiums for those Members determined by Human Services Agency to be eligible, the PLAN shall be responsible for effecting coverage on the tenth (10^{th}) calendar day following the PLAN's receipt of notification of eligibility from the San Mateo Human Services Agency. PLAN's responsibilities shall include welcome calls and the mailing of the identification card, provider list, and the combined Member Handbook and Evidence of Coverage booklet to the Member's Responsible Party.

SECTION IV
PREMIUMS/FAMILY CONTRIBUTION

4.1 Premium Amounts

Premiums for the Covered Services under this Agreement are set forth in Appendix B, attached hereto, and incorporated herein by reference.

4.2 Premium Payment

Total Quarterly Premium Amount is payable to PLAN at PLAN's corporate office by electronic file transfer via ACH, wire transfer, or check via mail addressed to: Chief Financial Officer, Health Plan of San Mateo, 701 Gateway Blvd, Ste. 400, South San Francisco, CA 94080. The Quarterly Premium Amount is due by the last work day of January, April, July, and October. In the event PLAN submits a Membership Report to COUNTY later than the first (1^{st}) working day of a quarter, the Total Quarterly Premium Amount will be due no later than thirty (30) calendar days after receipt of the Membership Report by COUNTY.

4.3 Premium Calculation, Due Date and Grace Period

PLAN shall submit to the COUNTY a Membership Report by the first (1st) working day of each quarter. This report shall include the Actual Quarterly Premium Due (based on the number of actual member months of coverage for the previous quarter) and an Estimated Quarterly Premium Due (based on a projection of member months to be covered during the previous quarter).

Premiums shall be paid prospectively for the estimated number of member months of coverage for the current quarter. The Estimated Quarterly Premium Due shall be adjusted based on the difference between the Actual Quarterly Premium Due for the last quarter and the Estimated Quarterly Premium Due paid by COUNTY for the last quarter.

For the first month or partial month of a Member's coverage, COUNTY will pay one hundred percent (100%) of the Premium for Members with effective dates of coverage on the first (1^{st}) through sixteenth (16^{th}) day of the month. No Premium will be paid for the first partial month of coverage for Members whose coverage begins on the seventeenth (17^{th}) through the last day of the month of partial coverage.

COUNTY will pay premiums to PLAN as billed by PLAN. However, in the event of a disagreement as to the amount owed, COUNTY will communicate discrepancies to the PLAN, which will make an effort to resolve any discrepancy noted by the next billing period. Premium adjustments due to discrepancies will be incorporated into the next Total Quarterly Premium Amount due.

4.4 Retroactive Additions and Credits for Member Terminations

4.4.1 Retroactive additions will be honored at the discretion of the PLAN based upon the eligibility guidelines in the Evidence of Coverage. Newborn infants may be retroactively added back to their date of birth if the mother applies before the date of birth. Retroactive additions are subject to payment of all applicable Premiums and may be subject to all applicable Family Contributions.

4.4.2 Retroactive terminations for Members will be honored at the discretion of PLAN. COUNTY may receive credit for Premium related to a retroactive termination, but PLAN will not honor terminations for a period greater than sixty (60) days prior to the date of notification. The Premium amount credited to COUNTY will be based on the effective date of termination, subject to the terms of Section 3.2. Information regarding credits due to retroactive terminations will be included in the Membership Report.

4.4.3 COUNTY shall be responsible to pay PLAN Premiums for any eligible Members forwarded to PLAN to the extent PLAN enrolled these Members and paid claim(s) based on Human Services Agency's representation that the Member was eligible, when coverage was not actually valid.

4.4.4 COUNTY shall be responsible to pay PLAN Premiums up to a maximum of two months if a Responsible Party fails to pay an eligible Member's Family Contribution.

4.5 Family Contribution

4.5.1 The Children's Health Initiative sets the Family Contribution amount per Member per quarter. This amount shall be either, $12, $18, $36, or $60 per quarter, based on the Member's family size and family income as determined through the application process. Family Contribution will be treated differently than Premiums, and PLAN will not retain any portion of the Family Contribution. HPSM will deposit the Family Contributions into a separate account. The disbursement of funds from this account will be at the discretion of COUNTY with the understanding that funds will be used for expanding access of health care to children in San Mateo County. PLAN will remit to the COUNTY the entire balance of the Family Contribution account every six (6) months less cost of refunds, returned checks, and checking account fees.

4.5.2 The amount of the Family Contribution is determined at the time of application and the Responsible Party shall choose whether the Family Contribution will be paid on an annual or quarterly basis. As an incentive for Members to make Family Contribution payments on an annual basis rather than a quarterly basis, annual payments will be computed on the basis of three times the quarterly payment amount, i.e., Members who pay for three quarters at once will have the fourth quarter's Family Contribution requirement waived.

4.5.3 The Human Services Agency will determine whether a Responsible Party is eligible for either a total or partial reduction of the Family Contribution. HSA will

transmit information concerning changes in the amount of Family Contribution to PLAN with the eligibility record.

4.5.4 The Responsible Party will be notified at the point of application and in all communications that all payments of the Family Contribution should be made to the PLAN. PLAN will invoice the Responsible Party for either quarterly or annual payment related as determined at application or redeterminations. If payment is received prior to invoicing, PLAN will retain and apply payments as appropriate.

4.5.5 To prevent disenrollment due to nonpayment, PLAN will exercise its best efforts to contact the member by phone or mail. As appropriate, PLAN will notify the County Human Services Agency if the Responsible Party requests Family Assistance.

4.5.6 If all efforts to obtain the Family Contribution payment have proven to be unsuccessful, PLAN will disenroll Member effective the last day of the second month of the quarter for which the Family Contribution has not been made. COUNTY's obligation to pay Premiums on a Member's behalf shall be limited to two months' premium for a Member whose Responsible Party has not made Family Contribution, and PLAN shall not be obligated to provide services for the Member for more than two months without payment of the Family Contribution. PLAN will notify the Responsible Party of the Member's termination date due to nonpayment of the Family Contribution at least 15 days prior to the date of disenrollment.

SECTION V
TERM, TERMINATION, and AMENDMENTS

5.1 Effective Date

This Agreement shall become effective on February 12, 2005.

5.2 Term

The term of the Agreement shall begin with the effective date of the Agreement and last for three years. This Agreement may be renewed or extended by mutual agreement.

5.3 Termination on Notice

This Agreement may be terminated as follows:

5.3.1 Termination – Without Cause

PLAN or COUNTY may terminate the Agreement without cause upon providing the other party with sixty (60) days prior written notice and shall become effective at the end of the second month following the month in which notice is given. In the event of termination, PLAN shall furnish COUNTY copies of documents, reports, and studies prepared for COUNTY under this Agreement as well as access to data for Members covered under this Agreement.

5.3.2 Termination – For Cause

Either party shall have the right to terminate this Agreement for good cause upon providing thirty (30) days prior written notice to the other party. Good cause may include but not be limited to the termination of the funding parties' financial contributions to Healthy Kids.

5.3.2.1 The party claiming the right to terminate hereunder shall set forth in the written notice of intended termination the effective date of such termination and the facts underlying its claim that there is good cause to terminate this Agreement. Termination will be effective thirty days after delivery of the termination notice.

5.3.2.2 COUNTY may terminate this Agreement for unavailability of State funds. In this event, COUNTY shall inform the PLAN of such unavailability as soon as it is known, and to the extent legally possible, COUNTY shall pay all outstanding amounts due. Termination shall be effective on the last day of the month in which notification is received by PLAN. PLAN reserves the right to seek Premium amounts from other entities should COUNTY be unable to make Premium payments.

5.3.2.3 If COUNTY fails to make any past-due payment within fifteen (15) days after receipt of PLAN's written notice to COUNTY of past due amount, PLAN may terminate this Agreement. COUNTY shall be liable for all

unpaid Premiums through the termination date. Termination shall be effective on the last day of the month following the month in which notice of termination is given by the PLAN.

5.3.3 Termination Based upon Inability to perform due to changed legal, contractual or regulatory circumstances

In the event there are changes effected in (1) the PLAN's Medi-Cal contract with the State of California, or (2) in Healthy Kids, or (3) in the Federal Medicaid or SCHIP Programs, (4) in the Federal Medicare Program or (5) under other public or private health care insurance programs or policies, any of which changes will have a material detrimental financial effect on the operations of the COUNTY or PLAN, COUNTY or PLAN may terminate this Agreement effective on the last day of the month following the month in which notification of intent to terminate is received. In any case where such notice is provided, both parties shall negotiate in good faith in an effort to develop a revised Agreement which, to the extent reasonably practicable under the circumstances, will adequately protect the interests of both parties and members, consistent with the changed legal, contractual or regulatory circumstances which constitute the basis for exercising this termination provision.

5.3.4 Termination for Insufficient Provider Participation

If, for any reason, PLAN is unable to enter into or maintain service contracts with sufficient numbers of Participating Providers to assure adequate Member access to needed Covered Services, PLAN may terminate this Agreement upon thirty (30) days written notice to COUNTY.

5.4 Effect of Termination

As of the date of termination pursuant to any provision of this Agreement, this Agreement shall be of no further force or effect whatsoever, except for exception in Section VIII, and each of the parties hereto shall be relieved and discharged from any of the obligations it has undertaken, except that COUNTY shall remain liable for due, unpaid Premiums and PLAN shall remain liable for all Benefits rendered to Members up to the date of termination and for any Covered Services covered by the term of the Premium or required

by law, whichever is later, rendered hereunder after such date until such time as appropriate transfer (or other medically acceptable disposition) of Members receiving inpatient services as of the date of termination is achieved.

5.5 Amendment of Agreement

Should either COUNTY or PLAN desire a change in this Agreement, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within ten (10) calendar days of receipt of the proposal. Any proposal shall set forth a detailed explanation of the reason and basis for the proposed change and the text of the desired amendment to this Agreement that would provide for the change. If the proposal is accepted, this Agreement shall be amended to provide for changes mutually agreed to by COUNTY and PLAN in writing.

SECTION VI
MEMBER NOTIFICATION OF TERMINATION

6.1 It is the responsibility of the PLAN to notify Members of the termination of the Agreement in compliance with all applicable laws.

6.2 Termination shall not relieve COUNTY or PLAN from any obligation incurred prior to the date of termination of this Agreement.

SECTION VII
INDEPENDENT CONTRACTOR RELATIONSHIPS

7.1 Between COUNTY and PLAN

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

7.2 Between Participating Providers and PLAN.

The relationship between PLAN and Participating Providers is a contractual relationship among independent contractors. Participating Providers are not agents or employees of PLAN nor is PLAN an agent or employee of any Participating Provider. Participating Providers maintain their provider-patient relationship with Members and are solely responsible to their Member patients for any health services rendered to their Member patients.

A Participating Provider's participation may be terminated at any time by either the Participating Provider or PLAN and PLAN makes no express or implied warranties or representations concerning the continued participation of any particular Provider. In no event will PLAN be liable for the negligence, wrongful acts, or omissions in a Participating Provider's delivery of services regardless of whether such services are or would be covered under this Agreement, nor will PLAN be liable for services or facilities which for any reason beyond its control are unavailable to the Member.

SECTION VIII
RECORDS

8.1 Inspection Rights

8.1.1 PLAN and COUNTY agree to provide to any Federal or State department having monitoring or reviewing authority, or their appropriate audit agencies upon reasonable notice, access to and the right to examine and audit all records and documents necessary to determine compliance with relevant Federal, State, and local statues, rules and regulations, and this Agreement, and to evaluate the quality, appropriate and timeliness of services performed.

8.1.2 Both parties shall maintain and preserve all records relating to this Agreement for a period of five (5) years from the termination date of this Agreement or until audit findings are resolved, whichever is greater.

8.2 Confidentiality of Member Information

Protected Health Information shall be provided in a manner to protect the confidentiality of member information in accordance with applicable federal and state statutes and regulations.

SECTION IX
PROGRAM MONITORING AND EVALUATION

9.1 PLAN shall collect data pertaining to the goods and services furnished under the terms of this Agreement for each funded year and shall participate in countywide and/or statewide evaluations of the effectiveness of COUNTY's Healthy Kids efforts, whether they occur during or after the term of this contract. PLAN shall cooperate with any evaluator hired by COUNTY for this purpose. PLAN shall submit additional reports as requested by COUNTY and agreed to by PLAN. PLAN will provide COUNTY with monthly Member enrollment reports by various parameters, including but not limited to, hospital districts, age, and gender. In conjunction with COUNTY evaluator, PLAN will conduct a Provider survey every other year.

9.2 Within thirty (30) days of the Commission's approval of its annual audit, PLAN will provide COUNTY with a copy of the audit and a report listing the following information for the PLAN's previous fiscal year for Healthy Kids: (1) the Cost of Health Services for the Members, (2) the total Premiums accrued to PLAN, and (3) the remainder after subtracting the Cost of Health Services for the Members from the total Premiums paid to PLAN. The Cost of Health Services for Members will be broken down into three sub-categories: the total costs of providing Covered Services to Members, Administrative Costs, and projections to pay the costs of incurred but not reported Covered Services.

9.3 PLAN will provide services to retain members as particularly described in Exhibit C to this Agreement. In consideration of said services, COUNTY will pay PLAN the rates set forth in Exhibit C.

SECTION X
ADMINISTRATION OF THE AGREEMENT

10.1 Entire Agreement

This Agreement, including the Evidence of Coverage, any amendments, endorsements, insets or attachments, constitutes the entire Agreement between COUNTY and PLAN, and on the effective date as set forth in Section V supersedes all other prior and contemporaneous arrangements, understandings, agreements, negotiations and discussions between the parties, whether written or oral, regarding services provided by this Agreement.

10.2 The terms of the Agreement shall be subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), as amended and the regulations promulgated thereunder (the "Regulations"), to the extent applicable hereto, and any provision required to be in this Agreement by either the Act or Regulations shall bind PLAN and the PCP as appropriate, whether or not provided herein. If the Director of the Department of Managed Health Care or his/her successor requires further amendments to this Agreement, PLAN shall notify COUNTY in writing of such amendments. The COUNTY agrees to work with PLAN in good faith effort to accept such an amendment. If COUNTY does not agree to accept such an amendment, PLAN may terminate this Agreement pursuant to Section V. Amendments for this purpose shall include, but not be limited to, material changes to PLAN's Utilization Management, Quality Assessment and Improvement and Complaint and Grievance Programs and procedures and to the health care services covered by this Agreement.

10.3 Hold Harmless

10.3.1 PLAN and COUNTY agree that nothing in this Agreement shall cause either party to be liable or responsible for any debt, liability, or obligation of the other party or any third party, unless such liability or responsibility is expressly assumed by the party sought to be charged therewith. Each party shall be solely responsible for and shall indemnify and hold the other party harmless against any claim or obligation for the payment of wages, salaries or other compensation (including all state, federal, and local taxes and mandatory employee benefits), insurance and voluntary employment-related or other contractual or fringe benefits as may be due or payable by the party to or on behalf of the other party's employees, agents, and representatives.

10.3.2 Insurance

Upon request, each party shall furnish the other party with a certificate of insurance evidencing the required coverage set forth herein.

Bodily Injury Liability and Property Damage Liability Insurance: Each party shall maintain during the life of this Agreement such Bodily Injury Liability and Property Damage Insurance, self-insurance, or a combination thereof, as shall protect both parties from any and all claims for damages for bodily injury,

including accidental death, as well as any and all claims for property damage which may arise from operations under this Agreement. Such insurance shall be combined single limit bodily injury and property damage for each occurrence and shall not be less than the amount specified below.

Such insurance shall include:

(a) Comprehensive General Liability	$1,000,000.00
(b) Motor Vehicle Liability Insurance	$1,000,000.00
(c) Professional Liability	$2,000,000.00

10.3.3 COUNTY shall carry at its sole expense general and professional liability insurance or self-insurance of at least one million dollars ($1,000,000) per person per occurrence, three million dollars ($3,000,000) aggregate. If COUNTY obtains one or more claims-made insurance policies to fulfill its obligations under this Section, COUNTY will purchase or provide coverage that assures protection against claims based on acts or omissions that occur during the period of this Agreement but which are asserted after the claims-made insurance policy has expired. This insurance is against professional errors and omissions in providing services under the terms of this Agreement and is solely for the protection of the interest and property of COUNTY, its employees, Health Plan Members, and third parties.

10.3.4 Each party shall provide a certificate of insurance so that the other party shall be given immediate notice of lapse, termination, amendment or changes of coverage of any policy or insurance maintained by the other party.

10.3.5 Mutual Hold Harmless

a. It is agreed that PLAN shall defend, save harmless and indemnify COUNTY, its officers and employees from any and all claims which arise out of the terms and conditions of this Agreement and which result from the negligent acts or omissions of PLAN, its officers and/or employees.

b. It is agreed that COUNTY shall defend, save harmless, and indemnify PLAN, its officers and employees from any and all claims for injuries or damage to persons and/or property which arise out of the terms and conditions of this Agreement and which result from the negligent acts or omissions of COUNTY, its officers and/or employees.

c. In the event of concurrent negligence of COUNTY, its officers and/or employees, and PLAN, its officers and/or employees, then the liability for any and all claims for injuries or damage to persons and/or property which arise out of terms and conditions of this Agreement shall be apportioned according to the California theory of comparative negligence.

10.4 Compliance with Applicable Law

All services to be performed by Contractor pursuant to this Agreement shall be performed in accordance with all applicable Federal, State, County and Municipal laws, ordinances, regulations, including but not limited to appropriate licensure, certification regulations, confidentiality requirements, and applicable quality assurance regulations. Violation of the statutes and regulations, laws, including non-discrimination provisions, shall be considered a breach of this Agreement and shall serve as a basis for termination of this Agreement as well a disqualification for future contracts with the other party.

10.5 Waiver

PLAN's failure to implement, or insist upon compliance with, any provision of this Agreement or the terms of the Evidence of Coverage (Attachment A) incorporated hereunder, at any given time or times, shall not constitute a waiver of PLAN's right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of Premiums or Covered Services. This applies whether or not the circumstances are the same.

10.6 Assignability

10.6.1 Without the written consent of the other party, this Agreement is not assignable in whole or in part. Any assignment without the written consent of the other party violates this Agreement and shall automatically terminate this Agreement.

10.6.2 All assignees, subcontractors, or consultants used by either party shall be subject to the same terms and conditions applicable to the parties to this agreement, and the party assigning or subcontracting party shall be liable for the assignee's or the subcontractor's acts and/or omissions.

All agreements between PLAN or COUNTY and subcontractor and/or assignee for services pursuant to this Agreement shall be in writing and shall be available for review.

10.7 Notices

Any notice required or permitted under this Agreement shall be in writing and shall be deemed to have been given on the date when delivered in person, or, on the date received if delivered by first-class United States mail, UPS, FedEx, or other traceable mail service, proper postage prepaid, and properly addressed to the offices of the COUNTY or the PLAN at the following addresses:

Executive Director
Health Plan of San Mateo
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080

Office of the Director
San Mateo County Health Services
225 37th Avenue
San Mateo, CA 94403

10.8 Claim Determinations

PLAN has complete authority to review all claims for Covered Services under this Agreement. In exercising such responsibility, PLAN shall have discretionary authority to determine whether and to what extent eligible Members are entitled to coverage and construe any disputed or doubtful terms under this Agreement. PLAN shall be deemed to have properly exercised such authority unless PLAN abuses its discretion by acting arbitrarily and capriciously.

10.9 Third Parties

This Agreement shall not confer any rights or obligations on third parties except as specifically provided herein.

10.10 Inability to Arrange Services

In the event that due to circumstances not within the reasonable control of PLAN, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of PLAN's Participating Providers or entities with whom PLAN has arranged for services under this Agreement, or similar causes, the rendition of medical or Hospital benefits or other services provided

under this Agreement is delayed or rendered impractical, PLAN shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid Premiums held by PLAN on the date such event occurs. PLAN is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

10.11 Fraudulent or Material Misstatements

If any relevant fact as to a Member is found to have been misstated, an equitable adjustment of Premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is to exist and/or remain in force.

10.12 Clerical Errors

Incorrect information furnished to PLAN may be corrected, provided that PLAN has not acted to its prejudice in reliance thereon. Clerical errors or delays in keeping or reporting data relative to coverage will neither invalidate coverage which would otherwise be in force nor continue coverage which would otherwise be validly terminated nor grant additional benefits to Members if PLAN, in its sole discretion, determines that a clerical error has been made. Upon discovery of such errors or delay, an adjustment of Premiums may be made. In no case will adjustments in coverage or Premiums be made for a quantity more than two months coverage and/or more than two (2) Premium due dates prior to the date PLAN is notified in writing, on a form satisfactory to PLAN, of the requested addition, deletion, or change in coverage. Such correction time limitations may not apply for retroactive situations per Section 4.4.

10.13 Non-Discrimination

10.13.1 *Section 504.* Both parties shall comply with §504 of the Rehabilitation Act of 1973, which provides that no otherwise qualified handicapped individual shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of this agreement.

10.13.2 *General Discrimination.* No person shall, on the grounds of race, color, religion, ancestry, gender, age (over 40), national origin, medical condition (cancer), physical or mental disability, sexual orientation, pregnancy, childbirth or related medical condition, marital status, or political affiliation be denied any benefits or subject to discrimination under this agreement.

10.13.3 *Equal Employment Opportunity.* Both parties shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this agreement. Each party's equal employment policies shall be made available to the other party upon request.

10.13.4 *Compliance with Equal Benefits Ordinance.* With respect to the provision of employee benefits, both parties shall comply with the County Ordinance which prohibits contractors from discriminating in the provision of employee benefits between an employee with a domestic partner and an employee with a spouse.

County of San Mateo
Executed by:

_____

Authorized Signature for the
County of San Mateo

_____

Print Name

_____

Date

Commission
Executed by

Authorized Signature for the
San Mateo Health Commission

Jack R. Tayan

Print Name

4/25/2005

Date

ATTACHMENT A

MEMBER HANDBOOK AND EVIDENCE OF COVERAGE

The Healthy Kids Member Handbook and Evidence of Coverage is continually updated to incorporate new requirements and other regulatory changes. The Healthy Kids Member Handbook and Evidence of Coverage dated April 2005 is attached and incorporated herein.

Both parties agree that subsequent updates to the Healthy Kids Member Handbook and Evidence of Coverage as approved by the Department of Managed Health Care, become the current Healthy Kids Member Handbook and Evidence of Coverage and are incorporated herein.

ATTACHMENT B

PREMIUM SCHEDULE FOR 2005

Premium per Member per month.....$ 92.15

ATTACHMENT C

RETENTION GRANT REPORTING & PAYMENT SCHEDULE AND SCOPE OF WORK

C.1 Grant Work and Reporting

The Health Plan of San Mateo (PLAN) will hire a full-time employee to work on retention, navigation, and utilization of Healthy Kids (HK) Members, and in particular, to perform the activities described in section C.3 of this Exhibit. The employee will be hired through HPSM 's normal hiring processes and will be an HPSM employee, although extensive interactions and report communications will be to COUNTY's Children's Health Initiative (CHI) and Community Based Organizations (CBOs) contracting with the County Health Department for the express purpose of HK retention. The primary focus will be on children ages 0-5, although some work may affect members at higher age groups (families may have children both under and over 5, education efforts in the community may include families with children older than 5, etc.).

The following Scope of Work describes the primary duties of the position, and is intended to align with CHI's comprehensive retention initiative. This Scope of Work is designed to interface with the contracting CBOs SOW and activities conducted by CHI's Community Health Advocate (CHA) team.

Relevant to the Scope of Work, PLAN will provide COUNTY a Quarterly Activity Report covering the following areas:

- HK Enrollment (new members, terminated members, reasons for termination)
- Calls to Members (Welcome calls, Premium Payment reminder calls, 60-day follow-up calls)
- Communications to Members (newsletters, postcards, mass mailings)
- Provider Network and Access (# providers, network changes, access information)
- Enrollment/Promotional/Educational Activities
- Meetings
- Utilization Information (with a focus on preventive and emergency services)
- HPSM update (organizational, process, staffing changes)
- Continuous Improvement Analysis and Recommendations
- Other Efforts or Ideas

C.2 Grant Payment Schedule

On a quarterly basis, PLAN will invoice COUNTY for Retention Grant Payment based on weekly employment of full-time person for calendar quarter and submission of a Quarterly Activity Report. The Quarterly Activity Report will be submitted with Membership Report to COUNTY as referenced in Section 4.2. PLAN will be paid an amount equal to the person's weekly salary and benefits amount for work performed per this Attachment, up to a maximum of $48,750 for 2005. Payment beyond 2005 will be subject to another amendment to this contract.

COUNTY will pay Retention Grant Payment to PLAN as billed by PLAN. However, in the event of a disagreement as to the amount owed, COUNTY will communicate discrepancies to the PLAN, which will make an effort to resolve any discrepancy noted by the next invoice. Grant Payment adjustments due to discrepancies will be incorporated into the next Retention Grant Payment invoice.

C.3 Scope of Work

OBJECTIVE #1: All eligible members age 0-5 retain Healthy Kids membership. • Increase Healthy Kids reenrollment rates. • Analyze reasons for disenrollment.		
PRIMARY ACTIVITIES	**INTERFACE WITH**	**OUTCOMES MEASUREMENT**
Publicize and distribute gift certificate incentives to families to encourage timely reenrollment.	Certified Application Assistor Retention activities	90% of eligible families apply for renewal before their coverage year has ended.
Conduct welcome calls for new members to improve member understanding of their benefits, how to access health care, relevant managed care processes, premium payment processes, and the need for members to communicate any changes to their demographic information. At least 2 attempts will be made to contact each new member with call times adjusted as needed to optimize reaching of members.		100% of members receive a phone call upon enrollment.
Conduct calls to members to remind them to make Family Contribution Payments and the need for members to communicate any changes to their demographic information. Educate members on existence of Premium Assistance program and refer members to CHI as appropriate.		
Analyze family contribution process to assess impacts on reenrollment and provide suggestions for improvement	CHI	Family contribution system is effective and efficient. Policy and Procedures Committee is aware of system strengths and weaknesses.
Analyze reenrollment process to assess impact on intended 'member friendly' process and provide suggestions for improvement. Participate in discussions to identify and develop additional reenrollment incentives.	Healthy Families State CHI Policies Policy and Procedures Committee	0% disenrollment due to administrative burden, inaccessibility or cumbersome process.

OBJECTIVE #2: Multi-agency collaboration leading to development and implementation of comprehensive retention activities.		
• Collaboration with contracting Community Based Organizations. • Collaboration with Children's Health Initiative.		
PRIMARY ACTIVITIES	**INTERFACE WITH**	**OUTCOMES MEASUREMENT**
Train CBOs on HPSM benefit plans and processes, preventive health services, special member education and wellness promotion projects, retention activities, and health navigation tools. Assist in field presentations and/or health fairs.	Contracting CBOs CHI CBO Coalition	Three contracting CBOs are following similar procedures and sharing best practices/
Educate Healthy Kids members and potential members about the merits of the program, how to obtain assistance, and information on reenrollment timeline. Assist in field presentations and/or health fairs. Provide and use culturally and linguistically accessible educational materials.		
Collaborate with Contracting CBOs and CHI to identify and develop additional partnerships such as schools and childcare centers.		Network of community resources concentrating on retention increases.
Participate in CHI Workgroups.		
Analyze retention data, processes and strategies and communicate results.	Contracting CBOs CHI	All partners are on the same page regarding retention numbers.

OBJECTIVE #3: Increased use of medical and dental preventative health services.		
• Analyze utilization data. • Track provider network numbers.		
PRIMARY ACTIVITIES	**INTERFACE WITH**	**OUTCOMES MEASUREMENT**
Collate and analyze information from member interactions, community feedback, and other internal HPSM data, to analyze provider network and identify opportunities for improvement. • Primary Care • Medical Specialists • Dental	CHI	More providers accept HK insurance.
Analyze utilization rates for dental, preventative care and emergency room visits.		CBOs and CHI are abreast of utilization rates and can therefore use this data as a benchmark/evaluation figure.
Follow-up with parents of newly enrolled children between 60 and 90 days of enrollment to see if they have used their insurance benefits. Identify barriers to access, promote benefits of preventive health and dental services, assist members in navigating the health care system.		Target information for low-utilization is obtained.