## SERVICE AGREEMENT

THIS SERVICE AGREEMENT (hereinafter referred to as the "AGREEMENT") is entered into this ____th day of _____ 2008, between the San Mateo Health Commission, hereinafter referred to as "HPSM", and the County of San Mateo, Health System, hereinafter referred to as "Health System."

WHEREAS, HPSM currently has a contract with the San Mateo Medical Center, hereinafter referred to as "SMMC," for the purpose of administering benefits provided under the Coverage Initiative/ACE program which was approved by the Board of Supervisors on November 6, 2007;

WHEREAS, it is now necessary and desirable that the HPSM be retained by the Health System for the purpose of administering the benefits provided under the consolidated ACE program, which includes both the Coverage Initiative/ACE program and the WELL program;

WHEREAS, this agreement supersedes and replaces the Agreement between HPSM and SMMC dated November 6, 2007;

NOW THEREFORE, in consideration of the mutual promises and agreement herein contained, HPSM and the Health System hereby agree as follows:

### ARTICLE 1
### DEFINITIONS

1.1 ACE Program. The term "ACE Program" or "San Mateo ACE Program" or "Access and Care for Everyone Program" shall mean the consolidated program that includes both the Coverage Initiative benefit and the formerly named Wellness-Education-Linkage-Low Cost (WELL) Program. San Mateo County maintains ultimate responsibility for the ACE Program and, through this AGREEMENT, is engaging HPSM to administer the benefits available under this program.

1.2 Benefit Plans. The term "Benefit Plan" shall mean the scope of benefits indicated in the current WELL Program guidelines which includes Claims processing parameters and other information specifying healthcare coverage for Eligible Participants, as those parameters currently exist or may be amended in the future. SMMC will provide HPSM with certain information relating to such Benefit Plan ("Benefit Plan Information") including, but not limited to, the names of the Eligible Participants entitled to services under the Coverage Initiative and WELL, Eligible Participant's Copayment, maximum benefit amount, deductible amount, and other parameters of the Eligible Participants' Benefit Plan as HPSM may reasonably request from time-to-time.

1.3 Copayment. The term "Copayment" shall mean such amounts as are required to be collected by Providers from Eligible Participants, pursuant to the Benefit Plan. Copayments are only payable to Primary Care Providers, Pharmacies, and SMMC.

1.4 Coverage Initiative. The term "Coverage Initiative" shall mean the allocation of State monies as a result of SB1448, to fund proposals to expand the number of Californians who have health care coverage.

1.5 Covered Services. The term "Covered Services" means those Medically Appropriate services and supplies specified in the Eligible Participant's Benefit Plan.

1.6 Downstream Entity. "Downstream Entity" means any party that enters into an acceptable written arrangement with HPSM below the level of this AGREEMENT to provide the services which HPSM has contracted to provide pursuant to this AGREEMENT. Any party that enters into an agreement with HPSM, other than the Health System, to provide services specifically related to fulfilling HPSM's obligations to the Health System under this agreement shall be a Downstream Entity.

1.7 Effective Date. The term "Effective Date" shall mean the date upon which this Agreement shall be effective. The Effective Date is January 1, 2009. Until the Effective Date, the existing agreement between San Mateo County and HPSM approved by the BOS on November 6, 2007 shall remain in effect.

1.8 Eligible Participants. The term "Eligible Participants" shall mean those individuals who are entitled to Health Care Services through the Coverage Initiative/ACE Program and WELL as identified in the Eligible Participant List prepared and maintained by the Health System, and delivered to HPSM.

1.9 Eligible Participant List. The term "Eligible Participants List" shall have the meaning set forth in Section 2.1.

1.10 Formulary. The term "Formulary" shall mean the list of prescription drugs and medications that are recommended by the SMMC for routine use and which will be dispensed through those pharmacies described in Appendix 1-B to Eligible Participants. (Note: this definition does not reference prescribers; it only states that the SMMC is responsible for deciding what is included on the formulary.)

1.11 Identification Cards. The term "Identification Cards" ("ID Cards") shall mean printed identification cards containing information about the benefits to which the Eligible Participants are entitled. The parties shall mutually agree to have the ID cards bear the applicable HPSM logo or other method of identifying the fact that HPSM is the administrator of the health care benefit in a form acceptable to the Health System.

1.12 Implementation Date. The term "Implementation Date" shall mean the date upon which HPSM completes the input of an Eligible Participant List, unless such date is extended because the data provided by the Health System requires conversion or is in a format that is unacceptable to HPSM, pursuant to Section 2.1.

1.13 Medically Appropriate. The term "Medically Appropriate" means services and medical supplies which are required for prevention, diagnosis, or treatment of sickness or injury,

and which are:

1.13.1 Consistent with the symptoms of a medical condition or treatment of a medical condition;
1.13.2 Appropriate with regard to standards of good medical practice and generally recognized by the medical scientific community as effective;
1.13.3 Not solely for the convenience of the Eligible Participant or provider of the service or medical supplies; and
1.13.4 The most cost effective of the alternative levels of service or medical supplies which can be safely provided to the Eligible Participant in HPSM's judgment.

1.14 Non-Covered Services. The term "Non-Covered Services" means those services and supplies that HPSM is not required to provide to Eligible Participants under the terms of the Benefit Plan.

1.15 Non-Participating Provider. The term "Non-Participating Provider" means a provider of health care services or equipment that does not have a contract with HPSM to provide such services or equipment to Eligible Participants.

1.16 Participating Providers. The term "Participating Providers" shall mean those individuals or organizations which contract directly with HPSM to provide health care services or equipment for Eligible Participants of the Coverage Initiative.

1.17 Primary Care Provider (PCP). The term "Primary Care Provider" or "PCP" means a Participating Provider selected by a Member to render first contact medical care and certain Covered Services.

1.18 PCP Assignment. The term "PCP Assignment" refers to the process by which an Eligible Participant is assigned by HPSM to a PCP for provision of certain Covered Services, or to the PCP assigned for a particular Eligible Participant.

1.19 Prescription Drug Services. The term "Prescription Drug Services" shall mean those outpatient prescription drug services or supplies provided as a covered benefit to Eligible Participants as set forth in the Benefit Plan.

1.20 Processed Claims or Claim Forms. The terms "Processed Claims," "Claims," or "Claim Forms" shall mean all Claims transmitted to HPSM by Participating Providers either electronically or in paper form for services provided to Eligible Participants under the ACE Program.

1.21 Third Party Administrator (TPA). The term "Third Party Administrator" or "TPA" shall mean the role HPSM serves in conducting the services set forth in this AGREEMENT.

1.22 Wellness-Education-Linkage-Low Cost (WELL) Program. The former name of San Mateo County's indigent care program, which is being consolidated under the ACE Program.

## ARTICLE 2
## DUTIES TO BE PERFORMED BY HEALTH SYSTEM

2.1 Eligible Participant List. The Health System shall provide to HPSM a data file of Eligible Participants (the "Eligible Participants List") on a daily basis and at least fourteen (14) days prior to the Implementation Date provided that the data is supplied in a format acceptable to HPSM via its contracted eligibility vendor, One-E-App. The Health System shall be solely responsible for ensuring the accuracy of this Eligible Participants List. The Health System shall be obligated to pay HPSM for Claims accepted by HPSM that are submitted by or on behalf of persons listed on any Eligible Participants List. The Health System bears the entire risk of all fraudulent Claims submitted by Eligible Participants or by unauthorized persons using an Eligible Participant's ID Card or identification number. HPSM shall notify the Health System within (30) thirty days of any potential fraudulent use of the Participant ID Card or identification number that it identifies. The Eligible Participants List shall contain the following minimum information:

2.1.1 Eligible Participant's full name (last, first, and middle initial);
2.1.2 Eligible Participant's date of birth;
2.1.3 Eligible Participant's gender
2.1.4 Eligible Participant's address;
2.1.5 the date the Eligible Participant's participation under the Coverage Initiative and/or WELL becomes effective;
2.1.6 the date the Eligible Participant's participation under the Coverage Initiative and/or WELL is terminated;
2.1.7 the names and addresses for the Primary Care Provider for the Eligible Participant (if available);
2.1.8 the Eligible Participant's preferred spoken and written language;
2.1.9 the benefit to which the Eligible Participant is entitled (CI/CI fee waiver/WELL/WELL fee waiver);

If Primary Care Provider information is not available for a particular Eligible Participant on the Eligible Participant List, HPSM shall assign the SMMC 39th Avenue Clinic as the Eligible Participant's Primary Care Provider.

The Health System shall indemnify HPSM for any damages related to One-E-App's failure to provide accurate and timely data described in this Section 2.1.

2.2 Benefit Plan Information. The Health System will deliver to HPSM detailed Benefit Plan Information. Such information shall contain all of the elements required by HPSM (as set forth in Section 1.1) so that HPSM may verify, price, and pay the Claims submitted by Participating Providers, and to prepare the various reports as described in Exhibit A. In addition, the Health System shall provide any Benefit Plan Information changes to HPSM within thirty (30) days of the date such changes shall become effective (the "change date"), except that changes to Benefit Plan Information that are to be effective

on January 1st of any given year must be provided to HPSM at least ninety (90) days prior to January 1st in order to be processed. Failure to provide Benefit Plan Information changes within the time frames described in this Section 2.2 may result in postponement of the proposed change date.

2.3 Provision of Eligibility Information. HPSM may provide Eligible Participant List information to the Participating Providers. HPSM will not pay any Claims for persons not listed on the Eligible Participants List. The Health System shall indemnify HPSM for any damages arising from inaccuracies in the Eligible Participants List. HPSM shall notify the Health System within (30) thirty days of any problems with the Eligible Participants List that it identifies.

2.4 Notification Requirements. The Health System will review all reports, statements, and invoices provided by HPSM and shall notify HPSM in writing of any errors or objections within ninety (90) days of receipt. Specifically, this shall also apply to all service requests, benefit change requests, and any operation change requests. Until Health System notifies HPSM in writing of any errors or objections, HPSM will be entitled to rely on the information contained in the reports, statements, and invoices. If the Health System does not notify HPSM in writing of any errors or objections within the ninety (90) day period, the information contained therein will be deemed accurate, complete, and acceptable to the Health System, and thereafter HPSM shall have no liability related thereto. This does not apply with respect to any undercharges or underpayments of the Health System. HPSM shall document and retain supporting documentation for audit purposes. If the Health System notifies HPSM within the ninety (90) day period of any errors or objections, HPSM shall compensate the Health System for any verifiable errors or objections. Nothing in this article will absolve HPSM of any liability of errors, discrepancies, objections, or omissions identified under 5.3 of this contract.

## ARTICLE 3
## DUTIES TO BE PERFORMED BY HPSM

3.1 Provision of Services to the Health System. HPSM shall provide to the Health System the services listed in Exhibit A, attached hereto and incorporated herein as referenced. These services shall be provided at the agreed upon rates listed in Exhibit B, attached hereto and incorporated herein as referenced.

3.2 Compliance with Laws and Regulations. HPSM shall comply with all applicable Federal laws, regulations, reporting requirements, CMS instructions, and with the Health System's contractual obligations with the California Department of Health Care Services, including, but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Federal criminal law, the False Claims Act (31 U.S.C. §3729 et.seq.) and the Anti-Kickback statute (section 1128B(b) of the Act), HIPAA, and the HIPAA administrative simplification rules at 45 CFR Part 160, 162, and 164. HPSM agrees to include the requirements of this section in its contracts with any Downstream Entity, and to require any Downstream Entity to comply accordingly.

## ARTICLE 4
## PAYMENT DUE HPSM AND TO HEALTH CARE PROVIDERS

4.1 Monthly Statement for Payment of TPA Services. Upon receipt of each monthly statement ("TPA Statement") from HPSM for payment of the monthly administration fee for TPA services as set forth in Exhibit A of this Agreement, the Health System shall remit payment to HPSM within thirty (30) calendar days. If the Health System questions the amount of the TPA Statement, the Health System shall notify HPSM of its questions regarding said amount and shall still be obligated to remit the amount of the TPA Statement not in dispute within thirty (30) calendar days. If HPSM receives such a notice, both HPSM and the Health System shall make a reasonable effort to resolve such questions within thirty (30) calendar days. Upon and in accordance with such resolution, the Health System will remit to HPSM any outstanding amount due, if applicable, to HPSM within thirty (30) calendar days of the resolution.

4.2 Advance Payment/Health Care Cost Reserve. Within in two weeks of the execution of this Agreement, the Health System shall pay HPSM nine million dollars ($9,000,000) as an advance payment to fund a Health Care Cost Reserve. This amount is equal to the expected cost of Covered Services provided to the maximum expected number of Eligible Participants for two (2) months. HPSM will deposit this amount into a separate and distinct bank account that will house the Health Care Cost Reserve for the ACE Program. All payments made by HPSM to eligible health care providers for Covered Services to Eligible Participants will be drawn from this account. Likewise, all payments received from the Health System as repayment for health care costs, as described in Section 4.3 below, shall be deposited to this account. The Health System and HPSM agree to review the sufficiency of the Health Care Cost Reserve every three months and make adjustments as necessary to ensure that it holds sufficient funds to cover each month's health care payments. Interest earned on this account is to be credited therein and be used at the discretion of the Health System.

4.3 Payment to Health Care Providers. HPSM shall process and issue payments to health care providers on a monthly basis, based on approved claims for Covered Services provided to Eligible Participants. These payments shall be drawn from the Health Care Cost Reserve described in Section 4.2 above, assuming sufficiency of funds in the Health Care Cost Reserve to issue payment in full to all health care providers who are due payment on the monthly payment cycle. These payments may be co-approved by County staff. Notwithstanding the review of fund sufficiency described in Section 4.2 above, if for any given month there is not enough funding in the Health Care Cost Reserve to issue payment in full to all health care providers who are due payment on the monthly payment cycle, HPSM shall hold all payments to health care providers for the monthly payment cycle until such time as HPSM has received payment from the Health System to cover payment in full. HPSM shall notify the Health System of the insufficient funds on the first business day that HPSM learns of the insufficiency.

4.4 Monthly Statement for Payment of Health Care Costs. Based on each month's payments, HPSM shall send a monthly statement to the Health System for health care costs paid under this AGREEMENT ("Health Care Costs Statement"). The Health System shall issue payment in the full amount of the Health Care Costs Statement to HPSM within thirty (30) calendar days from the date of the statement. Should said amount not be paid within thirty (30) calendar days, the Health System shall be subject to interest charged on all amounts due at an amount equal to one and one-half percent (1.5%) per month, to accrue on a daily basis on the unpaid balance. If the Health System questions the amount of the Health Care Costs Statement, Health System may notify HPSM of its questions regarding said amount and shall still be obligated to pay the full amount of the Statement within thirty (30) calendar days. If HPSM receives such a notice, it shall make a reasonable effort to respond to such questions within thirty (30) calendar days.

4.5 Suspension of Services. If thirty (30) calendar days have elapsed from the time said amount described in Section 4.3 was due HPSM, and payment (including any accrued interest) has not been made to HPSM, then HPSM shall give notice to the Health System of HPSM's intent to suspend its services and system operations for Health System. If thirty (30) calendar days after receiving such a notice of HPSM's intent to suspend, Health System does not remit to HPSM said amount plus interest, HPSM may suspend its services. At any time thereafter, HPSM may terminate this AGREEMENT as provided in Section 10.2 below. If Health System makes only partial payment of the full amount including interest, HPSM may still suspend its services and systems operations and terminate this AGREEMENT as provided herein. Health System shall be responsible for all costs of collection and agrees to reimburse HPSM for such costs and expenses.

## ARTICLE 5
## RECORDS

5.1 Maintenance of Records. HPSM shall maintain documentation of all Claims processed for six (6) years from the date of adjudication of the Claim. Such documentation shall be in a format and media deemed appropriate by HPSM and the Health System, and accessible to the Health System upon thirty (30) days prior written notice.

5.2 Use of Information. HPSM and the Health System may use, reproduce, or adapt information obtained in connection with this Agreement, including Claims data information and eligibility information, in any manner they deem appropriate, except that each party and its agents, employees, and contractors shall maintain the confidentiality of this information to the extent required by applicable Law, including the provisions of the Health Insurance Portability and Accountability Act of 1996, Subtitle F – Administrative Simplification, (referred to in this Agreement as "HIPAA"), and may not use the information in any way prohibited by Law. Each party shall be solely responsible for its own use of the information, and shall indemnify and hold the other party harmless for, from and against any and all costs, losses, and damages incurred by such other party as a result of such use.

5.3 Right to Audit Claims and Business Records. The Health System and representatives of a regulatory or accreditation agency may inspect and audit, once annually, HPSM's business records that directly relate to billings made to the Health System for Claims. HPSM may inspect and audit, or cause to be inspected and audited, once annually, the books and records of the Health System directly relating to this Agreement, including the existence and number of Eligible Participants. The Health System and HPSM shall fully cooperate with representatives of each other, with independent accountants hired by either party, and with representatives of any regulatory or accreditation agency, to conduct any such inspection or audit. To the extent that the Health System and/or HPSM have control of the following, such audits shall be at the auditing party's sole expense and shall only be made during normal business hours, following thirty (30) days written notice, without undue interference to the audited party's business activity, and in accordance with reasonable audit practices. Where a regulatory or accreditation agency imposes demands that do not meet the above standards for conducting an audit, the Health System and HPSM will cooperate with the requirements of the auditing agency to the extent possible. An audit of HPSM's records shall be conducted at HPSM's office where such records are located and shall be limited to transactions over the twenty four (24) month period preceding such audit. If a completed audit reveals a discrepancy in the results and the previous calculations of the audited party, then the auditing party shall deliver written notice setting forth in reasonable detail the basis of such discrepancy. The parties shall use reasonable efforts to resolve the discrepancy within thirty (30) days following delivery of the notice, and such resolution shall be final, binding, and conclusive upon the parties. Upon a final and conclusive determination of a discrepancy revealed by an audit procedure under this Agreement, the party that owes money shall pay such sums to the other party within thirty (30) days of the delivery of the conclusive audit findings.

## ARTICLE 6
## INDEMNIFICATION

6.1 Indemnity by the Health System. The Health System shall indemnify and save harmless HPSM, its officers, agents, employees and servants from all claims, suits or actions of every name, kind and description brought for, or on account of: (A) injuries to or death of any person, including the Health System staff, or (B) damage to any property of any kind whatsoever and to whomsoever belonging, (C) any sanctions, penalties or claims of damages resulting from HPSM's failure to comply with the requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all Federal regulations promulgated thereunder, as amended, or (D) any other loss or cost, including but not limited to that caused by the concurrent active or passive negligence of HPSM, its officers, agents, employees, or servants, resulting from the performance of any work required of HPSM or payments made pursuant to this Agreement, provided that this shall not apply to injuries or damage for which HPSM has been found in a court of competent jurisdiction to be solely liable by reason of its own negligence or willful misconduct.

The duty of the Health System to indemnify and save harmless as set forth herein, shall include the duty to defend as set forth in Section 2778 of the California Civil Code.

6.2 Indemnity by HPSM. HPSM shall indemnify and save harmless the Health System, its officers, agents, employees and servants from all claims, suits or actions of every name, kind and description brought for, or on account of: (A) injuries to or death of any person, including HPSM staff, or (B) damage to any property of any kind whatsoever and to whomsoever belonging, (C) any sanctions, penalties or claims of damages resulting from the Health System's failure to comply with the requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all Federal regulations promulgated thereunder, as amended, or (D) any other loss or cost, including but not limited to that caused by the concurrent active or passive negligence of the Health System, its officers, agents, employees, or servants, resulting from the performance of any work required of the Health System or payments made pursuant to this Agreement, provided that this shall not apply to injuries or damage for which the Health System has been found in a court of competent jurisdiction to be solely liable by reason of its own negligence or willful misconduct.

The duty of HPSM to indemnify and save harmless as set forth herein, shall include the duty to defend as set forth in Section 2778 of the California Civil Code.

6.3 Concurrent Negligence. In the event of concurrent negligence of the Health System, its officers and/or employees, and HPSM, 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.

**ARTICLE 7**
**NON-DISCRIMINATION**

7.1 Non-Discrimination.

7.1.1 HPSM 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.

7.1.2 *General non-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.

7.1.3 *Equal employment opportunity.* HPSM 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. HPSM's equal employment policies shall be made available to the Health System upon request.

7.1.4 *Violation of Non-discrimination provisions.* Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject HPSM to penalties, to be determined by the County of San Mateo County Manager ("County Manager"), including but not limited to:

7.1.4.1 termination of this Agreement;
7.1.4.2 disqualification of HPSM from bidding on or being awarded a contract with the County of San Mateo for a period of up to 3 years;
7.1.4.3 liquidated damages of $2,500 per violation;
7.1.4.4 imposition of other appropriate contractual and civil remedies and sanctions, as determined by the County Manager.

To effectuate the provisions of this section, the County Manager shall have the authority to examine HPSM's employment records with respect to compliance with this paragraph and/or to set off all or any portion of the amount described in this paragraph against amounts due to HPSM under the Service Agreement or any other Service Agreement between HPSM and the Health System.

HPSM shall report to the County Manager the filing by any person in any court of any complaint of discrimination or the filing by any person of any and all charges with the Equal Employment Opportunity Commission, the Fair Employment and Housing Commission or any other entity charged with the investigation of allegations within 30 days of such filing, provided that within such 30 days such entity has not notified HPSM that such charges are dismissed or otherwise unfounded. Such notification shall include the name of the complainant, a copy of such complaint, and a description of the circumstance. HPSM shall provide the Health System with a copy of their response to the Complaint when filed.

7.1.5 *Compliance with Equal Benefits Ordinance.* With respect to the provision of employee benefits, HPSM shall comply with the San Mateo 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.

7.1.6 Where applicable, HPSM shall comply fully with the non-discrimination requirements required by 41 CFR 60-741.5(a), which is incorporated herein as if fully set forth.

7.1.7 *Jury Service.* HPSM shall comply with the San Mateo County Ordinance with respect to provision of jury duty pay to employees and have and adhere to a written policy that provides that its employees shall receive from HPSM, on an annual basis, no less than five days of regular pay for actual jury service in San Mateo County. The policy may provide that employees deposit any fees received

for such jury service with HPSM or that HPSM deduct from the employees' regular pay the fees received for jury service.

## ARTICLE 8
## CONFIDENTIALITY

8.1 Confidential Information. The term "Confidential Information" means information of a confidential or proprietary nature relating to the subject matter described in this Agreement which is taken from or disclosed by one party (the "Disclosing Party") to the other (the "Receiving Party"). Confidential Information includes, but is not limited to, matters of a technical nature such as trade secrets, methods, compositions, data and know-how, designs, systems, processes, computer programs, files and documentation, similar items or research projects, and any information derived therefrom; matters of a business nature, such as the terms of this Agreement (including any pricing terms and contract terms which must be subject to a protective order), marketing, sales, strategies, proposals, and lists of actual or potential Eligible Participants, Participating Providers as well as any other information that is designated by either party as confidential.

8.2 Treatment of Confidential Information. Subject to the California Public Records Act and related state and federal legislation, the Receiving party agrees: (i) to hold the Disclosing Party's Confidential Information in strict confidence and to take reasonable precautions to protect such Confidential Information (including, without limitation, all precautions Receiving Party employs with respect to its own confidential materials); (ii) not to divulge any such Confidential Information or any information derived therefrom to any third party unless required in the performance of the Receiving Party's duties under this Agreement or pursuant to controlling law; (iii) not to make any use whatsoever at any time of such Confidential Information except for the purpose of this Agreement and will not use it for its own or any third party's benefit; and (iv) not to copy, analyze, transcribe, transmit, decompile, disassemble or reverse engineer any such Confidential Information, and not use such Confidential Information in any patent application. The confidentiality obligations of this Section 8.2 shall not apply to information which, as evidenced in writing:

8.2.1 is or becomes publicly known by Receiving Party through no breach of this Agreement;
8.2.2 is learned by the Receiving Party from a third party entitled to disclose it;
8.2.3 is rightfully obtained by the Receiving Party prior to this Agreement; or
8.2.4 is required by law to be disclosed.

The confidential obligations contained in the foregoing clauses (i), (ii), (iii) and (iv) shall be perpetual. Receiving Party may make disclosures required by law or court order provided Receiving Party uses diligent, reasonable efforts to afford the Disclosing Party the opportunity to limit disclosure and to obtain confidential treatment or a protective order.

8.3 No Transfer Or Right Or Title. Receiving Party acknowledges that it shall not acquire any rights or title to any Confidential Information merely by virtue of its use or access to such Confidential Information hereunder. Neither the execution of this Agreement nor the furnishing of any Confidential Information hereunder shall be construed as granting, either expressly or by implication, or otherwise, the Receiving Party any license under any invention or patent now or hereafter owned by or controlled by the Disclosing Party. Each party agrees that it may not be adequately compensated for damages arising from a breach or threatened breach of any of the covenants contained in this Article 8 by the other party, and each party shall be entitled to injunctive relief and specific performance in addition to all other remedies. None of the information that may be submitted or exchanged by the parties shall constitute any representation, warranty, assurance, guarantee, or inducement by a party to the other with respect to the infringement of patents, copyrights, trademarks, trade secrets, or any other rights of third persons.

## ARTICLE 9
## EXCLUSIVITY

9.1 Exclusivity. The Health System agrees that HPSM shall be the sole and exclusive agent providing third party administration for the ACE Program during the term of this Agreement.

## ARTICLE 10
## TERM AND TERMINATION

10.1 Term. This Agreement shall become effective on the Effective Date and shall be for a term of three (3) years, ending December 31, 2011, with the understanding that administration of the Coverage Initiative may not extend beyond August 31, 2010, depending on the availability or lack thereof of additional funding under the Coverage Initiative. At the option of COUNTY and upon the availability of funding, two one (1) year terms may be extended with the same terms and conditions upon the execution of an Addendum that shall be finalized ninety (90) days prior to each anniversary date. Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination.

10.2 Termination With Cause. This Agreement may be terminated at anytime by either party based on a material breach of any terms or conditions herein stated provided that thirty (30) days' advance written notice of such material breach shall be given to the other party and such party shall have the opportunity to cure such material breach during such thirty (30) day notice period. Notwithstanding the foregoing, this Agreement services provided for the administration of the Coverage Initiative may be terminated immediately under this contract by the County if its participation in the Coverage Initiative is terminated; this Agreement shall continue to be in effect for non-Coverage Initiative program services through the remainder of the term of the Agreement.

10.3 Effect of Termination. If this Agreement is terminated pursuant to this Article 10: (i) all further obligations of the parties under this Agreement shall terminate (but not such party's obligation to make payments arising prior to the termination of this Agreement or any obligation surviving the termination hereof); (ii) all Confidential Information provided by either party shall, except for Confidential Information required by law to be retained by a party, be immediately returned by a Receiving Party (as defined in Section 9.1), or such Receiving Party shall certify to the Disclosing Party that such materials have been destroyed; (iii) should HPSM have a deposit from the Health System (as described in Section 4.2, above), such deposit shall be reduced by any offsets for payment defaults and collection costs before being returned; (iv) neither party shall be relieved of any obligation or liability arising from any prior breach of such party or any provision of this Agreement; and (v) the parties shall, in all events, remain bound by and continue to be subject to the provisions set forth in Sections 5.1, 5.2, 5.3, 6.1, 6.2, 6.3, 8.1, 8.2, 8.3, 11.1, 11.7, 11.9, 11.10, 11.13, 11.17, 11.18 and 11.19.

## ARTICLE 11
## GENERAL PROVISIONS

11.1 Use of HPSM Software. The Health System acknowledges that HPSM owns, or possesses license rights (including off-the-shelf vendor agreements) from certain third parties to the entire software system used by HPSM in processing Claims and preparing reports including computer programs, system and program documentation, and other documentation relating thereto (collectively, including certain license rights, the "HPSM Software System"), and that the HPSM Software System is the exclusive and sole property of HPSM. The Health System disclaims any rights to the HPSM Software System as described above (including access to any applicable source codes), any resultant reports, procedures or forms developed by HPSM, as well as development or modification of the HPSM Software System as a result of any customization performed by any party.

11.2 Insurance. Each party shall obtain (to the extent not already possessed) and maintain, with respect to the activities in which such party engages pursuant to this Agreement, professional liability (errors and omissions) insurance in amounts reasonable and customary for the nature and scope of business engaged in by such party and comprehensive liability insurance. Upon request, either party shall promptly deliver to the other party evidence of such insurance. Each party agrees to notify the other party immediately upon such party's receipt of any notice canceling, suspending or reducing the coverage limits of its professional liability insurance or comprehensive liability insurance.

11.3 Successors and Assigns. Neither this Agreement nor any of the rights, interests or obligations hereunder shall be assigned by either party hereto (whether by operation of law or otherwise) without the prior written consent of the other party hereto. Subject to the preceding sentence, this Agreement shall be binding upon, inure to the benefit of and be enforceable by the parties and their respective successors and permitted assigns.

Notwithstanding anything to the contrary contained in this Agreement (including this Section 12.3), no consent shall be required and this Agreement will apply to, be binding in all respects upon, and inure to the benefit of any successors of the Health System to this Agreement resulting from a Change of Control. A "Change of Control" shall occur if as a result of one or a series of related transactions: (i) all or substantially all the assets of SMMC are disposed of to any entity not wholly owned and controlled by the Health System, outside the ordinary course of business; (ii) SMMC effects a merger with one or more other entities in which the Health System is not the surviving entity; or (iii) The Health System engages in a transaction that results in any entity holding securities possessing a majority of the voting power that does not hold such voting power as of the time of this Agreement. The Health System shall provide HPSM with thirty (30) days' advance written notice in the event of any transaction(s) resulting in a Change of Control, as well as an Officer's Certificate from the successor entity, agreeing to be bound by the terms and conditions of this Agreement.

11.4 Waiver. Any term or condition of this Agreement may be waived at any time by the party that is entitled to the benefit thereof, but no such waiver shall be effective unless set forth in a written instrument duly executed by or on behalf of the party waiving such term or condition. No waiver by any party of any term or condition of this Agreement, in any one or more instances, shall be deemed to be or construed as a waiver of the same or other term or condition of this Agreement on any future occasion.

11.5 Severability. In the event that any provision of this Agreement shall be determined to be invalid, unlawful, void or unenforceable to any extent, the remainder of this Agreement, and the application of such provision other than those as to which it is determined to be invalid, unlawful, void or unenforceable, shall not be impaired or otherwise affected and shall continue to be valid and enforceable to the fullest extent permitted by law.

11.6 Further Assurances. Each party hereto shall execute and cause to be delivered to each other party hereto such instruments and other documents, and shall take such other actions, as such other party may reasonably request (at or after the date hereof) for the purpose of carrying out or evidencing any of the transactions contemplated by this Agreement.

11.7 Choice of Law. This Agreement shall be construed, interpreted, and governed according to the laws of the State of California without regard to its conflict of laws and rules.

11.8 Force Majeure. The performance obligations of HPSM and/or the Health System respectively hereunder shall be suspended to the extent that all or part of this Agreement cannot be performed due to causes which are outside the control of HPSM and/or the Health System, and could not be avoided by the exercise of due care, including but not limited to suspension of the Coverage Initiative funding, acts of God, acts of a public enemy, acts of a sovereign nation or any state or political subdivision or any department or regulatory agency thereof or entity created thereby, acts of any person engaged in a subversive or terrorist activity or sabotage, fires, floods, earthquakes, explosions, strikes, slow-downs, lockouts or labor stoppage, freight embargoes, or by any enforceable law,

regulation or order. The foregoing shall not be considered to be a waiver of any continuing obligations under this Agreement, and as soon as conditions cease, the party affected thereby shall fulfill its obligations as set forth under this Agreement. In order to benefit from the provisions of this Section 11.8, the party claiming force majeure must notify the other reasonably promptly in writing of the force majeure condition. If any event of force majeure, in the reasonable judgment of the parties, is of a severity or duration such that it materially reduces the value of this Agreement, then this Agreement may be terminated without liability or further obligation of either party (except for any obligation expressly intended to survive the termination of this Agreement and except for all amounts that have become or will become due and payable hereunder).

11.9 Entire Agreement; No Third Party Beneficiaries. This Agreement, including the Exhibits: (i) constitutes the entire agreement among the parties with respect to the subject matter hereof and supersedes all prior agreements and understandings, both written and oral, among the parties with respect to the subject matter hereof; and (ii) is intended solely for the benefit of each party hereto and their respective successors or permitted assigns, and it is not the intention of the parties to confer third party beneficiary rights, and this Agreement does not confer any such rights, upon any other third party.

11.10 Use of Name. Neither party shall use the other party's name, trade or service mark, logo, or the name of any affiliated company in any advertising or promotional material, presently existing or hereafter established, except in the manner and to the extent permitted by prior written consent of the other party.

11.11 Notice. Any notice required or permitted by this Agreement, unless otherwise specifically provided for in this Agreement, shall be in writing and shall be deemed given: (i) one (1) day following delivery to a nationally reputable overnight courier; (ii) one (1) day following receipt by facsimile during the receiving party's business hours with written confirmation thereof; or (iii) three (3) days after the date it is deposited in the United States mail, postage prepaid, registered or certified mail, or hand delivered addressed as follows:

To: Health System: Charlene Silva, Interim Chief
Health System
225 37th Avenue
San Mateo, CA 94403

To: SMMC: Sang-Ick Chang, Chief Executive Officer
San Mateo Medical Center
222 West 39th Ave
San Mateo, CA 94403

To HPSM: Maya Altman, Executive Director
Health Plan of San Mateo
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080

Any party may at any time change its address for notification purposes by mailing a notice stating the change and setting forth the new address.

11.12 Counterparts; Facsimile. This Agreement may be executed in one or more counterparts, all of which shall be considered one and the same agreement and shall become effective when one or more counterparts have been signed by each of the parties and delivered to the other parties, it being understood that all parties need not sign the same counterpart. This Agreement may be executed and delivered by facsimile and upon such delivery the facsimile signature will be deemed to have the same effect as if the original signature had been delivered to the other party. The original signature copy shall be delivered to the other party by express overnight delivery. The failure to deliver the original signature copy and/or the nonreceipt of the original signature copy shall have no effect upon the binding and enforceable nature of this Agreement.

11.13 Independent Contractors. The Health System and HPSM are independent entities and nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee or principal and agent or franchiser and franchisee or any relationship, fiduciary or otherwise, other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement. Nothing in this Agreement is intended to be construed, or be deemed to create, any rights or remedies in any third party, including but not limited to an Eligible Participant. Nothing in this Agreement shall be construed or deemed to confer upon HPSM any responsibility for or control over the terms or validity of the Covered Services. HPSM shall have no final discretionary authority over or responsibility for the Health System's administration. Further, because HPSM is not an insurer, plan sponsor, or a provider of health services to Eligible Participants, HPSM shall have no responsibility for: (i) any funding of Health System or ACE Program benefits; (ii) any insurance coverage relating to Health System or any plan contract of Health System or Eligible Participants; or (iii) the nature or quality of professional health services rendered to Eligible Participants, except as described in Exhibit A.

11.14 Consent to Amend. This Agreement or any part or section of it may be amended at any time during the term of this Agreement only by mutual written consent of duly authorized representatives of HPSM and the Health System.

11.15 Headings. The headings of Articles, Sections and Exhibits contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

11.16 Compliance with Laws and Regulations. This Agreement will be in compliance with all pertinent federal and state statutes and regulations. If this Agreement, or any part hereof, is found not to be in compliance with any pertinent federal or state statute or regulation, then the parties shall renegotiate the Agreement for the sole purpose of correcting the non-compliance.

11.17 Construction.

11.17.1 For purposes of this Agreement, whenever the context requires: the singular number shall include the plural, and vice versa; the masculine gender shall include the feminine and neuter genders; the feminine gender shall include the masculine and neuter genders; and the neuter gender shall include the masculine and feminine genders.

11.17.2 The parties hereto agree that any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not be applied in the construction or interpretation of this Agreement.

11.17.3 As used in this Agreement, the words "include" and "including," and variations thereof, shall not be deemed to be terms of limitation, but rather shall be deemed to be followed by the words "without limitation."

11.17.4 Except as otherwise indicated, all references in this Agreement to "Articles," "Sections" and "Exhibits" are intended to refer to Articles of this Agreement, Sections of this Agreement and Exhibits to this Agreement.

11.18 Remedies Cumulative; Specific Performance. The rights and remedies of the parties hereto shall be cumulative (and not alternative). The parties to this Agreement agree that to the extent permitted by applicable law, in the event of any breach or threatened breach by any party to this Agreement of any covenant, obligation or other provision set forth in this Agreement for the benefit of any other party to this Agreement, such other party shall be entitled (in addition to any other remedy that may be available to it) to: (i) a decree or order of specific performance to enforce the observance and performance of such covenant, obligation or other provision; and (ii) an injunction restraining such breach or threatened breach. Neither party shall be required to provide any bond or other security in connection with any such decree, order or injunction or in connection with any related action or legal proceeding.

11.19 HIPAA Compliance. For the purposes of this Agreement, HPSM is deemed to be a "Business Associate" of the Health System as such term is defined in the Privacy Standard of the Federal Register, published on December 28, 2000 (Business Associate Requirements, Exhibit C, attached hereto and incorporated herein as referenced). The parties will endeavor to comply with all applicable regulations published pursuant to HIPAA, as of the effective enforcement date of each standard. In addition, without limiting any other provision of this Agreement:

11.19.1 all services provided by HPSM under this Agreement will be provided in such a manner as to enable the Health System to remain at all times in compliance with all HIPAA regulations applicable to the Health System, to the extent that the Health System's compliance depends upon the manner in which such services are performed by HPSM;

11.19.2 all software, application programs and other products licensed or supplied by HPSM under this Agreement will contain such characteristics and functionality (including as applicable, but not limited to, the ability to accept

and securely transmit data using the standard HIPAA transaction sets) as necessary to ensure that the Health System's use of such software, application programs and other products and associate documentation from HPSM, when utilized by the Health System in the manner as directed by HPSM, will fully comply with the HIPAA regulations applicable to Health System. In the event any amendment to this Agreement is necessary for Health System to comply with the HIPAA regulations as they relate to this Agreement or its subject matter, including, but not limited to, requirements pertaining to Business Associate agreements, the Health System and HPSM will negotiate in good faith and amend this Agreement accordingly, with such amendment to be effective prior to the date compliance is required under each standard of the HIPAA regulations; and

11.19.3 all software, application programs, eligibility lists or other member-specific information and other products licensed or supplied by the Health System under this Agreement will contain such characteristics and functionality (including as applicable, but not limited to, the ability to accept and securely transmit data using the standard HIPAA transaction sets) as necessary to ensure that HPSM's use of such software, application programs and other products and associate documentation from Health System, when utilized by HPSM in the manner as directed by the Health System, will fully comply with the HIPAA regulations applicable to HPSM. In the event any amendment to this Agreement is necessary for HPSM to comply with the HIPAA regulations as they relate to this Agreement or its subject matter, including, but not limited to, requirements pertaining to Business Associate agreements, HPSM and the Health System will negotiate in good faith and amend this Agreement accordingly, with such amendment to be effective prior to the date compliance is required under each standard of the HIPAA regulations.

The provisions of this Agreement shall bind and inure to the benefit of the parties hereto and their heirs, legal representatives, successors and assignees. This Agreement constitutes the entire understanding between the parties hereto.

| | |
|---|---|
| SAN MATEO HEALTH COMMISSION<br>d.b.a. HEALTH PLAN OF SAN MATEO | COUNTY OF SAN MATEO |
| BY<br>**MAYA ALTMAN**<br>**EXECUTIVE DIRECTOR** | BY<br>**ADRIENNE J. TISSIER**<br>**PRESIDENT, BOARD OF SUPERVISORS** |
| DATE | DATE |

## EXHIBIT "A"
## SCOPE OF SERVICES

In consideration of the payments set forth in Exhibit "B", HPSM shall provide the following services. These services will be provided by HPSM as set forth in the corresponding Appendix referenced below.

- ☒ Appendix 1-A: Claims Processing and Data Management
- ☒ Appendix 1-B: Outpatient Pharmacy Benefit
- ☒ Appendix 1-C: Provider Relations
- ☒ Appendix 1-D: Utilization and Medical Management
- ☒ Appendix 1-E: Collection of Participant Fee
- ☒ Appendix 1-F: Customer Service
- ☒ Appendix 1-G: Grievances and Appeals
- ☒ Appendix 1-H: Quality Assessment and Improvement
- ☒ Appendix 1-I: Participant Informing Materials
- ☒ Appendix 1-J: Reporting

## APPENDIX 1-A
## CLAIMS PROCESSING AND DATA MANAGEMENT

1. Claims Processing. With the exception of claims for outpatient pharmacy benefits that shall be provided by HPSM's contracted benefit administrator(s), as described in Appendix 1-B, and dental benefits, which shall continue to be processed by the Health System, HPSM shall process claims for payment from Participating Providers, and Non-Participating Providers as needed, for authorized Covered Services on behalf of the Health System. Claims shall be processed at least once per month.

2. Payment to Participating Providers. Assuming sufficiency of funds in the Health Care Cost Reserve as detailed in Section 4.3 of the Agreement, HPSM shall make payments to Participating Providers, and Non-Participating Providers as needed, for Covered Services to Eligible Participants in accordance with Exhibit D. HPSM shall not be obligated to pay Participating Providers (i) for services that are not Covered Services; (ii) if Participating Providers fail to verify an individual's eligibility for Covered Services in accordance with Coverage Initiative Policies and the individual is not an Eligible Participant, or (iii) if information provided to the HPSM by Participating Provider is materially inaccurate, and HPSM should later reasonably determine either that the individual was not eligible or the services were not Covered Services.

3. Encounter Data. HPSM shall submit encounter data to the Health System in electronic form. HPSM shall supply encounter data at least monthly, by the 10th of the month following the month of claim processing. HPSM will employ appropriate data security procedures to ensure rapid recovery and transmittal of all encounter data.

## APPENDIX 1-B
## OUTPATIENT PHARMACY BENEFIT

HPSM shall provide the outpatient pharmacy benefit to Eligible Participants under this contract using its pharmacy benefit manager (PBM). The outpatient pharmacy benefit shall be provided in accordance with Health System guidelines. HPSM shall work with its PBM to implement a Health System-approved formulary applicable to Eligible Participants. Medications not included on the formulary shall require prior authorization.

Eligible members must receive outpatient medications from contracted pharmacies. Contracted pharmacies under the ACE Program shall only include those pharmacies that have contracts with Entities receiving 340b pricing for prescription drugs. The PBM will process claims from contracted pharmacies for the outpatient pharmacy benefit provided to Eligible Participants, but will not issue payment to the pharmacies. HPSM shall be responsible for reporting pharmacy costs and fill fees to the Health System. However, HPSM shall not be responsible for issuing payment for outpatient pharmacy services provided to Eligible Participants except in limited cases to be mutually agreed upon by HPSM and the Health System. The Health System shall maintain responsibility for issuing payments to contracted pharmacies as reported by HPSM.

Prior authorization for the pharmacy benefit, as specified in the Benefit Plan, shall be conducted by HPSM. All potential denials shall be forwarded to HPSM for review by a Medical Director. Requests for non-formulary medications shall be forwarded to SMMC Pharmacy Director for review.

HPSM shall oversee the PBM's claims processing and supplier contracting processes to ensure quality of service delivery.

## APPENDIX 1-C
## PROVIDER SERVICES

HPSM shall be responsible for credentialing and executing contracts with Participating Providers, as designated by the Health System, to provide services to Eligible Participants under the ACE Program. Contracts shall utilize the rates described in Appendix D. Credentialing requirements will be waived if HPSM already has on file an up-to-date credentialing record. However, HPSM will re-credential the provider in accordance with the Participating Provider's existing credentialing schedule.

HPSM will also engage in standard provider services activities with Participating Providers, including maintaining a Claims department responsible for responding to inquiries related to claims processing, claims submission, and claims payment; maintaining a Member Services department responsible for responding to inquiries related to participant eligibility and PCP assignment; and a Health Services department responsible for responding to inquiries related to prior authorization for Covered Services. Departments will be available to respond to provider inquiries during regular business hours, from 8:00 a.m. to 5:00 p.m. Monday through Friday.

HPSM will also maintain a website and an interactive voice response (IVR) system 24 hours a day, 7 days a week, which providers can use to verify participants' eligibility.

Pharmacy inquiries will be directed to HPSM's pharmacy benefit manager.

## APPENDIX 1-D
## UTILIZATION AND MEDICAL MANAGEMENT

1. Referral Authorization. HPSM shall review and process requests for referral to hospital, specialty, and other service providers that are neither part of the San Mateo Medical Center hospital and clinic system nor the Ravenswood Family Health Center clinic system in accordance to guidelines used and approved by the Health System.

2. Prior Authorization Review. HPSM shall perform initial review of prior authorization requests for Covered Services as determined by the Benefit Plan. HPSM agrees that in performance of prior authorization requests, HPSM shall comply with the prior authorization policies and procedures, and guidelines used and approved by the Health System. HPSM shall make authorization decisions based on relevant documentation received.

3. Timeframes. HPSM shall make authorization decisions on all emergent and urgent authorizations within 24 hours of receipt of the information reasonably necessary to make a decision. HPSM shall make authorization decisions on all non-urgent authorizations within five (5) business days of receipt of the information reasonably necessary to make a decision.

4. Retroactive Authorizations. HPSM shall have a written process for reviewing retroactive authorizations for Covered Services and take action on all retroactive authorizations within thirty (30) calendar days of receipt of the information reasonably necessary to make a decision.

5. Concurrent Review. HPSM shall perform concurrent review of Eligible Participants admitted for inpatient stays approved as Covered Services and provided at an approved hospital location. Concurrent review shall be conducted to ensure that only medically necessary days are charged to the ACE Program and shall be conducted in accordance with guidelines used and approved by the Health System.

6. Notification of Decision. HPSM agrees that it shall notify the Eligible Participant, Participating Provider, and/or Referring Provider of the specific benefits that were denied, modified, or deferred, in writing, by mail. HPSM agrees that such notification to Eligible Participants shall be in English and Spanish.

7. Utilization Management and Quality Review Programs. HPSM shall cooperate with, participate in, and comply with the Health System's Utilization Management and Quality Review Programs, including any revisions and updates that may occur upon review.

8. Medical Management. HPSM shall provide medical management of Eligible Participants by ensuring that each Eligible Participant is assigned to a Primary Care Provider (PCP). Eligible Participants shall be informed of the identity of their PCPs via their Participant

Informing Materials. Eligible Participants may change their PCPs to another Participating Provider every month.

## APPENDIX 1-E
## COLLECTION OF PARTICIPANT FEE

HPSM will collect annual participation fees as follows:

1. HPSM will work in collaboration with the Health System staff and vendors (i.e. One-E-App) to identify the appropriate participation fee for each Eligible Participant.

2. Eligible Participants will be given the option of making payment in full upon enrollment or paying in installments throughout the year.

3. For Eligible Participants who do not pay in full, HPSM will send a monthly invoice indicating the unpaid balance of the Coverage Initiative/WELL participation fee.

HSPM will not be responsible for conducting any follow-up for participants who fail to make payments in a timely manner, nor for billing participants who are no longer eligible under the consolidated ACE Program. For such cases, HPSM will report outstanding balances to the San Mateo Medical Center's Patient Accounting Department for follow-up, or to another San Mateo County office as directed.

## APPENDIX 1-F
## CUSTOMER SERVICE

HPSM shall make available to Eligible Participants a toll-free customer service call center number that is open during usual business hours and provides customer telephone services, in accordance with standard business practices. HPSM will comply with the following in providing such services:

- Call center will operate during normal business hours, which include Monday through Thursday, 8:00 AM to 6:00 PM, and Friday, 9:30 AM to 6:00 PM;

- Eighty percent (80%) of all incoming customer calls will be answered within sixty (60) seconds;

- The abandonment rate of all incoming calls will not exceed five percent (5%).

- Call center staff will answer Eligible Member's questions on the benefit plan, including co-payments, annual fees, and Participating Providers;

- Call center staff itself, or through contracted services, will provide service to non-English speaking and hearing impaired beneficiaries.

HPSM will also designate specific individuals to serve as Program Specialists for the consolidated San Mateo ACE Program. These individuals or their designees will be responsible for attempting at least two welcome calls to new participants and following up on all inquiries and requests related to the ACE Program.

## APPENDIX 1-G
## GRIEVANCES AND APPEALS

HPSM shall process Eligible Participant complaints if an Eligible Participant or applicant is dissatisfied with his/her experience under the ACE Program. HPSM will accept complaints in writing, by phone, or through HPSM's website.

Complaints include both appeals and grievances, as follows:

- Appeals. Appeals are complaints related to HPSM or the Health System's decision to deny a benefit to the member to which he/she believes he/she is entitled. Appeals are generated in response to a denied request for authorization. HPSM differentiates between standard Appeals and expedited Appeals. HPSM processes an Appeal on an expedited basis when the standard timeframe for processing an appeal could seriously jeopardize the participant's life, health, or ability to regain maximum function.

- Grievances. Grievances are complaints related to any other aspect of HSPM or Coverage Initiative operations, excluding Appeals. Examples of grievances are complaints related to quality of care, access problems, or provider interactions.

HPSM acknowledges receipt of all Appeals or Grievances within 5 business days. Standard Appeals and Grievances shall be resolved within 30 calendar days from the date of receipt. Expedited Appeals shall be resolved within 72 hours from the time of receipt.

## APPENDIX 1-H
## QUALITY ASSESSMENT AND IMPROVEMENT

HPSM shall provide the following quality assessment and improvement services:

- HPSM shall collect information on HEDIS quality indicators related to adult preventive care and chronic disease care required by the Medi-Cal program.
- HSPM conducts several quality improvement projects related to prevalent chronic conditions. HPSM shall include Coverage Initiative Eligible Participants in these quality improvement projects, as deemed appropriate in accordance with selection criteria.
- HPSM shall review utilization trends to identify repeated hospital admissions and avoidable emergency room visits. HPSM shall work with Eligible Participants' PCPs to address patterns of overutilization.
- HPSM shall provide access for all Eligible Participants to HPSM's Nurse Advice Line.

The Health System acknowledges and agrees that it is the ultimate decision maker on quality assurance programs and that it agrees to the quality assurance services set forth herein.

## APPENDIX 1-I
## PARTICIPANT INFORMING MATERIALS

HPSM shall provide the following materials to Eligible Participants upon enrollment:

- Participant identification card
- Participant handbook, which provides information about covered benefits, participating providers, cost-sharing requirements, rights and responsibilities, grievance and appeals procedures, and more.
- Formulary

These materials, with the exception of the identification card, shall be provided in English and Spanish.

HPSM shall provide the same information continuously on its website, www.hpsm.org.

If substantive changes occur with respect to benefits, rights and responsibilities, or plan procedures, HPSM will notify members at least 30 days prior to implementation.

## APPENDIX 1-J
## REPORTING

HPSM shall supply such demographic, encounter, quality and cost data as the Health System may require to perform its disclosure, planning, reporting, administrative, supervisory, and other functions required under the Coverage Initiative Contract with the California Department of Health Care Services and under applicable State and Federal laws and regulations or as requested, which may include the following (contingent upon services to be performed by HPSM under this Addendum).

**Quarterly Reports:**

- Prior Authorization. HPSM will report quarterly information about the use of the prior authorization tool, including but not limited to: (i) the number of requests denied due to the need for prior authorization; (ii) the number of prior authorizations requested; (iii) the number of prior authorizations approved.

- Inpatient and outpatient utilization and cost reports. HPSM will report quarterly information about the use of services under the Coverage Initiative, including:

    - Inpatient Utilization
    - Outpatient Utilization
    - Pharmacy Utilization; and
    - Durable Medical Equipment Utilization.

- Grievances and Appeals. HPSM will report quarterly information about the receipt and processing of grievances and appeals, including but not limited to:

    - The number of grievances received;
    - The number of grievances resolved beyond 30 days;
    - The number of appeals received;
    - The number of appeals upheld;
    - The number of appeals overturned;
    - The number of appeals resolved beyond 30 days; and
    - Any quality of care concerns identified through grievances and appeals.

**Annual Reports:**

HPSM shall report annual utilization rates and provide other ad hoc reports as required by the Health System to conduct cost and quality analyses.

**EXHIBIT "B"**
**PAYMENT**

For the Third Party Administrative (TPA) services provided pursuant to the Agreement, the Health System shall pay HPSM $15.50 per participant per month. Participation shall be determined by the Eligible Participant count reflected in the One-E-App eligibility system with which the Health System contracts as of the 15th of each month. HPSM shall retrieve the participation count on the 15th of each month and submit an invoice (TPA Statement) to the Health System on the 16th of each month.

The Health System's total fiscal obligation for the TPA services provided by HPSM shall be based on the expected maximum number of Eligible Participants participating in the WELL/Coverage Initiative, or 15,000 Eligible Participants per month. As such, the Health System's total fiscal obligation for TPA services under this Agreement shall not exceed $2,790,000 per year or $8,370,000 over three years. Notwithstanding the foregoing, TPA services provided for the administration of the Coverage Initiative may be terminated immediately under this contract by the County if its participation in the Coverage Initiative is terminated; this Agreement shall continue to be in effect for non-Coverage Initiative program services through the remainder of the term of the Agreement. If there is a material change in the volume of Eligible Participants enrolled in the program of ten percent or greater below the expected enrollment of 11,500 participants, then HPSM reserves the right to renegotiate the per participant per month fee to accurately reflect its administration costs.

The Health System is fully responsible for the health care costs incurred under Agreement in so far as they are properly adjudicated and paid by HPSM in accordance with the Benefit Plan for services provided to Eligible Participants as identified on the Eligible Participants List. Payment for these health care costs shall be provided in accordance with Article 4 of this Agreement and shall be separate and distinct from the Health System's total fiscal obligation of $2,790,000 per year or $8,370,000 over three years, noted above. Costs for health care are estimated at $300 per member, per month for an annual total of $54,000,000 or $162,000,000 for the term of the contract.

Total costs for this contract payable by the County shall not exceed $179,370,000 during the term of the Agreement.

## EXHIBIT "C"
## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
## BUSINESS ASSOCIATE REQUIREMENTS

### Definitions

Terms used, but not otherwise defined, in this Schedule shall have the same meaning as those terms are defined in 45 Code of Federal Regulations section 160.103 164.304 and 164.501. (All regulatory references in this Schedule are to Title 45 of the Code of Federal Regulations unless otherwise specified.)

a. *Designated Record Set.* "Designated Record Set" shall have the same meaning as the term "designated record set" in Section 164.501.
b. *Electronic Protected Health Information.* "Electronic Protected Health Information" ("EPHI") means individually identifiable health information that is transmitted or maintained in electronic media, limited to the information created, received, maintained or transmitted by Business Associate from or on behalf of Covered Entity.
c. *Individual.* "Individual" shall have the same meaning as the term "individual" in Section 164.501 and shall include a person who qualifies as a personal representative in accordance with Section 164.502(g).
d. *Privacy Rule.* "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Part 160 and Part 164, Subparts A and E.
e. *Protected Health Information.* "Protected Health Information" shall have the same meaning as the term "protected health information" in Section 164.501 and is limited to the information created or received by HPSM from or on behalf of the Health System.
f. *Required By Law.* "Required by law" shall have the same meaning as the term "required by law" in Section 164.501.
g. *Secretary.* "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his or her designee.
h. *Security Incident.* "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system, but does not include minor incidents that occur on a daily basis, such as scans, "pings", or unsuccessful random attempts to penetrate computer networks or servers maintained by Business Associate
i. *Security Rule.* "Security Rule" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subparts A and C.

### Obligations and Activities of HPSM

a. HPSM agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as required by law.
b. HPSM agrees to use appropriate safeguards to prevent the use or disclosure of the Protected Health Information other than as provided for by this Agreement.
c. HPSM agrees to mitigate, to the extent practicable, any harmful effect that is known to HPSM of a use or disclosure of Protected Health Information by HPSM in violation of the requirements of this Agreement.
d. HPSM agrees to report to the Health System any use or disclosure of the Protected Health Information not provided for by this Agreement.
e. HPSM agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by HPSM on behalf of the Health System, agrees to the same restrictions and conditions that apply through this Agreement to HPSM with respect to such information.
f. If HPSM has protected health information in a designated record set, HPSM agrees to provide access, at the request of the Health System, and in the time and manner designated by the Health System, to Protected Health Information in a Designated Record Set, to the Health System or, as directed by the Health System, to an Individual in order to meet the requirements under Section 164.524.
g. If HPSM has protected health information in a designated record set, HPSM agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Health System directs or agrees to make pursuant to Section 164.526 at the request of the Health System or an Individual, and in the time and manner designed by the Health System.
h. HPSM agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by HPSM on behalf of, the Health System available to the Health System, or at the request of the Health System to the Secretary, in a time and manner designated by the Health System or the Secretary, for purposes of the Secretary determining the Health System's compliance with the Privacy Rule.
i. HPSM agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for the Health System to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.
j. HPSM agrees to provide to the Health System or an Individual in the time and manner designated by the Health System, information collected in accordance with Section (i) of this Schedule, to permit the Health System to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.
k. HPSM shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that HPSM creates, receives, maintains, or transmits on behalf of the Health System.
l. HPSM shall conform to generally accepted system security principles and the requirements of the final HIPAA rule pertaining to the security of health information.

m. HPSM shall ensure that any agent to whom it provides EPHI, including a subcontractor, agrees to implement reasonable and appropriate safeguards to protect such EPHI.
n. HPSM shall report to the Health System any Security Incident within 5 business days of becoming aware of such incident.
o. HPSM shall makes its policies, procedures, and documentation relating to the security and privacy of protected health information, including EPHI, available to the Secretary of the U.S. Department of Health and Human Services and, at the Health System's request, to the Health System for purposes of the Secretary determining the Health System's compliance with the HIPAA privacy and security regulations.

**Permitted Uses and Disclosures by HPSM**

Except as otherwise limited in this Schedule, HPSM may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the Health System as specified in the Agreement; provided that such use or disclosure would not violate the Privacy Rule if done by the Health System.

**Obligations of the Health System**

a. The Health System shall provide HPSM with the notice of privacy practices that the Health System produces in accordance with Section 164.520, as well as any changes to such notice.
b. The Health System shall provide HPSM with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect HPSM's permitted or required uses and disclosures.
c. The Health System shall notify HPSM of any restriction to the use or disclosure of Protected Health Information that the Health System has agreed to in accordance with Section 164.522.

Permissible Requests by the Health System

The Health System shall not request HPSM to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by the Health System, unless the HPSM will use or disclose Protected Health Information for, and if the Agreement provides for, data aggregation or management and administrative activities of HPSM.

Duties Upon Termination of Agreement

Upon termination of the Agreement, for any reason, HPSM shall return or destroy all Protected Health Information received from the Health System, or created or received by HPSM on behalf of the Health System. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of HPSM. HPSM shall retain no copies of the Protected Health Information.

In the event that HPSM determines that returning or destroying Protected Health Information is infeasible, HPSM shall provide to the Health System notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, HPSM shall extend the protections of the Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as HPSM maintains such Protection Health Information.

**Miscellaneous**

a. *Regulatory References.* A reference in this Schedule to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required.
b. *Amendment.* The Parties agree to take such action as is necessary to amend this Schedule from time to time as is necessary for the Health System to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.
c. *Survival.* The respective rights and obligations of HPSM under this Schedule shall survive the termination of the Agreement.
d. *Interpretation.* Any ambiguity in this Schedule shall be resolved in favor of a meaning that permits the Health System to comply with the Privacy Rule.
e. *Reservation of Right to Monitor Activities.* The Health System reserves the right to monitor the security policies and procedures of HPSM

| HPSM's Signature | Date | HPSM's Name (Please Print) |
|---|---|---|

## EXHIBIT "D"
## COSTS FOR COVERED SERVICES

HPSM shall adjudicate and pay claims payable to Participating Providers for Covered Services provided to Eligible Participants under the benefits plan for the ACE Program as directed by the Health System and described as follows:

**Primary Care Providers**

HPSM shall adjudicate and pay Primary Care Providers on a fee-for-service basis in accordance with 100% of the Medicare Fee Schedule. Primary Care Providers shall only include those clinics associated with the San Mateo Medical Center and Ravenswood Family Health Center.

**Hospital Providers**

HPSM shall adjudicate and pay Hospital Providers in accordance with HPSM's hospital payment rates under its Medi-Cal line of business. Payments to SMMC for hospital services shall reflect the same Medi-Cal rates that are paid to all other San Mateo County hospitals.

**Specialty Providers and Other Services Providers**

HPSM shall adjudicate and pay contracted Specialty Providers and Other Service Providers on a fee-for-service basis in accordance with HPSM's payment schedule to Medi-Cal Specialty Providers and Other Service Providers, respectively.

**Pharmacy Providers**

For all eligible pharmacies, HPSM shall not make any payment for any prescription drugs provided by the pharmacies to Eligible Participants, except for prescription drugs dispensed by approved pharmacies in Half Moon Bay ("Half Moon Bay pharmacies"). For prescription drugs dispensed at all pharmacies except the Half Moon Bay pharmacies, HPSM shall only collect utilization data in the form of a processed claim. For these claims, payment shall be set at $0 for each pharmacy claim. HPSM shall track pharmacy costs by matching utilization data against 340b pricing lists provided to HPSM by SMMC. For prescription drugs dispensed at the Half Moon Bay pharmacies, HPSM shall make payment in accordance with drug costs and fill fees negotiated with its pharmaceutical benefits manager. Such payment shall be drawn from the Health Care Cost Reserve and included on the Monthly Statement for Payment of Health Care Costs.

For Covered Services provided by non-Participating Providers who are approved by HPSM, HPSM shall adjudicate and pay claims at 100% of the Medi-Cal fee schedule applicable on the date of service.