THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
ACTION AGENDA SUMMARY

DEPT: HEALTH SERVICES AGENCY

Urgent_____ Routine X

CEO Concurs with Recommendation YES X NO____
(Information Attached)

BOARD AGENDA # *B-8

AGENDA DATE October 2, 2001

4/5 Vote Required YES____ NO____

SUBJECT: APPROVAL OF THE PERMANENTE MEDICAL GROUP INC. PROFESSIONAL SERVICES AGREEMENT TO PROVIDE PRIMARY AND SPECIALTY CARE SERVICES.

STAFF RECOMMENDATIONS:

1. APPROVAL OF THE PERMANENTE MEDICAL GROUP INC. PROFESSIONAL SERVICES AGREEMENT TO PROVIDE PRIMARY AND SPECIALTY CARE SERVICES.

2. AUTHORIZE THE HEALTH SERVICES MANAGING DIRECTOR OR HER DESIGNEE TO SIGN AND EXECUTE THE AGREEMENT.

FISCAL IMPACT: Acceptance of this agreement will increase the Health Services Agency reimbursement revenue for Primary Care Services by 3% and allow a new source of revenue for the Urgent Care Center. The 3% increase is estimated to result in a revenue increase of approximately $16,200 in the first year, $36,000 in the second and $60,500 in the third year. Additional volume through the Urgent Care site is estimated to result in an annual revenue increase of approximately $156,000.

BOARD ACTION

No. 2001-749

On motion of Supervisor Simon , **Seconded by Supervisor** Blom
and approved by the following vote,
Ayes: Supervisors: Mayfield, Blom, Simon, Caruso, and Chair Paul
Noes: Supervisors: None
Excused or Absent: Supervisors: None
Abstaining: Supervisor: None

1) X **Approved as recommended**
2) _____ **Denied**
3) _____ **Approved as amended**
MOTION:

Christine Ferraro

ATTEST: CHRISTINE FERRARO TALLMAN, Clerk **By: Deputy**

File No.

1010-08 L

DISCUSSION: The Health Services Agency entered into an agreement with The Permanente Medical Group to provide primary care services in September of 1998. Since then, Kaiser has enjoyed the strong enrollment growth. Presently the Kaiser relationship with the County accounts for more than half of the Health Services Agency's commercial business.

Since the original agreement was executed for primary care services, additional agreements were entered to expand the relationship to include Oncology services and stat lab services. Last year an amendment was executed for each of the existing agreements for the purpose of adding the language required by the Balanced Budget Act of 1997.

The proposed agreement, which would replace each of the existing agreements, primarily modifies the existing relationship in the following ways:

1. Annually increases the capitated reimbursement rates for primary care services by 3%.
2. Adds the Urgent Care Center as an approved site for all Kaiser members (patients) needing urgent care services. Currently, Kaiser members who cannot be accommodated by their selected Primary care clinic must use Kaiser's contracted hospital's prompt care (Memorial).
3. Replaces the separate agreements and amended language currently in existence with one global agreement.

The term of the proposed agreement is three years, with options to renew annually thereafter.

POLICY ISSUES: This agreement promotes the Board of Supervisors' goal of ensuring a safe, healthy community and efficient government operations.

STAFFING IMPACTS: There are no related staffing impacts.

Stanislaus County
Health Services Agency

memorandum

Date: January 11, 2002

To: Suzi Seibert

From: Mary Ann Lee

Re: Contract Document for Board of Supervisors File

2002 JAN 14 P 2:45

BOARD OF SUPERVISORS

Please find the attached contract with the Permanente Medical Group (Kaiser). This agreement corresponds to Board Agenda item B-8 on October 2, 2001. A copy of the Action Agenda Summary has been enclosed for reference.

A copy will also be maintained in the Managed Care department and Finance department files at the Health Services Agency.

Please call me if you have any questions or need further information at 558-7249.

PROFESSIONAL SERVICES AGREEMENT

BETWEEN

THE PERMANENTE MEDICAL GROUP, INC.

AND

STANISLAUS COUNTY HEALTH SERVICES AGENCY

FOR

PRIMARY CAREAND SPECIALIST SERVICES

CONTENTS OF AGREEMENT

This Professional Services Agreement ("Agreement") is entered into and is effective as of this first day of April, 2001 ("Effective Date") between The Permanente Medical Group, Inc., a California professional medical corporation ("TPMG"), and Stanislaus County Health Services Agency ("Contractor").

RECITALS

A. Kaiser Foundation Health Plan, Inc., a California nonprofit public benefit corporation ("Health Plan") operates health care benefit plans and provides or arranges for the provision of medically necessary health care services to Members as defined herein.
B. Health Plan has entered into an agreement with Kaiser Foundation Hospitals, a California nonprofit public benefit corporation ("KFH"), under which KFH agrees to provide or arrange for certain medically necessary hospital services for Members.
C. Health Plan has entered into an agreement with TPMG under which TPMG agrees to provide or arrange for certain medically necessary professional and other inpatient and outpatient services for Members.
D. TPMG desires to arrange for the provision of certain professional services to Members by contracting with providers, such as Contractor. Contractor desires to provide Services (as defined below) to Members in accord with the terms of this Agreement.

AGREEMENTS

NOW THEREFORE, the parties agree as follows:

ARTICLE I
DEFINITIONS

1.1 AGREEMENT means this Professional Services Agreement and any amendments, exhibits and attachments hereto.

1.2 APPROVED EMERGENCY CLAIM has the meaning ascribed to that term in Section 2.8.

1.3 AUTHORIZATION means either the procedure for obtaining prior written approval of KP for the provision of Covered Non-emergency Services as set forth in Section 2.9, or the document indicating such prior written approval, as the context requires. Authorization shall be documented on a KP-approved Authorization Form.

1.4 AUTHORIZED SERVICES means those Covered Benefits for which Authorization has been obtained or for which no Authorization is required.

1.5 COPAYMENTS are amounts payable by the Member pursuant to the Member's Membership Agreement that are charged by Health Plan to the Member or collected from the Member by Contractor if Contractor is directed to do so pursuant to Section 3.5(b)(i) of this Agreement.

1.6 COVERED BENEFITS are health care services and benefits that the Member is entitled to receive, provided by and through Health Plan, under its commercial, Medicare+Choice, Medi-Cal managed care, and other plans, and employers' self-funded plans, as set forth in the applicable Membership Agreement.

1.7 COVERED SERVICES are those Services rendered by Contractor to Members that are (a) Covered Benefits, and are (b) Authorized Services or Approved Emergency Claims as described in Section 2.8, below.

1.8 DAYS. Any reference to "days" in this Agreement shall mean calendar days, unless otherwise noted.

1.9 DHS means the California Department of Health Services.

1.10 EMERGENCY SERVICES are those Covered Services necessary to evaluate and stabilize an emergency medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (a) serious jeopardy to the Member's health or, in the case of a pregnant woman the health of the woman or her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Coverage for Emergency Services is subject to the notification and approval requirements, as set forth in Section 2.8, and the applicable Membership Agreement.

1.11 GOVERNMENT OFFICIALS has the meaning ascribed to that term in Section 5.4 of this Agreement.

1.12 HCFA means the Department of Health and Human Services, Health Care Financing Administration.

1.13 JCAHO means the Joint Commission on Accreditation of Healthcare Organizations.

1.14 KNOX KEENE ACT refers to the California Knox-Keene Health Care Service Plan Act of 1975 (California Health and Safety Code Section 1340, *et seq.*), including all its amendments and successor provisions.

1.15 KP means Health Plan, KFH, and TPMG, or any two or one of them.

1.16 MEMBER refers to a covered individual and his or her eligible family dependents entitled to health care services under a Membership Agreement or other arrangement with Health Plan or its Affiliated Payors as defined in Exhibit 1.3. Members include the following categories:

(a) "Medicare+Choice Members" are Members enrolled under a Medicare+Choice contract between Health Plan and HCFA.

(b) "Regular Medicare Members" are Members entitled to coverage under Part A only or Part B only or Parts A and B of Medicare but (i) not enrolled under a Medicare+Choice contract between Health Plan and HCFA and (ii) not required to elect or have not elected their employer's group health plan as primary coverage.

(c) "Medi-Cal Members" are Members enrolled in Health Plan under a prepaid Medi-Cal program contract between Health Plan and the State of California or between Health Plan and an organization under contract to the State of California (together "Health Plan Medi-Cal Contracts").

(d) "Commercial Members" are Members who are not Medicare+Choice, Regular Medicare or Medi-Cal Members.

1.17 MEMBERSHIP AGREEMENT refers to the Health Plan Medical and Hospital Service Agreement, as amended from time to time, under which Members are entitled to receive services. Membership Agreement also refers to other agreements under which Health Plan has agreed to provide or arrange health care services to Members, including, but not limited to employer self-insured plan arrangements, Workers' Compensation programs, and Health Plan Medi-Cal Contracts. Membership Agreement includes the Evidence of Coverage issued to a Member, as amended from time to time.

1.18 NCQA means the National Committee for Quality Assurance.

1.19 NON-EMERGENCY SERVICES are Covered Services that are not Emergency Services.

1.20 PARTICIPATING PRACTITIONER refers to those professional health care practitioners (including allied health professionals such as physician assistants and nurse practitioners) who, by way of ownership of, employment by, or contracts with Contractor may be providing Covered Services to Members pursuant to this Agreement.

1.21 PEER REVIEW BODY means any such body as defined in California Business and Professions Code Section 805(a)(1) and its successor provisions.

1.22 REQUIRED MODIFICATION has the meaning ascribed to that term in Section 9.8 of this Agreement.

1.23 SERVICES refers to those professional services and supplies, of the type described in Exhibit 1.2, that Contractor or its Participating Practitioners are licensed, as applicable, to provide and do customarily provide in all applicable treatment settings, including all consults, studies and procedures that are ordinary and necessary for the diagnosis and treatment of its patients. Services also include all administrative services provided by Contractor pursuant to this Agreement. Exhibit 1.2 may be amended by the parties in accordance with Section 9.8 from time to time to reflect changes in Services to be provided under this Agreement.

1.24 SUBCONTRACT means an agreement between Contractor and Subcontractor(s) or a written agreement between two or more Subcontractors for provision of Services to Members under this Agreement.

1.25 SUBCONTRACTOR means a participating practitioner, participating practitioner group or any other entity who provides or arranges for Services to Members pursuant to a direct or indirect contract, agreement or other arrangement with Contractor.

1.26 TPMG PHYSICIAN means any duly licensed physician employee or shareholder of The Permanente Medical Group, Inc.

ARTICLE II
CONTRACTOR'S OBLIGATIONS

2.1 REPRESENTATIONS AND WARRANTIES OF CONTRACTOR.

(a) Contractor represents and warrants that the terms of this Agreement do not conflict with the terms of its agreements with Contractor's Participating Practitioners. Nonetheless, Contractor represents that the terms of this Agreement shall apply in any situation where there is an inconsistency or conflict with the terms of any agreement between the Participating Practitioner and Contractor, and that Contractor shall be responsible to TPMG for any such inconsistency or conflict of terms. This provision shall supersede any similar provision in any agreement between Contractor and a Participating Practitioner.

(b) Contractor represents and warrants that it has, or will have prior to the provision of any Services hereunder, the ability to provide the Services contemplated by this Agreement, either directly or through its Participating Practitioners, in the manner and at the times contemplated herein. In those circumstances where Contractor is providing any or all Services through Participating Practitioners, references to responsibilities and obligations of "Contractor" in this Agreement shall be interpreted to apply to Participating Practitioners as appropriate under the circumstances.

(c) Contractor represents and warrants that where it is paid directly by KP or its affiliated payors for Covered Services which have been subcontracted, Contractor will pay Subcontractor within forty-five (45) working days of receipt of a properly submitted and undisputed invoice, or within such other time frame as may be required by law of Health Plan under similar circumstances. Contractor further represents and warrants that should Contractor pay Subcontractor beyond the forty-five (45) working days, Contractor will automatically include interest with all late payments at the same interest rate which is required of by law of Health Plan under similar circumstances. Contractor represents and warrants that should Contractor fail to automatically include interest on late payments to Subcontractor, it will include such additional penalty, if any, which is required by law of Health Plan under similar circumstances.

(d) Contractor represents and warrants that it will create a forum that will permit its Subcontractors, direct and indirect, to resolve all invoice payment disputes in a fast, fair and cost effective manner.

(e) Contractor represents and warrants that it will submit reports for direct and indirect Subcontractors indicating the timeliness of payments made by Contractor or Subcontractor for Covered Services, any interest or late payment penalties paid, and any invoice payment disputes initiated and resolved, as requested by KP, and which is reasonably necessary for Health Plan to comply with the reporting requirements imposed upon it by law or otherwise to comply with requirements of governmental regulators or accreditation organizations.

(f) Contractor represents and warrants that it will comply with Sections 2.1, subsections (c), (d), (e), and Section 2.3 (h) and further represents that if Contractor or any of Contractor's Subcontractors fails to fulfill such obligations as are described therein, resulting in a penalty or assessment against Health Plan by any regulatory body, TPMG may offset an amount equal to such penalty or assessment against any future payment to Contractor.

2.2 SERVICES TO BE PROVIDED.

(a) Contractor shall provide or arrange for the provision of Authorized Services and Emergency Services to Members. (When required by Exhibit 1.2, Contractor shall be available to provide or arrange for Emergency Services twenty-four (24) hours per day, seven (7) days per week.)

(b) Contractor) must be credentialed as set forth in Section 7.3 before providing Covered Services to Members.

(c) Contractor shall be available to provide to Members prompt urgent Services that are Authorized, on a same-day basis.

(d) If current medically acceptable diagnostic laboratory or x-ray results are provided by TPMG to Contractor in connection with Contractor's rendering of Covered Services, Contractor shall not duplicate such diagnostic laboratory or x-ray procedures.

(e) Contractor shall make Services available to all classes of Members, including Medicare+Choice Members, in the same manner, in accordance with the same standards, and with the same availability, as to Contractor's other patients.

(f) Contractor shall ensure that Services provided under this Agreement are readily available and accessible, provided in a prompt and efficient manner without delays in terms of wait times or scheduling of appointments, and consistent with professionally recognized standards of practice and any applicable KP policies, procedures or guidelines.

(g) Contractor shall ensure that all information about treatment options, including the option of no treatment, is provided to Members in a culturally competent manner. Contractor shall ensure that Members with disabilities are able to communicate effectively with Contractor in making decisions regarding treatment options.

(h) Contractor shall prescribe drugs and medications in accord with applicable state and federal law and any applicable KP policies, procedures or guidelines.

(i) To the extent Contractor provides Services in any KP entity accredited by JCAHO, Contractor agrees to provide such Services in accordance with applicable JCAHO standards.

(j) For each Member who is a Medicare+Choice Member for whom Contractor has primary responsibility for the coordination of the Member's care, Contractor shall:

(i) Comply with KP's program for making an initial assessment of each Member's health care needs and for coordinating care. Based on such assessment and to the extent necessary as part of Contractor's scope of Services, Contractor shall establish a treatment plan that identifies any complex or serious medical conditions; provides for assessment and monitoring of those conditions; and allows for the implementation of a treatment for those conditions, including recommendations about medically necessary and appropriate care from specialists, including an adequate number of direct access visits. Each treatment plan must provide for consideration of the Member's input, be time-specific and updated periodically.

(ii) For each woman Member, upon request of such woman Member, provide direct access to a women's health specialist for routine and preventive health services provided as basic Covered Benefits and to mammography screening.

(iii) Provide direct access to influenza and pneumococcal vaccines. Members shall not be required to pay for these vaccines.

(k) In the event of any termination of the contract between HCFA and Health Plan, Contractor shall continue to provide Covered Services to any Medicare+Choice Member who is hospitalized at the time of such termination through the period for which premiums were paid. In the event of the insolvency of or cessation of operations by KP, Contractor shall continue to provide such Services to any Medicare+Choice Member confined to a facility until such Medicare+Choice Member's discharge. This provision shall survive the termination of this Agreement, regardless of the reason for termination, including the insolvency of KP, and shall supersede any oral or written agreement between Contractor and such Medicare+Choice Member.

(l) Where any Services are to be provided by Participating Practitioners, Contractor shall ensure that such Participating Practitioners comply with all applicable provisions of this Agreement including, without limitation, this Section 2.2 and all applicable obligations described in Section 2.3, below.

(m) Contractor shall refer the Member to providers approved by KP including but not limited to TPMG's own providers and KFH facilities.

2.3 CONTRACTOR-PRACTITIONER CONTRACTS. Prior to providing Services to Members, Contractor agrees to enter into such written Subcontracts with health care professionals pursuant to which such health care professionals shall serve as Participating Practitioners, as may be necessary to fulfill Contractor's obligations to provide or arrange for the provision of Covered Services under this Agreement. Each Subcontract shall meet the requirements set forth in this Section 2.3.

(a) Each Subcontract shall require that the Participating Practitioner shall comply with all applicable obligations of this Agreement as amended, including but not limited to those provisions relating to:

(i) Acceptance of Members upon referral from a TPMG physician, or such other entity to which TPMG delegates such authority, or upon the Member's self-referral in accordance with KP policies or as required by law.

(ii) If a Participating Practitioner has primary responsibility for coordination of a Medicare+Choice Member's care, Participating Practitioner's obligations relating to initial assessment and treatment plans, access to women's health specialists, and access to specified vaccines.

(iii) Advance Directives.

(iv) Access to Services.

(v) Accountability and delegation.

(vi) Continuation of services.

(vii) Termination.

(viii) Notice and hearing rights upon suspension or termination of this Agreement.

(ix) Participating Practitioner credentialing and selection.

(x) Any provider manual.

(xi) Compliance with laws.

(xii) Acceptance of payment from Contractor or such other entity as designated in Section 3.5(b) of this Agreement or Exhibit 2 for Covered Services as payment in full, and the requirements that Participating Practitioners may not bill (a) Members (except for authorized Copayments); or (b) Health Plan or its Affiliated Payors, KFH or TPMG, if TPMG has previously paid Contractor for such Covered Services.

(xiii) Compliance with KP Authorization requirements and any other applicable KP policies, procedures or guidelines.

(xiv) Compliance with the professional liability insurance requirements set forth in Section 6.1 of this Agreement.

(xv) Compliance with all state and federal requirements regarding submission of reports and retention of and access to records, including but not limited to the requirements set forth in Article V of this Agreement.

(xvi) Participation in and cooperation and compliance with all decisions rendered in connection with KP's utilization management and quality assurance programs, including those described in Exhibit 3.

(xvii) Provision of Covered Services to Members after termination of this Agreement, or in case of Contractor's insolvency, in accordance with the provisions of this Agreement and the provisions of Contractor's agreement with the Participating Practitioner, until TPMG has arranged for an alternative provider of Covered Services for Members undergoing medical treatment.

(xviii) Compliance with the dispute resolution, arbitration and complaint provisions (with respect to KP and Members) set forth in Article VIII.

(xix) Compliance with the confidentiality provisions set forth in Section 5.7 of the Agreement.

(xx) Compliance with the non-discrimination provisions of Section 7.2, below.

(xxi) Application of the termination provisions of Article IV.

(b) Each Subcontract shall require that each Participating Practitioner shall provide adequate personnel and facilities in order to perform the duties and responsibilities of this Agreement.

(c) Each Subcontract shall require that each Participating Practitioner or subcontracting medical group providing Services to Members shall comply with all applicable laws, rules, requirements and standards for the delivery of care and any applicable KP policies, procedures or guidelines.

(d) Each Subcontract shall require that each Participating Practitioner cooperate with and comply with all decisions rendered in connection with KP's credentialing, peer review, utilization review and quality assurance programs.

(e) To the extent that Contractor has financial responsibility for payment to Participating Practitioners who render Emergency Services or urgent care services to Medicare+Choice Members, each Subcontract shall require Contractor to comply with all the provisions for prompt payment and interest payments as required by HCFA and this Agreement.

(f) Each Subcontract shall include termination provisions that are adequate to meet the notice requirements of Section 2.7(a), below.

(g) To the extent that Contractor permits any Participating Practitioner to further subcontract with any professional health care practitioners for the provision of Services under this Agreement, each Subcontract shall require the Participating Practitioner to incorporate the requirements of this Agreement into its subcontracts.

(h) Each Subcontract shall contain language warranting that payments will be paid within forty-five (45) working days of receipt of a properly submitted and undisputed invoice, or within such other time frame as may be required pursuant to Contractor's Agreement with TPMG.

(i) Each Subcontract shall contain language which warrants that any payment which is not paid in accordance with Section 2.3(h) shall automatically include interest at the same rate as TPMG is required to pay Contractor as set forth in section 3.2(c).

(ii) Each Subcontract shall contain language which warrants that any interest payment which is not paid in accordance with Section 2.3(h)(i) shall include such additional penalty, if any, as TPMG is required to pay to Contractor as set forth in section 3.2(c).

(iii) Each Subcontract shall require language describing a fast, fair and cost effective mechanism by which Subcontractors, either direct or indirect, may resolve any disputes related to invoice payment by Contractor for Covered Services.

(iv) Each Subcontract shall require that should Subcontractor further subcontract its duties to perform Covered Services, each of Subcontractor's contracts with its subcontractors must include all of the requirements in Section 2.3(h) and its subsections, as well as the reporting requirements of Section 2.1(e).

(i) Each Subcontract shall require Participating Practitioners and any other Subcontractor to comply with all applicable requirements of the PIP Rules (as that term is defined in Section 2.4(a) of this Agreement).

Within ten (10) days of TPMG's request, Contractor's forms of contract with Participating Practitioners, along with executed signature pages to each such contract, shall be provided to TPMG and to such Government Officials and accreditation surveyors as TPMG may request. Contractor shall notify TPMG within thirty (30) days whenever Contractor alters or amends its contracts with Participating Practitioners.

2.4 PHYSICIAN INCENTIVE PLAN DISCLOSURE AND COMPLIANCE.

(a) Representations. Contractor hereby affirmatively represents that Contractor complies, and during the term of this Agreement shall comply, with the applicable requirements of 42 CFR 422.208 and 422.210 or successor regulations (the "PIP Rules"), including physician incentive plan disclosure and maintenance of stoploss protection, and shall comply with information requests and audits by KP and HCFA regarding compliance with the PIP Rules. Contractor further affirmatively represents that, during the term of this Agreement, Contractor's contracts with Subcontractors shall require Subcontractors to comply with such PIP Rules, information requests and audits of Contractor and Subcontractors.

(b) Disclosure and Compliance. Upon request, Contractor shall obtain and disclose to KP and HCFA the terms of the payment arrangements between Contractor and any Subcontractors, as well as between a Subcontractor and its Subcontractors, and shall provide evidence of compliance with applicable requirements of the PIP Rules, such as stoploss protection. For example, if Contractor contracts with a physician group, Contractor shall obtain and disclose the terms of the payment arrangement between Contractor and the physician group, as well as the terms of the payment arrangement between the physician group and its individual physicians providing services to Members, and shall provide evidence of compliance with any applicable stoploss protection requirements under the PIP Rules. Contractor shall obtain and provide such information in a format specified by or acceptable to such requesting entity, and shall include all information required under the PIP Rules.

2.5 SUBSTITUTE PRACTITIONERS.

(a) Contractor will arrange for coverage by one or more appropriately credentialed substitute practitioners when Contractor is temporarily unavailable as required to cover Contractor's responsibilities under this Agreement. Such substitute practitioners shall have complied with all provisions of Section 7.3 of this Agreement prior to providing Services to Members. Substitute Services will be rendered in strict compliance with the terms of this Agreement. TPMG will render payment to Contractor for such substitute Covered Services in accord with Article III and Exhibit 2, attached hereto. Procurement of and payment to any substitute practitioner is Contractor's sole responsibility.

(b) If Contractor arranges for the provision of some Services from any substitute practitioner, Contractor shall enter into written arrangements with such substitute practitioners. Such written arrangements shall comply with the requirements of Section 2.3. Upon termination of this Agreement, such written arrangements shall terminate with respect to Covered Services provided to Members. Upon request, Contractor shall make such written agreements available to DHS, Medi-Cal plans with which Health Plan contracts for the provision of services to Medi-Cal Members ("Medi-Cal Plans"), other entities where required by law or by contract, and KP, for review and approval.

2.6 PARTICIPATING PRACTITIONER ROSTER.

(a) At least annually, Contractor shall provide TPMG with a roster of the names, specialties, office hours, practice locations, federal tax identification numbers, state health care practitioner license numbers (if applicable), Drug Enforcement Agency registration numbers (if applicable), Medicare certification numbers, Medi-Cal provider number, professional practice names, and the business hours of all Participating Practitioners in a format acceptable to TPMG. The professional practice name registered to each federal tax identification number shall be included.

(b) Contractor warrants that Participating Practitioners will provide Covered Services at the location(s) set forth in the roster and/or at other locations at which Contractor and its Participating Practitioners provide services to their other patients as well as at KP locations as appropriate for the scope of Services contemplated by this Agreement.

(c) At such frequency as TPMG may request, Contractor shall notify TPMG of any additions, changes or deletions to the Participating Practitioner roster. Any notices of termination of any Participating Practitioner shall be provided to TPMG within three (3) business days of Contractor's receipt of any such notice or within such other longer timeframe as TPMG may require or authorize. Contractor shall include in each such notice to TPMG its specific recommendations regarding the reassignment of any Member receiving Services from such terminated Participating Practitioner to a geographically accessible and medically appropriate Participating Practitioner. Nothing herein shall prohibit or restrict Contractor from seeking to include additional providers of health care as Participating Practitioners under this Agreement, but TPMG reserves the right to decline to have any Participating Practitioner provide Services to Members pursuant to this Agreement.

2.7 TERMINATION OF CONTRACTOR-PARTICIPATING PRACTITIONER AGREEMENTS.

(a) Contractor shall notify TPMG in writing at least 60 days prior to the effective date of any action by Contractor to terminate a Participating Practitioner's Subcontract, provided, however, that in the event that Contractor terminates Participating Practitioner's Subcontract due to any determination that such Participating Practitioner constitutes an immediate threat to the life or health of the Members, Contractor shall notify TPMG as soon as practicable after such termination. Contractor shall immediately notify TPMG whenever a Participating Practitioner fails to renew his or her agreement with Contractor, whenever Contractor has reason to believe a Participating Practitioner will fail to renew his or her agreement with Contractor, and whenever Contractor knows of an occurrence giving rise to an immediate termination of a Participating Practitioner under Section 2.7(b) of this Agreement.

(b) Contractor shall terminate the provision of Services under this Agreement by any Participating Practitioner immediately upon the earlier of the request of TPMG, or upon receipt of actual notice of:

(i) Participating Practitioner's failure to comply with KP's quality assurance program and/or KP's credentialing criteria;

(ii) any misrepresentation or fraud by a Participating Practitioner in the credentialing process;

(iii) any action by a Participating Practitioner which constitutes conduct that falls below the standard of care;

(iv) a Participating Practitioner's failure to maintain professional liability insurance in accordance with Section 6.1 of this Agreement;

(v) a Participating Practitioner's loss, suspension or restriction of his or her license to practice medicine or other applicable profession, narcotic registration certificate issued by the Drug Enforcement Agency, certification to participate in Medicare or Medicaid, or loss, restriction or reduction of clinical privileges or employment by a Peer Review Body based upon medical disciplinary cause or reason as defined in California Business and Professions Code Section 805(a)(6), and its successor provisions; or

(vi) termination of this Agreement, subject to the obligations of Section 2.2(k), above.

2.8 APPROVAL OF EMERGENCY SERVICES CLAIMS. Subject to applicable law, Contractor shall notify KP of any Emergency Services provided to a Member immediately upon stabilization of the Member's emergency medical condition. KP shall review Emergency Services claims. If approved, such claim shall be deemed an "Approved Emergency Claim." Compensation for Emergency Services provided to Members is payable to Contractor only if the Emergency Services are determined by KP to be Covered Benefits and there is an Approved Emergency Claim.

2.9 PRIOR AUTHORIZATION OF NON-EMERGENCY SERVICES.

(a) In accordance with KP policies and procedures, Contractor shall obtain Authorization prior to the provision of Non-emergency Services to a Member (except for those Covered Benefits for which no Authorization is required). The process for identification of those Covered Benefits for which no Authorization is required is delineated in KP's Provider Manual. Contractor shall be responsible for verifying whether Authorization is required prior to providing Non-emergency Services.

(b) The Authorization shall be based upon a referral by a TPMG physician or a contracted Stanislaus provider and the Authorization Form shall be signed by a TPMG Physician, or designee. The Authorization Form shall outline the scope of Covered Services to be provided. Any Services, including tests, procedures, and consulting services, not specifically described in the scope of Services on the Authorization, must be approved in advance by a TPMG Physician, or designee. Compensation for Non-emergency Services provided to Members is payable to Contractor only if such Services are Authorized Services.

(c) An Authorization may be terminated prior to its expiration date by KP on prior written notice to Contractor. Notwithstanding Section 9.10 (Notices), such notice may be provided in the manner in which the Authorization was originally sent. Compensation for Non-emergency Services provided to Members is payable to Contractor only if the services are covered by an Authorization issued prior to the date of service and that Authorization has neither expired nor been terminated as of the date of service.

2.10 UTILIZATION MANAGEMENT. Contractor hereby acknowledges that KP conducts utilization management and review ("UM") programs relating to health care services provided to Members. The pertinent policies and procedures of KP's UM programs are discussed in Exhibit 3 and the Provider Manual. Contractor shall participate in and cooperate and comply with the provisions of KP's UM programs, including prospective, concurrent and retrospective review by KP's UM committees and staff. Upon reasonable notification, Contractor shall allow KP UM personnel, or their designees, physical and telephonic access to review, observe and monitor Member care and Contractor's performance of its obligations under this Agreement.

2.11 DELEGATED SERVICES.

(a) KP may, at its discretion, delegate utilization management, credentialing, medical records review, and other activities consistent with regulatory and accrediting standards to Contractor ("Delegated Activities"). Such delegation may occur at any time during the term of this Agreement if KP determines that Contractor is capable of performing such activities and if this Agreement includes or is amended to include such delegation.

(b) To the extent that KP delegates any activities described in the preceding paragraph to Contractor, KP shall retain the right to audit these Delegated Activities on an ongoing basis and to revoke such delegation at any time by giving notice as provided in Section 9.10. In the event that Contractor has the responsibility or authority under this Agreement to select or credential Participating Practitioners, contractors or subcontractors to provide Covered Services, directly or indirectly, to Members, KP retains the right to approve, suspend or terminate any such responsibility or authority. Any contracts or arrangements between Contractor and such Participating Practitioners or entities must acknowledge KP's authority to do so as to its Members.

(c) To the extent that Contractor has been delegated any Delegated Activities which are the responsibility of KP, Contractor shall make such periodic and other reports as reasonably required by KP in order for KP to meet its obligations under state and federal law and accreditation requirements, such as NCQA and JCAHO. KP shall at all times retain the right to monitor Contractor's performance of such delegated functions and contractor shall fully cooperate with such monitoring and oversight activities. KP reserves the right to revoke such delegation in the event that either KP or a state or federal government agency or authorized accreditation entity determines that such Delegated Activities have not been performed in a satisfactory manner.

(d) Delegated Activities shall be specified in Exhibit 4 to this Agreement. This Exhibit may be amended from time to time during the term of this Agreement to reflect changes in delegation standards, delegation status, performance measures, reporting requirements and the like.

2.12 QUALITY ASSURANCE AND IMPROVEMENT.

(a) Contractor hereby acknowledges that the quality assurance and improvement programs of KP require KP to monitor the quality assurance and improvement activities of contracting practitioners. Contractor agrees:

(i) To participate in KP's quality assurance and improvement programs, including review by KP's quality assurance and improvement committees and staff;

(ii) To abide by KP's quality assurance and improvement plan in accordance with Exhibit 3, the Provider Manual and KP policy; and

(iii) To cooperate with KP to objectively monitor and evaluate the quality of Services provided pursuant to this Agreement including, but not limited to, the availability, accessibility, acceptability, and continuity of such care.

(b) Contractor shall investigate and respond immediately to all quality issues, and shall work with KP to resolve any accessibility and other quality issues related to Services provided to Members. Contractor will remedy, as soon as reasonably possible, any condition related to patient care that has been determined by KP or any governmental or accrediting agency to be unsatisfactory. The parties shall work together to continuously assess and improve the quality and accessibility of care provided to Members and to resolve problems related to the provision of Services.

(c) Contractor shall provide information for use in quality assurance and improvement activities conducted by KP, including but not limited to Participating Practitioner-specific and patient-specific information. KP shall protect the confidentiality of such information to the extent required under state and federal law. Upon request, Contractor shall provide data, information and records (i) which KP must review for accreditation by NCQA and for credentialing activities that meet NCQA standards; or (ii) which are required by other accrediting organizations. Contractor shall provide KP access to all patient care protocols, policies and procedures, and any modifications, upon request. Contractor shall cooperate with representatives of NCQA or JCAHO and any other independent quality review and improvement organization or external review organization retained by KP as part of its administration of its quality assurance and improvement program.

(d) Contractor shall permit, at reasonable times with reasonable notice, inspection of its site(s) by NCQA, JCAHO and other accrediting organizations. Contractor shall permit KP and Government Officials to conduct periodic site evaluations of Contractor's site(s). Contractor will participate in all utilization management, quality assurance and improvement, credentialing, recredentialing, peer review and any other activities required by regulatory and accrediting agencies.

(e) KP's duty hereunder does not relieve Contractor of any duty of care to provide Members with Services in accord with the appropriate standard of care.

2.13 NOTIFICATION OF CHANGES. If Contractor decides to cease providing or suspend any Service at any of its sites, then Contractor shall notify TPMG in writing at least ninety (90) days prior to any such cessation or suspension. However, if Contractor provides primary care physician services as described in Exhibit 1.2, Contractor shall give at least one hundred eighty (180) days' prior written notice of any such cessation or suspension. Contractor will notify TPMG immediately of any changes in operation, emergency conditions or factors that may significantly affect Services provided to any Member. Contractor shall also notify TPMG promptly of any material change in ownership, control, legal status, name, location, tax identification number, Medicare or Medi-Cal number. Any material change of ownership, legal status or control is subject to the requirements of Sections 9.6 and 9.7.

2.14 ECONOMIC PROFILING. If Contractor uses economic profiling information related to any of its Participating Practitioners, it shall provide a copy of such information related to an individual Participating Practitioner, upon request, to that Participating Practitioner in accordance with the requirements of Section 1367.02 of the California Health and Safety Code. Additionally, upon request Contractor shall make available to TPMG its policies and procedures related to economic profiling used by the Contractor. The term "economic profiling" as used in this Section 2.14 shall be defined the same as that term is defined in Section 1367.02 of the California Health and Safety Code and its successor provisions. The requirement of this Section 2.14 to provide a copy of economic profiling information to an individual Participating Practitioner shall survive the termination of this Agreement in accordance with Section 1367.02 of the Health and Safety Code.

2.15 PROVIDER MANUAL. KP's Provider Manual sets forth KP's administrative procedures for operationalizing many of the requirements of this Agreement. Any Modifications to Provider Manual will be submitted to the Stanislaus Leadership Council, as defined in Exhibit 5, and will apply only after the Council has agreed to proposed modification . Contractor shall be bound by those provisions and requirements of KP's Provider Manual that are applicable to Contractor, including all amendments and updates thereto. KP shall provide Contractor with a copy of the Provider Manual, which copy, including all updates, shall remain the property of KP and shall be returned to KP upon termination of this Agreement. While the Provider Manual is in Contractor's possession, Contractor is responsible for maintaining the Manual and its updates and ensuring Contractor's compliance with its provisions. Further, Contractor is responsible for providing copies of the Provider Manual to all its Subcontractors and Participating Practitioners and assuring that its Subcontractors and Participating Practitioners adhere to all applicable

provisions of the Manual. In the event of any inconsistency between the Provider Manual and this Agreement, the terms of this Agreement shall govern.

ARTICLE III
BILLING AND PAYMENT

3.1 INVOICE FORMAT AND SUBMITTAL. Contractor shall submit to TPMG all invoices for Services rendered to Members in accordance with the billing procedures set forth in Exhibit 2. Such invoices shall be submitted to and received by TPMG within 180 days of the provision of Services or such other time frame as is indicated in Exhibit 2, as a condition for payment. TPMG may deny payment for any invoices not submitted to TPMG by Contractor within 180 days of the date of Service or such other time frame as is indicated in Exhibit 2.

3.2 PAYMENT OF COMPENSATION.

(a) In accordance with the provisions of this Article III and Exhibit 2 of this Agreement, TPMG shall pay Contractor for Covered Services rendered to Members. Contractor shall accept such amounts paid by TPMG and any Copayments Contractor is directed to collect, as payment in full.

(b) Emergency Services must be Approved Emergency Claims and other Services must be Authorized Services as a condition for payment.

(c) Payment for Covered Services shall be made within forty-five (45) working days of receipt of a properly submitted and undisputed invoice as described in Section 3.1, or within such other time frame as may be required by applicable federal or state laws, rules or regulations. Both parties shall use reasonable efforts to resolve disputes regarding invoices in accordance with Section 8.1(b). Upon resolution of the dispute, the invoice shall be paid within forty-five (45) working days of the date of resolution. Interest and penalties on any late payments will be paid as required of Health Plan by law.

(d) Any compensation paid to Contractor under this Agreement for Covered Services provided by Contractor or its Participating Practitioners shall be considered full and complete satisfaction of TPMG's compensation obligations under this Agreement with respect to such Covered Services, notwithstanding Contractor's failure to thereafter compensate any Participating Practitioner. Compensation paid directly to any Participating Practitioner pursuant to an invoice submitted in compliance with Exhibit 2 for Covered Services provided by such Participating Practitioner shall be considered full and complete satisfaction of TPMG's compensation obligations with respect to such Covered Services towards both Contractor and Participating Practitioner. In the event TPMG pays compensation to Participating Practitioner pursuant to an invoice that does not comply with Exhibit 2 or because of TPMG error, TPMG shall notify Contractor. Contractor shall then notify Participating Practitioner to refund promptly such payment to TPMG. Thereafter, recovery of such improper payment is the responsibility of TPMG and not of Contractor.

3.3 ADJUSTMENTS TO PAYMENT. KP may review and audit any and all invoices, prior to or subsequent to payment, to ensure that coding complies with commonly accepted standards adopted by KP, that covered billed charges are customary and reasonable, that services rendered are appropriate and medically necessary, and that payment is in accord with this Agreement. If KP determines that services rendered are inappropriate or not medically necessary, coding practices do not comply with KP standards, covered billed charges are not reasonable and customary, or payment is not in accord with the terms of this Agreement, KP reserves the right to deny, reduce or otherwise adjust payment to Contractor. If an audit conducted by KP shows that Contractor owes monies to TPMG, TPMG will notify Contractor, and Contractor shall refund such overpayment to TPMG within thirty (30) days. After such period, TPMG may offset future payments to Contractor by such overpayment. If this Agreement is terminated for any reason prior to TPMG having fully recovered such overpayment, the remaining amount shall become due and owing immediately upon the termination's effective date.

3.4 CHANGE OF PAYMENT RATE. The rate of compensation shall not change until January 1, 2005 (except as required by changes in Medicare relative values and conversion factors as set forth in Exhibit 2 or as otherwise required by this Agreement). Either party may propose a change to the rate of compensation at least sixty (60) days

prior to January 1, 2005 and subsequent anniversary dates of the Effective Date. The payment rates in effect as of the date of submission of such proposed change shall remain in effect unless the parties mutually agree to a change to the payment rates and execute a written amendment to this Agreement.

3.5 BILLING OTHER SOURCES.

(a) Contractor shall look solely to TPMG (or another responsible payor) for compensation for Covered Services rendered to Members under this Agreement, and, except as expressly provided in this Section, Contractor agrees that in no event, including but not limited to non-payment by TPMG, insolvency of KP or breach of this Agreement, shall Contractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, a person acting on the Member's behalf, the Department of Health Services ("DHS") or Medi-Cal Plans, for Services provided pursuant to this Agreement. Contractor shall not seek payment from Members for amounts denied by KP because covered billed charges were not customary or reasonable, because clinical data was not submitted promptly, or because Contractor did not submit the invoice in accordance with the time limits or other billing procedures set forth in Section 3.1, or in accordance with commonly accepted standard coding practices adopted by KP. Further, Contractor shall not bill Members or TPMG for a Member's failure to keep scheduled appointments. This provision shall survive the termination of this Agreement, regardless of the reason for termination, including the insolvency of KP, and shall supersede any oral or written agreement between Contractor and a Member.

(b) Contractor may assert claims for compensation other than claims against TPMG as set forth in Section 3.5(a) above, in the following circumstances:

(i) Copayments. The right to collect and retain Copayments applicable to Contractor's provision of Covered Services to Members is a right solely of Health Plan. Health Plan may require such Copayments to be collected and retained by Contractor, and may require such collection at the time Covered Services are provided. If Contractor is directed to collect such Copayments, compensation payable under this Agreement shall be reduced by the amount of such Copayments, as directed in Exhibit 2. and its subexhibits.

(ii) Other Coverage. If a Member is entitled to benefits under another carrier's health benefits, Workers' Compensation or other coverage, and such coverage is primary, Contractor will look first to the primary carrier for compensation for Services and then to TPMG unless Exhibit 2 indicates that KP reserves such right to bill and collect such sums from other payors to which it is secondary, in accord with Section 3.6 of this Agreement.

(iii) Services After Coverage Exhausted or Disallowed. If a Member elects to continue receiving Services from Contractor after such Member's benefits under his or her Membership Agreement or other agreements or arrangements governing the provision of health care services to Members have been exhausted, or KP determines in its sole discretion that such Services are not Covered Services, then Contractor shall seek compensation solely from such Member (or such Member's representative) for such Services unless Exhibit 2 specifically provides otherwise, and TPMG shall not be liable to Contractor for any charge in connection with such Services rendered by Contractor to such Member provided, however, that Contractor must first notify the Member that such Services are not Covered Services and that Member shall have financial responsibility for such Services.

(iv) No Benefit. Unless otherwise provided by this Agreement, if Contractor provides Services to a Member for which the Member has no Covered Benefit, then Contractor shall look solely to the Member (or such person's representative) for compensation, and neither Health Plan nor TPMG shall be liable to Contractor for any charge in connection with such Services rendered by Contractor to such Member provided, however, that Contractor must first notify the Member that such Services are not Covered Services and that Member shall have financial responsibility for such Services.

(v) Regular Medicare. If Contractor provides Services to a Regular Medicare Member, then Contractor shall submit the bill directly to HCFA unless Contractor is directed to bill TPMG directly in Exhibit 2. Upon receipt of a copy of the Explanation of Medicare Benefits and an invoice, TPMG shall pay Contractor any applicable Medicare coinsurance and deductible amounts, and any amounts due for Services that are Covered Benefits but are not covered by Medicare. Contractor shall not assert any claim for compensation against Regular Medicare Members for Medicare-covered Services, and shall not assert any claim for compensation, other than for the applicable Medicare coinsurance and deductible amounts, against TPMG for Medicare-covered Services provided to such Members. Contractor agrees to accept, as payment in full for Services provided to Regular Medicare Members, (A) the applicable Medicare payment, (B) the amounts paid by TPMG for the applicable Medicare coinsurance and deductible, and (C) the amount paid by TPMG, if any, for Services that are Covered Benefits but are not Covered by Medicare.

(c) Contractor shall not bill or collect from a Member any charges in connection with Services, even though such Services are not Covered Services, unless Contractor has obtained a written statement in a form acceptable to KP, signed by the Member or the person responsible for paying for Services rendered to the Member, acknowledging that the Member or such person is responsible for making such payments.

(d) Contractor understands and agrees that surcharges against Members are prohibited and KP is authorized to take appropriate action if surcharges are imposed. A surcharge is an additional fee, which is charged to a Member for a Service but which is not approved by the California Department of Managed Health Care or provided for under the applicable Membership Agreement or other agreements or arrangements governing the provision of health care services to Members.

(e) Contractor shall hold harmless the State of California, Medi-Cal Plans and Members in the event that TPMG or Health Plan cannot or will not pay for Services performed by Contractor or its Participating Practitioners pursuant to this Agreement.

3.6 COORDINATION OF BENEFITS/THIRD PARTY LIENS/SUBROGATION RIGHTS.

(a) When Health Plan is primary under applicable coordination of benefits ("COB") rules, TPMG shall pay to Contractor, as set forth in this Agreement the amount due for Covered Services rendered to Members.

(b) When Health Plan is secondary under applicable COB rules, or another payor is primary to Health Plan, then Contractor shall first bill the other payors to which Health Plan is secondary and forward a copy of such other payor(s) explanation of benefits along with billing information as required by Exhibit 2 to TPMG. TPMG shall pay for Covered Services that amount, if any, which, when added to sums owed to Contractor from all other payors for Covered Services provided to Members, equals one hundred percent (100%) of the amount payable for Covered Services in accordance with the rates set forth in Exhibit 2 herein. Payment is subject to the receipt of all information necessary to determine payor liability. However, if Exhibit 2 indicates that KP reserves the right to bill and collect such sums from other payors to which it is secondary, then Contractor shall not bill such other payors for such identified services and shall grant to KP the sole right to collect any payments due from other payors for such services.

(c) Contractor shall cooperate with and abide by Health Plan's administration of COB rules. Such cooperation shall include, without limitation the following: (i) Contractor shall screen each Member receiving Services to determine if the Member has Medicare coverage, or other health benefits, such as Workers' Compensation coverage or coverage through the Member's spouse, and shall provide such other coverage information to Health Plan upon request. (ii) If, following payment by TPMG for Services, Contractor discovers that Contractor is entitled to payment or receives payment for the same services from another payor that is primary to Health Plan, then Contractor shall notify TPMG and promptly refund to TPMG any amount paid by TPMG in excess of the amount set forth in Subsection (b) above.

(d) Health Plan, not Contractor, shall retain all rights to seek and recover, including all rights of reimbursement, lien or subrogation, any and all payment from Members or third parties for Covered Services

provided by Contractor to a Member hereunder, as a result of an injury or illness caused or alleged to be caused by a third party. Contractor shall cooperate with Health Plan or its designee in identifying such claims and in providing such information promptly to Health Plan.

ARTICLE IV
TERM AND TERMINATION

4.1 TERM. This Agreement will begin on the Effective Date, will continue in effect for three (3) years, and will thereafter automatically continue for successive one (1) year terms, unless terminated in accord with this Article IV.

4.2 TERMINATION, GENERALLY. Beginning on April 1, 2004 (for a termination effective date of March 31, 2005 or thereafter) , either party may terminate this Agreement at any time for any reason or for no reason by giving at least three hundred sixty-five (365) days' prior written notice of its intent to terminate this Agreement.

4.3 WITH CAUSE TERMINATION. Except as otherwise provided in Section 4.4, below, if a party materially breaches this Agreement and fails to cure the material breach to the satisfaction of the non-breaching party within thirty (30) days after the non-breaching party gives written notice of the material breach, the non-breaching party may terminate this Agreement immediately upon written notice to the other party.

4.4 IMMEDIATE TERMINATION.

(a) Contractor shall immediately notify TPMG and TPMG may immediately suspend this Agreement in the event there is a material adverse change in Contractor's insurance coverage. If Contractor does not provide adequate insurance coverage within thirty (30) days of the material adverse change, TPMG may terminate this Agreement immediately. Contractor shall immediately notify TPMG and this Agreement will terminate without further action of the parties if Contractor's insurance coverage is canceled, not renewed or expires, or if Contractor fails to obtain insurance coverage as required by this Agreement. If this Agreement terminates without further action of the parties, the effective date of termination shall be the date of the occurrence of such event or, at TPMG's option, such other date determined by TPMG in its sole discretion.

(b) Contractor shall immediately notify TPMG and TPMG may immediately suspend this Agreement if Contractor's license(s), Medicare or Medi-Cal certification, or credentialing status with TPMG or any Peer Review Body, is suspended or limited (including imposition of probation). If Contractor's license(s), certification or credentialing status is not fully reinstated within thirty (30) days of such suspension or limitation, TPMG may immediately terminate this Agreement. Contractor shall immediately notify TPMG and this Agreement will terminate without further action of the parties if Contractor's license(s), Medicare or Medi-Cal certification or credentialing status with TPMG is revoked, not renewed or expires, if Contractor's licensure or certification is not obtained as required by this Agreement, or if Contractor is excluded from participation in the Medicare or Medi-Cal programs. If this Agreement terminates without further action of the parties, the effective date of termination shall be the date of the occurrence of such event or, at TPMG's option, such other date determined by TPMG in its sole discretion.

(c) Contractor shall notify TPMG and TPMG may terminate this Agreement immediately upon written notice to Contractor if Contractor files a petition in or for bankruptcy, reorganization or an arrangement with creditors; makes a general assignment for the benefit of creditors; is adjudged bankrupt; is unable to pay debts as they become due; has a trustee, receiver or other custodian appointed on its behalf; or has a case or proceeding commenced against it under any bankruptcy or insolvency law.

(d) Contractor shall notify TPMG and TPMG may terminate this Agreement if:

(i) Contractor's or a Participating Practitioner's license to practice in any state is suspended, revoked, expired, not renewed or placed on probation;

(ii) The license, certification, or accreditation of any of Contractor's or any of its Participating Practitioner's sites, if any, is suspended, restricted, or revoked;

(iii) Contractor's or a Participating Practitioner's Drug Enforcement Agency certification, or Medicare or Medi-Cal certification, or other professional certification is suspended, limited, revoked or expired;

(iv) Contractor's or a Participating Practitioner's privileges or employment status with any Peer Review Body is revoked, suspended, not renewed or significantly (in the judgment of TPMG) reduced for any medical disciplinary cause or reason;

(v) Contractor or Participating Practitioner is not or ceases to be covered by professional liability coverage as required under this Agreement;

(vi) Contractor or Participating Practitioner is criminally charged with any act involving professional misconduct or moral turpitude;

(vii) The credentialing information provided to TPMG with respect to Contractor or Participating Practitioner was materially false; or

(viii) Contractor or Participating Practitioner no longer satisfies the credentialing standards of TPMG.

(ix) Contractor or Participating Practitioner ceases to provide Services to Members at any location listed in Exhibit 1, or at any additional locations from time to time added according to the provisions of this Agreement.

In addition to having the authority to terminate the Agreement under the terms of this Section, TPMG shall have the option of requiring Contractor to discontinue the provision of Services hereunder through any affected Participating Practitioner.

(e) TPMG may terminate this Agreement immediately upon written notice to Contractor if (i) Contractor rejects a Required Modification pursuant to Section 9.8, or (ii) Contractor adds or deletes Participating Practitioners to its list without complying with the notice and approval requirements set forth in the introductory paragraph to Exhibit 1.1.

4.5 TERMINATION AS TO MEDICARE+CHOICE MEMBERS. In the event that the Medicare contract between HCFA and Health Plan is terminated or not renewed, this Agreement will be terminated as to Medicare+Choice Members unless HCFA and Health Plan agree to the contrary. Such termination as to Medicare+Choice Members shall be accomplished by delivery of written notice by TPMG to Contractor of the date upon which said termination will become effective.

4.6 EFFECT OF TERMINATION AND SURVIVAL.

(a) Upon termination of this Agreement, Contractor shall continue to provide Services to Members under the care of Contractor at the time of termination, until the Services being rendered are completed, unless KP makes reasonable and medically appropriate provision for the assumption of such Services by a new contractor or by KP. The terms and conditions of this Agreement will continue to apply to Services provided to each such Member until completion or until transfer to a new contractor or to KP. Contractor shall act in such a manner as to facilitate KP's or any new contractor's assumption of services.

(b) In the event of TPMG's or Health Plan's insolvency or other cessation of operations, Contractor will continue to provide Services to Members through the period for which premiums have been paid.

(c) Provisions of this Agreement including, but not limited to, Section 2.10 (Utilization Management), Section 2.12 (Quality Assurance and Improvement), Article V (Records and Confidentiality), Article VI (Insurance, Responsibility and Indemnification) and Article VIII (Dispute Resolution, Complaints and Inquiries) that are not fully performed or are not capable of being fully performed as of the date of termination shall survive termination of this Agreement.

(d) Contractor further agrees that Section 3.5(a) (Billing Other Sources) and Section 4.6(b) above (TPMG or Health Plan insolvency) shall (i) survive the termination of this Agreement regardless of the cause giving rise to termination; (ii) be construed to be for the benefit of the Members; and (iii) supersede any oral or written contrary agreement now existing or hereafter entered into by the parties. Any modification to this Section 4.6(d) shall become effective only after proper state and federal regulatory authorities have received written notification of the proposed change.

4.7 FAIR HEARING.

(a) In the circumstances delineated under KP's applicable notification and hearing procedures, as amended from time to time ("Procedures"), Contractor understands that it or its Participating Practitioners may be entitled to notice and certain fair hearing rights prior to or following suspension or termination of Contractor's or a Participating Practitioner's authority to provide services to Members. If KP determines that Contractor or any such Participating Practitioner is entitled to any such notice or hearing, KP shall so notify Contractor and, if necessary, the Participating Practitioner, and Contractor shall cooperate with KP so that KP may fulfill all relevant regulatory requirements.

(b) Nothing stated herein shall create any contract rights, whether express or implied, in favor of a practitioner, including, but not limited to, any Participating Practitioner, who is not a signatory to this Agreement.

ARTICLE V
RECORDS AND CONFIDENTIALITY

5.1 MAINTENANCE OF RECORDS. Contractor shall maintain books, charts, documents, papers, reports and records (including, but not limited to, financial, accounting, administrative, and patient medical records and prescription files) related to Services provided hereunder to Members, to the cost thereof, to payments received from Members or others on their behalf, and to the financial condition of Contractor ("Records"). Records also include those that are customarily maintained by Contractor for purposes of verifying claims information and reviewing appropriate utilization of Services. Contractor shall maintain Records in accord with applicable state and federal requirements, including privacy and confidentiality requirements, and in a form maintained in accordance with the general standards applicable to that form of book- or record keeping. The Member's medical record shall reflect whether or not the Member has executed an advance directive. Contractor shall be fully bound by the requirements in Title 42 CFR Section 2.1 et seq., relating to the maintenance and disclosure of Member Records received or acquired by federally assisted alcohol or drug programs. Contractor shall preserve Records for the longer of (i) seven (7) years after termination of this Agreement, (ii) one (1) year after the Member reaches the age of majority, if the Member is a minor, (iii) six years from the date of completion of any audit conducted by the Department of Health and Human Services, Comptroller General, or their designees, (iii) the period of time required by state and federal law and Health Plan Medi-Cal Contracts, including the period required by the Knox Keene Act and regulations, and by the Medicare and Medi-Cal programs and contracts to which KP is subject, or (iv) six (6) years from the final date of the Agreement or from the date of completion of any audit, whichever is longer, or longer if so required by HCFA.

5.2 ACCESS TO AND COPIES OF RECORDS. KP and its authorized agents shall have access to and may inspect the Records, subject to reasonable request and notification requirements. Contractor shall transmit Record information by written telecommunication (i.e. facsimile or electronic mail) to KP, as requested. Contractor shall, subject to any legal requirements regarding confidentiality, provide access to Records and other information as required by NCQA and other accrediting organizations. Contractor shall provide copies of Records to KP upon request at no charge.

5.3 COPIES OF CLINICAL INFORMATION. For all Members receiving Services, Contractor shall promptly forward copies of initial consultation reports upon completion of consult, and summaries of patient care or patient results upon completion of patient care or discharge, to the Stanislaus Program (as defined in Exhibit 5) primary care practitioner referring, prescribing or authorizing the Service in accordance with this Agreement and the Provider Manual. Contractor's failure to provide this clinical data promptly will be grounds for denial or reduction of payment to Contractor for Covered Services rendered to Members until such information is submitted. Contractor shall provide copies of such clinical information to the referring, prescribing or authorizing Stanislaus Program primary care

practitioner upon request at no charge.

5.4 DISCLOSURE TO GOVERNMENT OFFICIALS. Contractor shall comply with all provisions of the Omnibus Reconciliation Act of 1980 and the Balanced Budget Act of 1997 regarding access to books, documents, contractual agreements and records. Without limiting the foregoing, Contractor shall maintain, provide access to, and provide copies of Records, this Agreement and other information to the California Department of Managed Health Care, DHS, the Bureau of Medi-Cal Fraud, the California Office of the Attorney General, Medi-Cal Plans, the U.S. Department of Justice, the Secretary of the U.S. Department of Health and Human Services, the U. S. Comptroller General, HCFA, Peer Review Bodies, their designees, and such other officials entitled by law or under Health Plan Medi-Cal Contracts (collectively, "Government Officials") as may be necessary for compliance by KP with the provisions of all state and federal laws and contractual requirements governing KP, including, but not limited to, the Knox Keene Act, and the regulations thereunder, and the Medicare and Medi-Cal programs. Such Records shall be available at all reasonable times at Contractor's place of business or at some other mutually agreeable location in California.

5.5 GOVERNMENT-REQUIRED INFORMATION. Contractor shall supply KP with periodic reports and information pertaining to Services provided to Members by Contractor on such forms and within such times as requested by KP, and which will enable KP to meet all federal, state and contractual reporting requirements.

5.6 CERTIFICATION OF ACCURACY OF DATA. Contractor recognizes that KP is required to certify the accuracy, completeness and truthfulness of data that HCFA and other state and federal governmental agencies and accrediting organizations request. Such data include encounter data, payment data, and any other information provided to KP by its contractors and subcontractors. Contractor hereby represents and warrants that any such data submitted to KP by Contractor will be accurate, complete and truthful. Upon request, Contractor shall make such certification in the form and manner specified by KP in order to meet regulatory and accreditation requirements.

5.7 CONFIDENTIALITY OF INFORMATION.

(a) The parties shall keep in strictest confidence and in compliance with all applicable state and federal law: (i) this Agreement; (ii) any patient information; (iii) information concerning any matter relating to the business of the other, including, but not limited to, the other's employees, products, services, membership, prices, operations, business systems, planning and finance, policies, procedures and practice guidelines; (iv) materials, data, records or other information obtained from the other during the course of or pursuant to this Agreement; and (v) any information learned while performing obligations under this Agreement, which if provided by the other, would be required to be kept confidential. Neither party shall disclose such information unless authorized by the other, except as next provided in Subsection (b) below.

(b) The prohibitions on disclosure set forth in Subsection (a) above do not apply to information that (i) is required by law to be disclosed or to be provided to Government Officials or governmental agencies; (ii) is required by JCAHO, NCQA, or other accreditation organizations; (iii) is disclosed in legal or government administrative proceedings; (iv) was publicly known at the time of the disclosure; (v) becomes publicly known through no fault of the disclosing party after the disclosing party's receipt of the confidential information; (vi) was developed by the disclosing party independently of and without reference to any of the confidential information; or (vii) is disclosed as necessary to enforce a party's rights for coordination of benefits, liens, reimbursement or subrogation.

(c) Notwithstanding any other provision of this Agreement, names of Members receiving public social services hereunder are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR, Section 431.300 et seq. and Section 14100.2 of the California Welfare and Institutions Code and its successor provisions and regulations adopted thereunder. For the purpose of this Agreement, all information, records, data, and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by Contractor from unauthorized disclosure.

(d) With respect to any identifiable information concerning a Medi-Cal Member that is obtained by Contractor, Contractor (i) shall not use any such information for any purpose other than carrying out the express terms of this Agreement; (ii) shall promptly transmit to DHS and the applicable Medi-Cal Plan all requests for disclosure of such information; (iii) shall not disclose, except as otherwise specifically permitted by this Agreement, any such information to any party other than DHS and the applicable Medi-Cal Plan, without prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et. seq., and Section 14100.2 of the California Welfare and Institutions Code, and their successor provisions and regulations adopted thereunder; and (iv) shall, at the expiration or other termination of this Agreement, return all such information to DHS and the applicable Medi-Cal Plan or maintain such information according to written procedures sent to Health Plan by DHS and the applicable Medi-Cal Plan for this purpose.

5.8 USE OF NAME. Contractor and KP each reserves to itself the right to, and the control of the use of, its names, symbols, trademarks and service marks, presently existing or hereafter established, and, neither Contractor nor KP shall use the other's names, symbols, trademarks, or service marks in any advertising or promotional communication of any type or otherwise without the prior written consent of the other organization. Notwithstanding the above, KP may communicate to Members: Contractor's name, address(es), telephone number(s) and Participating Practitioners.

5.9 PUBLICITY. In the interest of presenting accurate information to the general public and Members, and maintaining good public relations, the parties will consult with each other regarding any issue relating to this Agreement or to a Member obtaining Services hereunder that gives rise to media interest or public relations concern, and will cooperate in developing any statements or press releases in connection with any such issue.

ARTICLE VI
INSURANCE, RESPONSIBILITY AND INDEMNIFICATION

6.1 INSURANCE.

(a) Contractor shall maintain or cause to be maintained the following insurance covering itself and each Participating Practitioner through whom Contractor provides Services: (i) a policy of commercial general liability and property damage insurance with limits of liability not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate, (ii) a policy of professional liability insurance with limits of liability not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate or (iii) such other insurance or self insurance as shall be necessary to insure it against any claim or claims for damages arising under this Agreement, including claims arising by reason of personal injury or death in connection with the performance of any Service, or use of any property or facility pursuant to this Agreement. Such insurance coverage shall apply to all site(s) of Contractor and to Services provided by Contractor and its Participating Practitioners to Members at any KP facility or other site.

(b) All insurance required under this Section shall be obtained from a company(ies) that is duly licensed to do business in the State of California or the state in which Contractor or its Participating Practitioners deliver Services and that either (i) has a Best's rating of at least A or has a comparable rating from another rating company or (ii) is acceptable to TPMG. Such insurance coverage must not be canceled, terminated, nonrenewed, or modified or must not expire without at least thirty (30) days' prior written notice to TPMG. Contractor shall require its insurance carrier to notify TPMG at the time of any change in insurance carrier, limits or deductibles. Contractor shall provide certificates of insurance evidencing such coverage to TPMG upon execution of this Agreement in a form acceptable to TPMG, and from time to time thereafter upon request. Both parties to this Agreement will maintain in full force and effect appropriate automobile coverage, and workers' compensation protection and unemployment insurance to the extent required by law.

(c) If Contractor obtains one or more claims-made insurance policies to fulfill its obligations under this Section, Contractor will (i) maintain coverage with the same company during the term of this Agreement and for at least ten (10) years following termination of this Agreement, or (ii) 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.

6.2 RESPONSIBILITY.

(a) Contractor will assume, for each Member to whom Services are rendered by or on behalf of Contractor, full responsibility for the manner in which Services are rendered. Contractor shall assume full responsibility for all losses or expenses (including costs and reasonable attorneys' fees) resulting from liability imposed by law upon Contractor because of injury or death to any person or on account of damages to property, including loss of use thereof, arising out of or in connection with this Agreement and due or claimed to be due to the negligence or wrongful conduct of Contractor and/or its Participating Practitioners, officers, directors, agents, or employees.

(b) TPMG shall assume full responsibility for all loss or expenses (including costs and reasonable attorneys' fees) resulting from liability imposed by law upon TPMG because of injury or death to any person or on account of damages to property, including loss of use thereof, arising out of or in connection with this Agreement and due or claimed to be due to the negligence or wrongful conduct of TPMG, its officers, directors, agents or employees.

6.3 INDEMNIFICATION

(a) To the extent permitted by law, Contractor agrees to indemnify and hold harmless TPMG, Health Plan and its Affiliated Payors, and KFH, and their officers, trustees, employees, agents and representatives, and their successors and assigns, from and against any and all claims, demands, actions, charges, liabilities and damages, including reasonable attorneys' fees ("Claims"), arising from or relating to Contractor's or any Participating Practitioner's negligent or intentional act or failure to act relating to activities performed pursuant to this Agreement. The parties shall cooperate with each other in the investigation and disposition of any claim arising out of or relating to the activities of this Agreement, provided that nothing shall require either party to disclose any documents, records or communications that are protected under the peer review privilege, the attorney-client privilege or the attorney work-product privilege. The provisions of this paragraph shall survive termination of this Agreement, regardless of the reason for such termination.

(b) TPMG agrees to indemnify and hold harmless Contractor, and its officers, trustees, employees, agents and representatives, successors and assigns, from and against any and all claims, demands, actions, charges, liabilities and damages, including reasonable attorneys' fees ("Claims"), arising from or relating to TPMG's negligent or intentional act or failure to act relating to activities performed pursuant to this Agreement. The parties shall cooperate with each other in the investigation and disposition of any Claim arising out of the activities of this Agreement, provided that nothing shall require either party to disclose any documents, records or communications that are protected under the peer review privileges, the attorney-client privilege or the attorney work-product privilege. The provisions of this paragraph shall survive termination of this Agreement, regardless of the reason for such termination.

(c) In accordance with the provisions of California Civil Code Section 3428, for services rendered on or after January 1, 2001, nothing in this Agreement shall be construed to require indemnification from Contractor for any liability imposed upon Health Plan as a result of Health Plan's duty to arrange for the provision of medically necessary health care services to Members where the health care service is a benefit provided under the Membership Agreement.

ARTICLE VII
LEGAL REQUIREMENTS AND CREDENTIALS

7.1 COMPLIANCE WITH LAWS.

(a) Contractor represents and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable local, state and federal laws and regulations, including, but not limited to, those (i) regarding licensure and certification; (ii) necessary for participation in the Medicare and Medi-Cal programs, including the antifraud and abuse laws and regulations and the patient self-determination amendments of the Omnibus Budget Reconciliation Act of 1990; (iii) regarding advance directives; (iv) regulating the operations and safety of facilities; and (v) regarding federal and state Occupational Health and Safety Administration (OSHA) standards. Any provision required to be in this Agreement by the rules and regulations governing Medicare, including the Medicare+Choice program, shall bind the parties whether or not provided in this Agreement. In addition, to the extent applicable, Contractor shall comply with the obligations in the contract between HCFA and Health Plan governing Health Plan's participation in the Medicare+Choice program.

(b) Contractor shall not employ or contract with, either directly or indirectly, entities or individuals excluded from participation in Medicare or Medicaid under Sections 1128 or 1128A of the Social Security Act or who have opted out of Medicare, for the provision of health care services, utilization review, medical social work, or administrative services with respect to Regular Medicare or Medicare+Choice Members.

(c) Contractor shall comply with all applicable regulations and laws of the State of California and the United States of America, including without limitation:

(i) Title 42 of the Code of Federal Regulations, Section 482.12(e), which requires that Services performed by Contractor under this Agreement at a health care facility are performed in a safe and effective manner; and

(ii) Title 22 California Code of Regulations Section 70713, which requires that KFH shall retain administrative and professional responsibility for all Services rendered by Contractor to inpatient and outpatient hospital patients of KFH.

(iii) The parties agree that the above Subsections (c)(i)-(ii) shall not modify the allocation of liability or indemnification obligations between the parties as set forth in this Agreement or as otherwise provided by law.

7.2 NONDISCRIMINATION.

(a) Contractor shall not unlawfully discriminate against or harass Members on the basis of any factor prohibited by law, including but not limited to race, color, creed, religion, sex, marital status, ancestry, sexual orientation, national origin, health status, age, physical or mental illness, handicap or disability, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), veteran's status, income, source of payment, status as a Member of Health Plan, or filing a complaint as a Health Plan Member. Contractor shall not condition treatment or otherwise discriminate on the basis of whether a Member has executed an advance directive. Contractor shall comply with Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975 and the Rehabilitation Act of 1973, all as amended. Contractor shall provide reasonable access and accommodation to persons with disabilities to the extent required of a health services provider under the American with Disabilities Act or any applicable state law.

(b) Contractor recognizes that as a government contractor, KP is subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action which also may be applicable to subcontractors. Contractor, therefore, agrees that any and all applicable equal opportunity and affirmative action clauses from the Federal Acquisition Regulation (FAR) at 48 CFR Part 52 shall be incorporated herein by reference as required by federal laws, executive orders, and regulations, including the following FAR clauses: (a) Equal Opportunity (Feb. 1999) at FAR 52.222-26; (b) Affirmative Action for Disabled Veterans of the Vietnam Era (April 1998) at FAR 52.222-35; (c) Affirmative Action for Workers with Disabilities (June 1998) at FAR 52.222-36, and (d) Small Business Subcontracting Plan (Oct. 1999) at FAR 52.219-9.

(c) During the performance of this Agreement, Contractor shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment on the basis of any factor prohibited by law, including those delineated in the preceding Subsection 7.2(a). Contractor shall insure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and harassment. Contractor shall comply with applicable provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor shall give written notice of its obligations under this clause to labor organizations with which it has collective bargaining or other agreements.

(d) Contractor shall promptly forward to KP any complaints by Members or Participating Practitioners regarding discrimination against Members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation or physical or mental handicap.

(e) Contractor shall comply with any policies and procedures developed by KP regarding identifying, referring, and treating special Medi-Cal Member populations.

7.3 LICENSURE, CERTIFICATION AND CREDENTIALS.

(a) Contractor warrants that all Participating Practitioners, including employees, contractors and agents of Contractor, who provide Services to Members, and Contractor and each of Contractor's and its Participating Practitioner's sites, if any, are, and shall be at all times during the term hereof, properly licensed by the State of California or the state in which Contractor or its Participating Practitioners deliver Services, certified, qualified and in good standing in accord with all applicable local, state and federal laws and in accord with all applicable standards and criteria of Contractor and its Participating Practitioners pertaining to the provision of healthcare services within its site(s), if any, pursuant to this Agreement. Contractor and all of its and its Participating Practitioner's sites, if any, shall be accredited by an appropriate accrediting body, if applicable. Contractor, Participating Practitioners, and Contractor's and its Participating Practitioner's sites, if any, shall meet applicable requirements and be properly certified under the Medicare and Medi-Cal programs, as set forth in Title XVIII and Title XIX, respectively, of the Social Security Act. Contractor and Participating Practitioners shall only provide Services within the scope of their licensure, training and experience. Contractor further warrants that each Participating Practitioner through whom it will provide Services shall (i) maintain a current, unrestricted license (if applicable) to practice his/her profession in California or the state in which Contractor or its Participating Practitioners deliver Services, (ii) be certified to participate in the Medicare and Medi-Cal programs, (iii) be board certified in the appropriate specialty as set forth in KP credentialing requirements, and (iv) maintain, as applicable, full active staff membership at one or more local hospitals, including all clinical privileges necessary for the Participating Practitioner to perform required Services at such hospital. Upon request, Contractor shall provide satisfactory documentary evidence of licensure, certification, accreditation and qualifications of Contractor, Participating Practitioners, and Contractor's and its Participating Practitioner's sites, if any.

(b) Contractor and each of its Participating Practitioners must be credentialed and privileged, as applicable, by KP prior to providing Services pursuant to this Agreement, and shall be recredentialed and reprivileged, as applicable, in accordance with KP credentialing and privileging policies. Contractor shall, and shall cause its Participating Practitioners to cooperate with KP's credentialing and privileging processes

(c) Contractor shall immediately notify TPMG if:

(i) The licenses, certifications or clinical privileges of Contractor or any Participating Practitioner are revoked, suspended, restricted, expired or not renewed;

(ii) The license, certification, or accreditation of any of Contractor's or any of its Participating Practitioner's sites, if any, is suspended, restricted, or revoked;

(iii) Any peer review action, inquiry or formal corrective action proceeding, or investigation is initiated against Contractor or a Participating Practitioner by any Peer Review Body;

(iv) Contractor or any Participating Practitioner is the subject of legal action or governmental action concerning qualifications or ability to perform Services;

(v) There is any formal report submitted to the Medical Board of California or the medical board or licensing agency of any state or U.S. territory, the Board of Registered Nursing or the National Practitioner Data Bank of adverse credentialing or peer review action regarding Contractor or a Participating Practitioner;

(vi) There is any material change in any of the credentialing or privileging information regarding Contractor or a Participating Practitioner;

(vii) Contractor or a Participating Practitioner is subject to sanctions under the Medicare or Medicaid programs; or

(viii) There is any incident that may affect any license, certification, privileges or accreditation held by Contractor, any Participating Practitioner, or any of Contractor's or any Participating Practitioner's site, if any, or that may materially affect Contractor's or any Participating Practitioner's performance of its obligations under this Agreement.

(d) Upon request, Contractor shall provide KP with copies of survey reports, investigations, assessments, formal evaluations or citations of Contractor or any Participating Practitioner by any governmental or private agency that regulates or accredits Contractor, its Participating Practitioners or Contractor's or Participating Practitioner's sites, if any.

(e) If at any time during the term hereof, any Participating Practitioner fails or ceases to meet KP's credentialing or privileging standards, or the license, certifications, or privileges of any Participating Practitioner are suspended, revoked, expired or not renewed, then Contractor shall ensure that such Participating Practitioner shall not thereafter provide Services to Members. If during the term hereof, any of the events listed in Subsection (c)(i) or Subsection 4.4(d)(iii), above, occur with respect to a Participating Practitioner, or there is conduct or performance by a Participating Practitioner that could adversely affect the health or welfare of a Member, upon the written request of KP, such Participating Practitioner shall not thereafter render Services to Members until the matter has been resolved to TPMG's satisfaction and TPMG consents in writing to the provision of Services by such Participating Practitioner.

(f) If at any time during the term hereof, Contractor's site(s) license, certification or accreditation is suspended, revoked, expired, or not renewed then Contractor shall ensure that Members do not receive Services at or in that site.

ARTICLE VIII
DISPUTE RESOLUTION, COMPLAINTS AND INQUIRIES

8.1 DISPUTE RESOLUTION.

(a) In the event of a claim, dispute or other matter arising out of, relating to, or in any way connected with this Agreement (collectively, "Disputes," or each, individually, a "Dispute"), including the performance of or failure to perform any term, covenant, or condition herein, either TPMG or Contractor shall submit a notice regarding the nature of the Dispute to the other party, at the address and telephone number listed in Section 9.10. Thereafter, TPMG and Contractor shall meet and confer in good faith to resolve the Dispute or Disputes; provided, however, that Disputes for which a hearing is requested and allowed pursuant to Section 4.7 shall proceed to a hearing.

(i) Contractor shall work directly with TPMG to reach a resolution of the Dispute, and shall not involve Members in any manner concerning such Dispute, except to the extent that a Member is an indispensable party in reaching a resolution.

(ii) If a Dispute is not resolved by the parties or by a hearing pursuant to Section 4.7, then it shall be submitted to binding arbitration in accord with all procedures and rules applicable to arbitration of claims, including the provisions governing arbitration set forth in the California Code of Civil Procedure, Section 1280, et seq., and the rights of discovery as provided for in Section 1283.05 of said Code, except that notice shall be given as set forth in Section 9.10 of this Agreement. The arbitration award may be entered as a judgment in accord with applicable law in any court having jurisdiction thereof. The obligation set forth in this subparagraph shall also apply to any claims, disputes, or other matters, irrespective of the legal theories asserted, between Contractor and/or Participating Practitioner, on the one hand, and TPMG, KFH or Health Plan, on the other hand, whether or not KFH and Health Plan are also parties to the Agreement. In the event of a Dispute solely between (i) TPMG, KFH and/or Health Plan, on the one hand, and (ii) Contractor and/or a Participating Practitioner, on the other hand, venue shall be Alameda County, California. An arbitration under this Section shall be consolidated with any other arbitration that includes claims by or against Members (or kindred parties) or KP based on the same incident, transaction or related circumstance.

(iii) The parties acknowledge that a breach of the obligations of confidentiality in Sections 5.7 and 5.8 of this Agreement would cause irreparable injury to the injured party which could not be compensated adequately in damages and that the injured party shall be entitled, in addition to any other remedies or damages, to a temporary restraining order and/or preliminary injunction to restrain the violation of Sections 5.7 and 5.8, without the necessity of proving irreparable injury. Such injunctive relief shall be granted without requiring the injured party to post bond or other security. Any party may seek such temporary or preliminary injunctive relief in a court of competent jurisdiction to restrain a violation of the confidentiality obligations, but any permanent injunctive relief as well as temporary or permanent injunctive relief to restrain the violation of other obligations under this Agreement shall be resolved by arbitration in accordance with Subsection 8.1 (c) above. The arbitrator shall have authority to issue final injunctive relief, and any orders necessary to carry out that relief, and such orders shall be confirmed as an enforceable judgment in a court of competent jurisdiction.

(b) Health Plan provides all Contractors with a fast, fair and cost effective invoice payment dispute mechanism under which Contractor may submit all disputes regarding invoices. This dispute resolution mechanism may be incorporated into the Provider Manual, but may also be communicated to Contractor prior to such incorporation through any other form. Contractor must submit a notice indicating its interest in resolving an invoice payment dispute under this provision at the address and telephone number, and in accordance with the requirements, set forth in Section 9.10. If Contractor is not satisfied with the outcome of procedure, Contractor may then elect to resolve an invoice payment dispute by exercising the rights and obligations set forth at Section 8.1(a)(i) through Section 8.1(a)(iii).

8.2 PATIENT COMPLAINTS, GRIEVANCES, INQUIRIES AND CLAIMS.

(a) When a Member complaint is brought to Contractor's attention, Contractor shall investigate such complaint and use its best efforts to resolve such complaint in a fair and equitable manner. Contractor shall cause its Participating Practitioners to communicate any Member complaints that are brought to their attention to Contractor, and Contractor shall immediately inform KP of any such complaints. Contractor shall, and shall cause its Participating Practitioners to, cooperate with KP in identifying, processing and resolving all Member complaints and grievances pursuant to KP's grievance procedures within the timeframes required by KP. Such cooperation will include, but not be limited to, meeting with representatives of KP, providing information bearing on the complaint to such representatives and taking all reasonable actions suggested by such representatives to resolve the Member's complaint. Contractor will promptly notify KP of receipt of all complaints from or on behalf of Members. The parties will each promptly notify the other of the receipt of any written complaint letters regarding Services provided to Members by or on behalf of Contractor. Contractor shall comply with KP's resolution of any such complaints and grievances.

(b) KP is responsible for administration of Covered Benefits, including decisions regarding discontinuation or denial. All inquiries regarding what services and benefits are Covered Benefits are to be referred to KP.

(c) Contractor will promptly notify TPMG of any professional liability claims filed or asserted regarding Services provided to Members by, or on behalf of, Contractor. Contractor shall submit to binding arbitration in accordance with the Membership Agreement or other agreements or arrangements governing the provision of health care services to Members, any claims asserted against Contractor, and Contractor shall accept and be bound by the Membership Agreement's arbitration provision therein or the arbitration provision of other agreements or arrangements governing the provision of health care services to Members, as it may be amended from time to time, in the resolution of such claims.

ARTICLE IX
MISCELLANEOUS

9.1 INDEPENDENT CONTRACTOR. Contractor enters into this Agreement, and will remain throughout the term of this Agreement, as an independent contractor. Nothing in this Agreement is intended to create nor shall it be construed to create between TPMG and Contractor a relationship of principal, agent, employee, partnership, joint venture or association. Neither TPMG nor Contractor has authorization to enter into any contracts, assume any obligations or make any warranties or representations on behalf of the other. No individual through whom Contractor renders Services, shall be entitled to or shall receive from TPMG compensation for employment, employee welfare and pension benefits, fringe benefits of employment, workers' compensation, life or disability insurance or any other benefits of employment, in connection with rendering Services. Contractor warrants that it will be responsible for all legally required tax withholding for itself and its employees. Contractor includes Contractor and its Participating Practitioners.

9.2 PRACTITIONER-PATIENT COMMUNICATION. Contractor acknowledges that TPMG's policy and practice is to allow open practitioner-patient communication regarding appropriate treatment alternatives without penalizing practitioners for discussing medically necessary or appropriate care for Member Patients.

9.3 ACCESS TO CARE. TPMG Physicians are obligated to make medical authorization decisions based on the medical needs of Members. KP does not compensate anyone for denying coverage or service, and KP does not use financial incentives to encourage denials of service. In order to maintain and improve Members' health, Contractor should be vigilant in identifying and reporting to TPMG any potential underutilization of care or service.

9.4 REPRESENTATION AND WARRANTY REGARDING YEAR 2000 (Y2K) READINESS. HCFA requires that KP demonstrate that its delivery system has addressed Y2K readiness issues. Accordingly, Contractor represents and warrants that it is using reasonable and diligent efforts to address Year 2000 issues that may have a significant impact on its delivery of health care and its business operations, including the performance of its obligations hereunder. Year 2000 issues include issues relating to processing and display of date/time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000 and thereafter, and leap year calculations. Reasonable efforts include, without limitation, a program to identify, analyze, prioritize, remediate, validate and test, as appropriate, systems and equipment critical to the delivery of health care and business operations for Year 2000 compliance.

9.5 NO THIRD PARTY BENEFICIARIES. This Agreement is not intended to, nor does it create, any third-party beneficiary rights in any person, including Members, except as provided in Section 4.6(d)(ii) and where indicated for KFH and Health Plan. Contractor and TPMG agree that Participating Practitioners are not third party beneficiaries to this Agreement. No action to enforce the terms of this Agreement may be brought against a party by a person who is not a party hereto, except for KFH and Health Plan.

9.6 ASSIGNMENT. Neither this Agreement nor any duties or obligations under this Agreement may be assigned or subcontracted by Contractor without the prior written consent of TPMG. Any material change of ownership or control shall be deemed an assignment of this Agreement requiring the prior written consent of TPMG. If DHS or a Medi-Cal Plan's approval is required by law or Health Plan Medi-Cal Contracts, assignment or delegation of this Agreement shall be void unless prior written approval is obtained from DHS and/or such Medi-Cal Plan.

9.7 SUCCESSORS AND ASSIGNS. Subject to the restrictions on assignment contained herein, this Agreement shall inure to the benefit of and be binding upon, the parties hereto and their respective successors and assigns.

9.8 AMENDMENT. Unless otherwise specifically provided in this Agreement including without limitation its Exhibits, this Agreement may be amended only by mutual written consent of TPMG's and Contractor's duly authorized representatives. Notwithstanding the foregoing, if Government Officials require any modification of this Agreement in order for this Agreement to be in conformity with federal or state law or if TPMG reasonably concludes that an amendment to this Agreement is required because of federal or state law or accreditation standards or in order for KP to participate in government-funded healthcare programs, then TPMG shall notify Contractor of such proposed modification(s) ("Required Modifications") and the date on which it is to go into effect, which shall not be less than thirty (30) days following the date of the notice unless otherwise required by law. Such Required Modifications shall be deemed accepted by Contractor and this Agreement so amended, if Contractor does not, within thirty (30) days following the date of the notice, deliver to TPMG its written rejection of such Required Modifications. TPMG and Contractor shall make all reasonable good faith efforts to resolve their differences over the proposed Required Modification in a timely fashion and the Required Modification shall not take effect until a resolution satisfactory to both parties is achieved unless otherwise required by law. However, notwithstanding this obligation to negotiate a resolution to the disagreement, TPMG has the right to immediately terminate this Agreement without penalty in accordance with Section 4.4(e) if Contractor rejects such Required Modification.

9.9 GOVERNING LAW. This Agreement will be governed by and construed in accord with all applicable California laws. Any provision required to be in this Agreement by the Knox Keene Act and Regulations (California Code of Regulations Title 10 Section 1300 et seq.) shall bind the parties whether or not provided in this Agreement. This Agreement shall also be governed and construed in accord with applicable contractual requirements of Health Plan, as required under the Medi-Cal program.

9.10 NOTICES. Any notices required to be given under this Agreement by either party, or which may be made by either party to the other, shall be in writing, delivered personally, by facsimile, by overnight delivery service with written proof of delivery or by mail, registered or certified, postage prepaid, with return receipt requested addressed as follows:

THE PERMANENTE MEDICAL GROUP, INC.

Medical Services Planning & Contracting Support
1814 Franklin Street, 3rd Floor

Oakland, California 94612
Attn: Administrator
PHONE: (510) 987-3035
FACSIMILE: (510) 873-5005

STANISLAUS COUNTY HEALTH SERVICES AGENCY
830 Scenic Drive
Modesto, CA 95350
Attn: Managing Director
PHONE: (209)-558-7163
FACSIMIILE: (209)-558-7123

With a copy of such notice to:

Medical Director
Kaiser Permanente Administration
1625 I Street
Modesto, CA 95354

with a copy of such notice to:

County Counsel
1010 10th street
Modesto, CA 95354

or to such other address as a party from time to time informs the other in writing. If required by law or Health Plan Medi-Cal Contracts, Contractor shall provide notice of amendment or termination of this Agreement to DHS and Medi-Cal Plans, by first class certified mail, postage prepaid.

9.11 NON-EXCLUSIVITY. This is not an exclusive Agreement. Contractor and TPMG may enter into similar agreements with other parties. TPMG reserves the right to arrange for any services for Members from any other provider.

9.12 NO VOLUME GUARANTEE. TPMG does not represent, warrant, or covenant any minimum volume of patients or Members to Contractor.

9.13 WAIVER. A failure of either party to exercise any right provided for herein shall not be deemed a waiver of any right hereunder. No party will be deemed to have waived any rights hereunder unless the waiver is made in writing and is signed by the waiving party's duly authorized representative.

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

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

9.16 ENTIRE AGREEMENT. This Agreement, including the Exhibits attached hereto, contains the entire agreement of the parties and as of the Effective Date supersedes any prior contracts, agreements, negotiations, proposals or understandings relating to the subject matter of this Agreement.

9.17 UNUSUAL OR UNEXPECTED CIRCUMSTANCES.

(a) Neither of the parties shall be liable nor deemed in default for any delay or failure in performance under this Agreement resulting directly or indirectly from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, machinery or supplies, vandalism, strikes, or other work interruptions, or other cause beyond the reasonable control of either party. However, both parties shall make good faith efforts to perform under this Agreement in the event of any such

circumstance.

(b) Each party reserves the right to suspend this Agreement or any part thereof in the event of such circumstance. Upon notification by the suspending party that such circumstance-giving rise to the delay or failure in performance under this Agreement has ceased, this Agreement shall be revived for the remainder of the term.

9.18 REMEDIES CUMULATIVE. The rights and remedies of this Agreement shall not be exclusive and are in addition to any other rights and remedies provided by law.

9.19 MULTIPLE ORIGINALS; FACSIMILE COPIES

(a) This Agreement may be executed in multiple originals, each of which shall be binding upon the party whose signature it contains, and the combined total of which shall constitute the entire document.

(b) A facsimile copy of the entire Agreement, including its Exhibits, that contains the signature of an authorized representative of one or more of the parties shall be accepted as an original document for all purposes.

9.20 EXHIBITS TO AGREEMENT. The exhibits attached to this Agreement and incorporated herein are delineated in the Table of Contents for the Exhibits which is located immediately following the signature page. The Parties agree to be bound by the terms of these exhibits whether or not the exhibits are specifically referenced in the main body of this Agreement.

(The rest of this page intentionally left blank)

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their respective duly authorized representatives as of the dates set forth below.

THE PERMANENTE MEDICAL GROUP, INC.

By: _____
(signature)

Donald Kimzey, M.D.
Medical Director
Stanislaus Network for
Jack L. Gilliland, M.D.
Physician in Chief, Stockton

Date: 10/9/01

Reviewed By: _____
(signature)

Bellinda Rossmiller

Administrator
TPMG Medical Services Planning & Contracting Support

Date: 11/14/01

CONTRACTOR

By: _____
(signature)

Date: 10/9/01

Approved As to Form:

_____
County Counsel

Date: 9-20-2001

Board Action # 2001-749
Chief Executive Office

Date: 10/2/01

TABLE OF CONTENTS
FOR EXHIBITS TO AGREEMENT

EXHIBIT 1

PARTICIPATING PRACTITIONERS, PROVISION OF SERVICES AND AFFILIATED PAYORS

Exhibit 1 ("Participating Practitioners") consists of the following:

Exhibit 1.1 – List of Participating Practitioners and Locations

Exhibit 1.1.1 – Obligations of Contractor Related to Participating Practitioners

Exhibit 1.2 – Provision of Covered Services

Exhibit 1.2.1 - Obligations of Contractor Related to Provision of Covered Services

Exhibit 1.2.2 – Primary Care Services

Exhibit 1.2.3 – Urgent Care Services

Exhibit 1.3 – Affiliated Payors

Exhibit 1.4 – Other Rights and Obligations of the Parties

EXHIBIT 1.1

LIST OF PARTICIPATING PRACTITIONERS AND LOCATIONS

1. Participating Practitioner. Contractor shall provide the following information related to Participating Practitioners to TPMG, as part of this Exhibit 1.1, prior to execution of the Agreement. Additional pages of this Exhibit 1.1 may be added as necessary to provide the information requested for each Participating Practitioner.

(a) Name

(b) Identification of Participating Practitioner as an employee, owner, or Subcontractor of Contractor

(c) California (and/or other state) license number(s), as applicable

(d) DEA number(s), as applicable

(e) Specialty/Area of Practice

(f) Medi-Cal provider number, as applicable

(g) Medicare provider number, as applicable

(h) Tax Identification Number(s) ("TIN") which will be used for billing or reporting of services under this Agreement

(i) Practice name registered to TIN(s)

(j) Practice office address(es)

(k) Practice office telephone number(s)

(l) Billing office address(es)

(m) Billing office telephone number(s)

(n) Billing office fax number(s)

EXHIBIT 1.1.1

OBLIGATIONS OF CONTRACTOR RELATED TO PARTICIPATING PRACTITIONERS

All capitalized terms used in Exhibit 1.1.1 which are not otherwise defined in the Agreement are defined as set forth in Exhibit 5.

1. Amendment of List of Participating Practitioners. In the event Contractor wishes to amend the list of Participating Practitioners set forth in Exhibit 1.1, Contractor shall give TPMG thirty (30) days' prior written notice of any addition, deletion or substitution to such list of Participating Practitioners. No addition of a Participating Practitioner shall be effective unless and until the Participating Practitioner meets all of the terms and conditions of this Agreement necessary to provide Covered Services, and TPMG approves such change.

2. Amendment of Participating Practitioner Locations. No addition, deletion, or substitution of a Participating Practitioner practice location under this Agreement shall be effective unless and until TPMG approves such change.

3. Authorization for Directory Listing. Contractor consents to the listing of its name, address, telephone number, the name of each Participating Practitioner listed in Exhibit 1.1, as amended from time to time according to this Exhibit 1.1.1, the areas of practice, and scope of service in directories produced by KP. In the event the listing information is or becomes inaccurate or incomplete, or this Agreement is terminated, KP shall have no obligation to correct, delete, or update such listing information until such time as it, in the normal course of business, issues a new directory.

4. Provision of Directory. KP shall provide to Contractor such directories as may be amended from time to time and such other information regarding the listed Kaiser Providers in the Stanislaus Program (other than TPMG providers) as may be appropriate.

EXHIBIT 1.2

PROVISION OF COVERED SERVICES

All capitalized terms used in Exhibit 1.2 which are not otherwise defined in the Agreement are defined as set forth in Exhibit 5.

1. Type of Services.

   Contractor and its Participating Practitioners shall provide the primary care services as described in this Exhibit 1.2 and its subexhibits.

   Contractor is also being retained to provide Medical Oncology specialty Services.

2. Type of Specialty.

   Family Practice
   Internal Medicine
   Medical Oncology/Hematology
   Stat or same day lab services
   Urgent Care
   Radiology (as needed for Urgent Care)

3. Emergency Services. Contractor and its Participating Practitioners shall provide or arrange for the provision of Emergency Services twenty-four (24) hours per day, seven (7) days per week.

4. Workers' Compensation Services. The scope of Services described in this Exhibit 1.2 includes provision of care to patients seen in conjunction with Workers' Compensation injury services provided by KP. The terms of the Agreement pertaining to Contractor's obligations to Members shall be interpreted also to apply to these Workers' Compensation patients who are Members to whom such Services are provided. Contractor shall comply with all state and federal laws applicable to Workers' Compensation services.

5. Other Special Services.

   Contractor may provide assistant surgeon services when such services are required, and have been pre-Authorized by KP.

   Contractor may provide diagnostic radiology services at Contractor's urgent care facility locations.

EXHIBIT 1.2.1

OBLIGATIONS OF CONTRACTOR RELATED TO PROVISION OF COVERED SERVICES

All capitalized terms used in Exhibit 1.1.2 which are not otherwise defined in the Agreement are defined as set forth in Exhibit 5.

1. Referrals.

1.1. Referrals to Other Health Care Providers. When medically necessary, Contractor shall refer Members to other health care providers, whether within or outside the Stanislaus Program, in accordance with the Provider Manual and with prior Authorization, if required.

1.2. Coordination of Care. Contractor shall coordinate the provision of Covered Services to Members referred by Contractor to other health care providers, whether within or outside the Stanislaus Program, in accordance with the Provider Manual.

1.3. Referrals to PCPs. Contractor shall refer Members to the Member's PCP or non-physician primary care practitioner for the provision of primary care Covered Services.

2. Waiting Times for Appointments. Appointment waiting times for Members shall not exceed the time frames set forth in the Provider Manual.

3. New Patients.

3.1. Previous Patients. Contractor shall accept as a patient each Member (and such Member's immediate family members) who is or has been a patient of Contractor at anytime during the two (2) years immediately prior to such Member requesting Covered Services from Contractor or selecting or being assigned to a Participating Practitioner as his/her PCPP.

3.2. Open Practice. In addition, Contractor shall accept any Member as a patient during such times that the Contractor's practice is open to new patients.

3.3. Choice of Primary Care Practitioners. A Member receiving Covered Services from Contractor shall have the same choice of primary care Participating Practitioners as do other patients of Contractor.

3.4. Closed Practice. Contractor shall notify TPMG immediately in the event Contractor's or a Participating Practitioner's practice is not open to new patients.

3.5. Services to Other Members. Contractor shall provide Covered Services to Members who are not regular patients of Contractor as set forth in the Provider Manual.

4. PCP Minimum Member Panel. Contractor shall at all times ensure that the PCPs employed by or contracted with Contractor remain available to accept Members. Contractor agrees that either:

(a) fifty percent (50%) of the overall practices of Contractor's PCPs shall remain open to accept new Members; or

(b) Contractor shall maintain at least the Minimum Average Membership; or

(c) the growth rate of Members for each of Contractor's PCPs shall be proportional to the growth rate of Health Plan Members selecting or assigned to all Core Medical Groups, including Contractor, and to other PCPs who are Kaiser Providers in the Stanislaus Program.

For purposes of this Section 4, in determining the size of a PCP's practice in connection with Members, Members who are under the age of one (1) or who are at least age sixty-five (65), as such age is determined by TPMG, shall each count as two (2) Members. The above requirements shall be adjusted for PCPs who work less than "full-time", as "full-time" is mutually defined by the parties. (Upon request, TPMG will provide Contractor with written examples of such adjustments.) PCPs newly associated with Contractor shall not be included in determinations under this Section 4 for the first twelve (12) months of their association with Contractor. In addition, TPMG shall not determine PCP minimum Member panel size under this Section 4 for the first six (6) months of the term of this Agreement.

EXHIBIT 1.2.2

PRIMARY CARE SERVICES

All capitalized terms used in Exhibit 1.2.2 which are not otherwise defined in the Agreement are defined as set forth in Exhibit 5.

The following tables provide CPT codes for services which are commonly performed by PCPPs within the Stanislaus Program. Contractor will provide these primary care Covered Services in accordance with the guidelines set forth in the Provider Manual but only when such primary care Covered Services are within the scope of Contractor's practice and training. Any services not listed in these tables are considered specialty services and are not primary care services. Any Covered Services set forth in this Exhibit 1.2.2 and Exhibit 1.2.3 provided during a primary care appointment shall be deemed to be primary care Covered Services hereunder, unless otherwise provided in this Agreement.

These tables are an all-inclusive list of PCPP services. Successor or replacement codes shall be automatically substituted for the codes and ranges of codes listed in this Exhibit 1.2.2 so long as the Covered Services described by the replacement codes remain substantially similar to those of the superseded codes.

TPMG may revise these tables from time to time.

GROUP A

Description	CPT Codes
CPT CODING	
Evaluation and Management ("E & M")	
Office & other outpatient services	99201 – 99215
Hospital observation services	99217 – 99220
Hospital inpatient services	99221 – 99239
Consultations	99241 – 99275
Emergency department services	99281 – 99288
Critical care services	99291 – 99292
Nursing facility services	99301 – 99313
Custodial care services	99321 – 99333
Home services	99341 – 99353
Prolonged services	99354 – 99360
Case management services	99361 – 99373
Care plan oversight services	99375 – 99376
Preventive medicine	99381 - 99429
Integumentary system	
Integumentary system procedures	10040 – 19499
Musculosketetal System	
Incision of soft tissue abscess; superficial	20000
Injection, tendon sheath, ligament, trigger points or ganglion cyst	20550
Arthrocentesis; aspiration and or injections of joints	20600 – 20610
Closed treatment of skull fracture without operation	21300
Closed treatment of nasal bone fracture without manipulation	21310

GROUP A

Description	CPT Codes
Closed treatment of rib fracture, uncomplicated, each	21800
Closed treatment of clavicular fracture; without manipulation	23500
Closed treatment of shoulder dislocation, with manipulation; without anesthesia	23650
Closed treatment of distal phalangeal fracture, finger or thumb, each	26750
Closed treatment of coccygeal fracture	27200
Closed treatment of fractured great toe, phalanx, or phalanges; without manipulation	28490
Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation. Each	28510
Strapping; hip	29520
Strapping; knee	29530
Strapping; ankle	29540
Strapping; toes	29550
Respiratory System	
Removal of foreign body, nose	30300
Control nasal hemorrhage	30901
Control nasal hemorrhage, posterior, initial nasal hemorrhage, posterior, subsequent	30905
Cardiovascular System	
Venipuncture IV < 3 years old	36400
Venipuncture, scalp vein	36405
Venipuncture, routine	36415
Digestive System	
Proctosigmoidoscopy	45300
Sigmoidoscopy, flexible	45330
Sigmoidoscopy, flexible, with biopsy	45331
Incision and drainage, perianal abscess; superficial	46050
Enucleation or excision of external thrombotic hemorrhoid	46320
Anoscopy	46600
Urinary System	
Aspiration of bladder by needle	51000
Catheterization, urethra; simple	53670
Male Genital System	
Destruction of lesions, simple; chemical	54050
Circumcision	54150 – 54160
Drainage of scrotal wall abscess	55100
Female Genital System	
Incision & drainage of Bartholin's gland abscess	56420

GROUP A

Description	CPT Codes
Destruction of lesions; simple, any method	56501
Irrigation of vagina, treatment of vaginal infection	57150
Insertion of pessary	57160
Diaphragm/cap fitting	57170
Biopsy, single or multiple (cervical polyp)	57500
Removal of IUD	58301
Nervous System	
Lumbar puncture	62270
Lumbar puncture; therapeutic, for drainage by needle or catheter	62272
Eye & Ocular Adnexa	
Removal of foreign body, external eye	65205
Removal of foreign body, corneal, without slit lamp	65220
Auditory System	
Drainage external ear, abscess or hematoma; simple	69000
Removal of foreign body, ear	69200
Cerumen removal	69210
Pathology and Laboratory	
Venipuncture	36410 – 36425
Urinalysis; routine with/without microscopy	81000 – 81007
Urinalysis; routine, microscopic only	81015
Pregnancy testing	81025, 84703
Occult blood testing	82270 – 82273
Glucose testing (except urine)	82947 – 82948
Hematocrit	85013, 85014
Hemoglobin	85018
Strep test	87880
TB skin test intradermal	86580
TB tine test	86585
Wet mount	87210 – 87211
Tissue exam for fungi	87220
Immunizations & Injections	
Immunization injections (excluding vaccines) ***(For vaccines, antigens, biological, and other injectibles see the appropriate HCPCS "J" Codes set forth in the Group B table)***	90281 – 90749
Therapeutic/Diagnostic infusions (excluding chemotherapeutic agents)	90780 – 90781
Therapeutic/Diagnostic injections	90782 – 90799
Allergy injections (excluding antigens)	95115 – 95117
Psychiatry	
Pharmacological management, including prescription, use, and	90862

GROUP A

Description	CPT Codes
review of medication with no more than minimal medical psychotherapy	
Otorhinolaryngologic Services	
Screening tests, pure tone, air and bone	92551 – 92553
Tympanometry	92567
Cardiovascular Services	
Electrocardiogram, complete	93000
Electrocardiogram, tracing	93005
Electrocardiogram report	93010
Rhythm ECG, with report	93040
Rhythm ECG, tracing	93041
Rhythm ECG report	93042
Pulmonary Services	
Spirometry	94010, 94060
Peak flow	94200, 94250
Nonpressurized inhalation treatment for acute airway obstruction	94640, 94650
Aerosol or vapor inhalations	94664, 94665
Allergy & Clinical Immunology	
Allergy injections (excluding antigens)	95115 – 95117
Central Nervous System	
Developmental testing	96110
HCPCS CODING	
Medical & surgical supplies	A4206 - A6406
Enteral & parenteral therapy	B4034 - B9999

GROUP B

Description	CPT Codes
CPT CODING	
Evaluation and Management ("E & M")	
Neonatal intensive care services ***(Need TPMG approval to provide such services under this Agreement)***	99295 - 99297
Well-woman exam ***(identified by indicating ICD-9 diagnostic code v72.3)***	99384 – 99387 99394 – 99397
New born care	99431 - 99440
Special E & M services, life/disability/workers' compensation	99450 - 99456
Other E & M services	99499
Musculosketetal System	
Application of long arm cast (shoulder to hand)	29065
Application of short arm cast (elbow to finger)	29075
Application of gauntlet cast (hand and lower forearm)	29085
Application of arm splints	29105, 29125, 29126
Application of finger splints	29130 - 29131
Application of leg casts	29345 - 29450
Application of leg splints	29505, 29515
Male Genital System	
Vasectomy	55250
Female Genital System	
Colposcopy with and without with biopsy	57452 - 57454
Endometrial biopsy	58100
Cardiovascular Services	
Electrocardiogram treadmill	93015
Holter monitor	93224
Osteopathic Manipulative Treatments	
Osteopathic Manipulative Treatments	98925 - 98929
Supplies	
Supplies and materials (surgical supplies, dressings, etc.)	99070
HCPCS CODING	
Cast & splint supplies for FFS cast/splint services	A 4570, A4580, A4590
Drugs administered other than oral	J0120 - J8999
Chemotherapy drugs	J9000 - J9999
Diagnostic radiology services (transportation of x-ray equip.) ***(While radiology services are generally considered specialty services, Contractor may provide such services in Contractor's urgent care facility(ies) as urgent care primary care services)***	R0070 - R0076

EXHIBIT 1.2.3

URGENT CARE PRIMARY CARE SERVICES

1. Urgent Care Services. Contractor shall provide urgent care primary care Covered Services in accordance with this Exhibit 1.2.3. In addition to the Group A Covered Services and Group B Covered Services when provided by Contractor on an urgent care basis, Contractor may also provide the medically necessary laboratory services and diagnostic radiology services, on an urgent basis, that Contractor customarily provides to Contractor's patients, which services shall be considered Group B Covered Services under Exhibit 1.2.2 for purposes of compensation under this Agreement.

2. Hours of Availability. Contractor shall provide urgent care primary care Covered Services hereunder during the established schedule based upon the patient population needs as indicated by the medical staff at the facility. Contractor may expand or contract the basic schedule as deemed necessary by Contractor. In general, Contractor is expected to be available to provide services seven days a week during hours designated by contractor excluding state and federal holidays.

3. Locations. Contractor shall provide urgent care primary care Covered Services pursuant to this Exhibit 1.2.3 at 830 Scenic Road, Modesto, California 95354, or such other additional or replacement locations as mutually agreed to by the parties. Contractor acknowledges that locations may be added or deleted only in accordance with Section 2.13 of this Agreement and Section 2 of Exhibit 1.1.1.

EXHIBIT 1.2.3.1

LABORATORY SERVICES

The following medically necessary laboratory services may be provided by Contractor in accordance with Section 1 of Exhibit 1.2.3. In the event event Contractor orders, at one time, for a single Member, any two (2) or more tests under one panel, Contractor shall bill for the panel instead of billing for each individual test separately.

Laboratory Services	
Basic Metabolic Panel (which includes the tests listed below)	**80048**
Sodium NA	84295
Potassium K	84132
Chloride CL	82435
Carbon Dioxide CO2	82374
Glucose	82947
Creatinine	82565
BUN	84520
Calcium	82310
Comprehensive Metabolic Panel (which includes the tests listed below)	**80053**
NA	84295
K	84132
CL	82435
CO2	82374
Glucose	82947
Creatinine	82565
BUN	84520
Calcium	82310
T.Bilirubin	82247
Direct Bilirubin	82248
Indirect Bilirubin	
ALT	84460
AST	84450
ALP	84075
T.Protein	84155
Albumin	82040
Globulin	
A/G Ratio	
CBC (which includes the tests listed below)	**85007 or 85025**
WBC	85021
RBC	
HGB	
HCT	

MCV	
MCHC	
PLT	
MPV w/ Auto pr Manual Diff.	
Electrolytes Panel (which includes the tests listed below)	**80051**
CL	82435
CO2	82374
K	84132
NA	84295
A/G Ratio	
Renal Function Panel (which includes the tests listed below)	**80069**

ALB	82040
CA	82310
CO2	82374
CL	82435
Creatinine	82565
Glucose	82947
PO4	84100
K	84132
NA	84295
BUN	84520
Hemogram Panel (which includes the tests listed below)	**85031**
WBC	85021
RBC	
HGB	
HCT	
MCV	
MCHC	
PLT	
MPV	
CSF/ Body Fluids (which includes the tests listed below)	**89060**
Cell count	89050
Total protein	84155
Glucose	82947
(Albumin on Acites Fluid only)	
Semen, Complete Analysis	89320
Semen, Presence or Absence	89321
Bleeding time	85002
Prothrombin time	85610
PTT	85730

EXHIBIT 1.3

AFFILIATED PAYORS

Contractor agrees that the following Affiliated Payors are covered under the terms of this Agreement. Contractor agree to provide Services under this Agreement to patients related to these Affiliated Payors even if these Affiliated Payors do not actively encourage their patients to use Contractor for emergency services.

Health Plan and the Affiliated Payors "actively encourage" Members and their subscribers and dependents, respectively, to use the contracted providers for non-emergency services through the use of financial incentives as described in Section 511.1(b)(2)(A) of the California Business and Professions Code. Under the agreements by which the Affiliated Payors cover their subscribers' and dependent's health care, coverage is provided for non-emergency services only if the services are authorized under those agreements. Services which are not covered become the financial obligation of the subscribers.

The "Affiliated Payors" are:

Kaiser Foundation Health Plan, Inc. and the following:

Kaiser Foundation Health Plan of Colorado
Kaiser Foundation Health Plan of Georgia, Inc.
Kaiser Foundation Health Plan of Kansas City, Inc.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Kaiser Foundation Health Plan of the Northwest
Kaiser Foundation Health Plan of Ohio
Kaiser Foundation Added Choice Health Plan, Inc.
Kaiser Foundation Health Plan of the Northwest
Group Health Cooperative (headquartered in Seattle, Washington)
Texas Health Choice

Kaiser Foundation Hospitals

The following Permanente Medical Group organizations:

Southern California Permanente Medical Group and the following subcontracting medical groups
Desert Medical Group, Inc.
Oasis Independent Practice Association
Alan Schoengold, M.D., P.C. doing business as "Seaview IPA"
Colorado Permanente Medical Group, P.C.
Hawaii Permanente Medical Group, Inc.
Mid-Atlantic Permanente Medical Group, P.C.
Northwest Permanente, P.C., Physicians and Surgeons
Ohio Permanente Medical Group, Inc.
Permanente Dental Associates
Permanente Medical Group of Mid-America, Inc.
The Southeast Permanente Medical Group, Inc.
Permanente Services of Hawaii
The Permanente Federation

EXHIBIT 1.4

OTHER RIGHTS AND OBLIGATIONS OF THE PARTIES

All capitalized terms used in Exhibit 1.4 which are not otherwise defined in the Agreement are defined as set forth in Exhibit 5.

1. Other Contractor Rights and Obligations.

1.1. Product Lines. Contractor shall provide Covered Services to Members in connection with all product lines of KP, as requested by TPMG.

1.2. Protocols. Contractor shall work with TPMG and the Stanislaus Leadership Council, where appropriate, to develop protocols for the care and referral of Members.

1.3. Prescriptions. When prescribing oral medications, Contractor shall prescribe oral medications in accordance with applicable KP policies and procedures and the Provider Manual.

1.4. Call Coverage. Contractor shall participate in call-coverage provided to unassigned Members only at Stanislaus Program hospitals and skilled nursing facilities, as appropriate, when mutually agreed to by the parties. Contractor will be compensated for Covered Services provided to such Members pursuant to such call-coverage in accordance with Exhibit 2 of this Agreement.

1.5. Hospital Privileges. Contractor shall ensure that all applicable Participating Practitioners maintain throughout the term of this Agreement full active staff privileges at Memorial Hospitals Association and Doctors Medical Center in Modesto, California, including all clinical privileges necessary for the Participating Practitioner to provide Covered Services.

1.6. Nondiscrimination. Contractor shall provide to Members the same access to primary care Participating Practitioners as is available to Contractor's patients who are not Members. Contractor and each Participating Practitioner shall be available to provide services to Members during the same hours, days and availability as is offered to patients who are not Members. Contractor shall not unlawfully discriminate against Members on the basis of the Member's health status, his or her status as a member of Health Plan, or the type of payment Contractor receives in connection with Covered Services provided to any Member.

1.7. Non-Solicitation of Members. During the term of this Agreement, and for one (1) year thereafter, Contractor shall not solicit, induce, or encourage: (i) any Member to disenroll from Health Plan; or (ii) any employer, labor union, or self-insured organization to cease offering Health Plan to its employees. Nothing in this Section 1.7, however, is intended to be construed as a prohibition of any open practitioner – patient communication permitted by Article IX of the Agreement and by applicable provisions of law.

1.8. Site Evaluations and Inspections. If during the course of an audit of Contractor's or Participating Practitioner's offices, facilities, or records, Government Officials, accreditation organizations such as the National Committee for Quality Assurance ("NCQA") or the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), or KP, in accordance with state or federal laws, regulations, or accreditation requirements, find any deficiencies, Contractor shall have sixty (60) days to substantially correct such deficiencies which are identified by such Government Officials, accreditation organizations, or KP. Contractor may request extensions of such sixty (60) calendar day correction period, as may be permitted by law, and KP shall have sole discretion in determining whether to approve the request for such extensions.

1.9. Verification of Eligibility. Contractor shall verify the eligibility of a Member prior to the provision of Covered Services hereunder, in accordance with the procedure set forth in the Provider Manual. Unless Contractor verifies a Member's eligibility prior to the provision of Covered Services, Contractor understands that Contractor may not be compensated for the provision of such Covered Services.

1.10. Stanislaus Leadership Council. At the request of the TPMG, Contractor shall appoint a representative to serve as a member of the Stanislaus Leadership Council.

1.11. Stanislaus Advisory Management Team. Contractor shall appoint a representative to serve as a member of the Stanislaus Advisory Management Team (the "Team"). Contractor shall also designate an alternate to attend Team meetings in the absence of Contractor's representative. In the event a decrease in the number of Core Medical Groups would cause the number of Core Medical Group representatives on the Team to be fewer than the combined number of TPMG and Health Plan representatives, TPMG and Contractor, along with the other Core Medical Groups, shall promptly meet and confer regarding revising the composition of the Team.

1.12. Specialist Services Agreement. In the event there is now or hereafter a separate agreement between TPMG and Contractor for specialist services not otherwise covered by this Agreement, such specialist services agreement shall remain or be in full force and effect according to its terms, and such specialist services agreement shall not be superseded by this Agreement. This Agreement shall not be superseded by such specialist services agreement.

1.13. Encounter Data. Contractor shall furnish to TPMG encounter data related to the provision by Contractor of capitated Covered Services to Capitated Members within thirty (30) days of the date of such Covered Services. Such encounter data shall be submitted in the format set forth in the Provider Manual and shall include, at a minimum, the information listed in Section 1.1(a) of Exhibit 2.3. Contractor shall provide such encounter data to TPMG even if such Services are provided by Participating Practitioners or other Subcontractors.

1.14. Payment to Participating Practitioners and Subcontractors. Contractor shall be responsible to compensate any and all Participating Practitioners and Subcontractors that provide Covered Services hereunder on Contractor's behalf. TPMG shall have no obligation to compensate such Participating Practitioners and Subcontractors for the provision of such Covered Services hereunder.

1.15. Compliance with HCFA Regulations Regarding Financial Solvency. If Contractor receives Capitation Payments for Medicare+Choice Members pursuant to Section 1.1 of Exhibit 2.4.2, Contractor will comply with all policies and procedures established by KP and/or HCFA in connection with maintenance of the financial solvency of Contractor. Contractor shall provide to KP reports as requested by HCFA or KP to demonstrate the financial solvency of Contractor and Contractor's timeliness of payment of claims, as applicable. Contractor shall allow HCFA or KP, or agents of HCFA or KP, access to its financial records and other information in order to audit Contractor's administrative capabilities, including without limitation assessment of claims processing, financial planning and reporting and incurred but not reported claims estimation capability. If HCFA or KP determines that Contractor's financial solvency is unstable, Contractor agrees to cooperate with any corrective plan of action implemented by KP.

1.16. Payment to Core Medical Groups. If a Capitated Member receives Group A Covered Services from a capitated Core Medical Group, other than Contractor, Contractor shall reimburse such Core Medical Group for the provision of such Services, based on the quarterly report provided by TPMG in accordance with Section 2.2 of this Exhibit 1.4. Contractor shall reimburse such Core Medical Group no later than ninety (90) days after receipt of the quarterly report from TPMG in accordance with the fees set forth in Exhibit 2.2 of this Agreement. TMPG shall identify any Core Medical Groups to which this Section 1.15 does not apply.

1.17. Payment for Covered Services Provided to Other Members. If Contractor provides Group A Covered Services other than urgent care primary care services as described in Exhibit 1.2.3, to a Member selecting or assigned to another capitated Core Medical Group, Contractor shall collect from such Core Medical Group compensation for the provision of such Services to such Members, based on the quarterly report provided by TPMG in accordance with Section 2.2 of this Exhibit 1.4, and Contractor shall accept from such Core Medical Group the fees set forth in Exhibit 2.2 of this Agreement as payment for the provision of such Services to such Members. TMPG shall identify any Core Medical Groups to which this Section 1.16 does not apply. Such urgent care primary care services to a Member selecting or assigned to another capitated Core Medical Group, shall be compensated as set forth in Exhibit 2.2.

2. Other TPMG Rights and Obligations.

2.1. Compensation. TPMG shall compensate Contractor for Covered Services provided hereunder in accordance with Exhibit 2 of this Agreement.

2.2. Quarterly Report. On a quarterly basis, TPMG shall provide Contractor with a report identifying the Group A Covered Services provided to Capitated Members by other capitated Core Medical Groups.

2.3. Protocols. TPMG, in conjunction with the Stanislaus Leadership Council, shall develop protocols for the care and referral of Members.

2.4. List of Capitated Members. On or before the twentieth (20^{th}) day of each month, TPMG shall provide to Contractor a list of Capitated Members who have selected or have been assigned to Contractor for that month. At all other times during normal business hours, KP shall answer inquiries from Contractor regarding Member eligibility and whether a Member has selected or been assigned to one of Contractor's PCPPs.

3. Other KP Rights and Obligations.

3.1. Changes in Primary Care Practitioner Assignment. KP may make additions and deletions to Member assignments to primary care practitioners.

3.2. Primary Care Practitioner Selection Procedures. KP shall develop, and, from time to time, may modify, procedures and policies governing selection of primary care practitioners by Members. KP may contact and discuss with Members the selection of primary care practitioners, changes in the selection of primary care practitioners, or any other matter which KP elects to discuss with such Member. KP may identify and contact Members to encourage re-assignments to another Stanislaus primary care provider when a Member has sought care from a non-Contractor primary care practitioner three (3) or more times during a calendar year. KP may automatically reassign Members, who continue to seek care from practitioners other than the primary care practitioner they have selected or been assigned to, to the most frequently used primary care practitioner. Contractor acknowledges that Members have the option to change primary care practitioner assignments at any time.

3.3. Termination of Agreement. In the event that either party terminates this Agreement in accordance with Section 4.2 of this Agreement, after consultation with Contractor, KP may take any of the following actions during the notice period:

(a) Stop assigning additional Members to, or permitting additional Members to select, Contractor; and/or

(b) Transfer or commence to transfer Members to other Core Medical Groups or other TPMG providers at anytime during the notice period, in KP's sole discretion.

EXHIBIT 2

COMPENSATION

Exhibit 2 ("Compensation") consists of the following:

Exhibit 2.1 – General Compensation and Related Terms

Exhibit 2.2 – Fee-For-Service Compensation

Exhibit 2.2.1 –Rate Schedule

Exhibit 2.3 – Fee-For-Service Billing Procedures and Encounter Data Submissions

Exhibit 2.4 – Compensation Related to Capitated Members

Exhibit 2.4.1 – Capitation Formula

Exhibit 2.4.2 – Medicare+Choice Members

Exhibit 2.5 – Additional Compensation

EXHIBIT 2.1

GENERAL COMPENSATION AND RELATED TERMS

All capitalized terms used in Exhibit 2.1 which are not otherwise defined in the Agreement are defined as set forth in Exhibit 5.

For the purposes of compensation, any other services not listed in Exhibit 1.2.2 or 1.2.3 are specialty services outside the scope of PCPP services. Only the specialty services set forth in Exhibit 1 and its subexhibits or those specialty services Authorized by KP shall be reimbursed under this Agreement.

1. Compensation. In consideration for the provision to Members by Contractor of Covered Services in accordance with Exhibit 1, TPMG shall pay Contractor in accordance with Exhibit 2.2 (Fee-for-Service Compensation) and Exhibit 2.4 (Capitation Payments). When compensation for Covered Services is provided to Contractor by TPMG under Exhibit 2.4, no compensation will be provided to Contractor by TPMG for such Covered Services under Exhibit 2.2; similarly, when compensation for Covered Services is provided to Contractor by TPMG under Exhibit 2.2, no compensation will be provided to Contractor by TPMG for such Covered Services under Exhibit 2.4. Contractor shall accept such compensation, along with applicable Member Copayments, as payment in full by TPMG to Contractor for the provision to Members by Contractor of all Covered Services and all administrative and other services set forth in this Agreement. Contractor shall be responsible to compensate any and all Participating Practitioners and Subcontractors that provide Covered Services hereunder on Contractor's behalf. TPMG shall have no obligation to compensate such Participating Practitioners or Subcontractors for the provision of such Services hereunder.

2. Adjustments to Compensation.

2.1. Adjustments Related to PCP Minimum Member Panels

Contractor acknowledges and agrees that ten percent (10%) of Contractor's Capitation Payments hereunder are paid by TPMG in consideration for the availability of Contractor's PCPs to accept Members as required under Section 4 of Exhibit 1.2.1. In the event Contractor, during any quarter, fails to comply with the obligations set forth in Section 4 of Exhibit 1.2.1, then TPMG shall decrease the Capitation Payments payable to Contractor in the following quarter by an amount equal to ten percent (10%) of Contractor's Base Capitation in effect during such quarter.

2.2. Adjustments Related to Actual Member Panel Size

If, during any quarter, the average number of Members per "full-time Contractor PCP" (as such term is mutually defined by the parties) is greater than or equal to the Minimum Average Membership but less than 1500 Members, TPMG shall pay Contractor during the following quarter, as compensation for Group A Covered Services provided hereunder, the Base Capitation in effect during such quarter. If, during any quarter, the average number of Members per full-time Contractor PCP is equal to or greater than 1500 Members, TPMG shall pay Contractor during the following quarter, as compensation for the provision of such Covered Services, one hundred five percent (105%) of the Base Capitation in effect during such quarter.

3. Special Compensation Rules.

3.1. Anesthesia Services. Compensation for anesthesia services provided by Contractor in conjunction with primary care Covered Services shall be included in the compensation paid to Contractor for the primary CPT code for the primary care Covered Services provided.

3.2. Pathology and Laboratory Services. Only the pathology and laboratory services listed in Exhibit 1.2.2 as primary care services will be compensated by TPMG in accordance with this Exhibit 2. Contractor will receive no compensation for laboratory tests, other than those listed in Exhibit 1.2.2 or Exhibit 1.2.3.

3.3. Special Services and Reports. All Services described as "special services and reports" under the CPT-4 code listings in effect as of the date of Service shall not be reimbursed unless such Services are listed as Group B Services in Exhibit 1.2.2 or unless otherwise required by law.

3.4. Modifiers. When appropriate, Contractor shall apply applicable modifiers to CPT codes when Contractor bills for Covered Services in accordance with this Exhibit 2, or when Contractor reports encounter data in accordance with Section 1.13 of Exhibit 1.4 in connection with Covered Services to the extent Contractor receives Capitation Payments.

3.5. Assistant Surgeon Services. If Contractor provides medically necessary assistant surgeon services, Contractor will be compensated in accordance with Exhibit 2.2 when such assistant surgeon services have been pre-authorized by KP.

3.6. Prescriptions. Contractor shall not receive any additional compensation for oral medications dispensed from the Participating Practitioner's office, other than oral vaccines prescribed in accordance with the Member's coverage.

3.7. Radiology Services. While radiology services are generally considered specialty services, if Participating Practitioners provide X-ray services in conjunction with urgent care services according to Exhibit 1.2.3, such services which are Covered Services hereunder will be reimbursed as Group B Covered Services.

4. Offsets Against Compensation. In addition to any other offsets allowed by this Agreement, TPMG may offset against compensation paid to Contractor hereunder any amounts paid by TPMG to any Core Medical Group or other medical groups that are Kaiser Providers in consideration for Group A Covered Services provided to Capitated Members.

5. Retroactive Enrollment/Termination of Members.

5.1. Retroactive Enrollment. In the event Health Plan retroactively enrolls an individual in Health Plan, TPMG shall compensate Contractor in accordance with Exhibit 2.2 and Exhibit 2.4, subject to applicable coordination of benefits rules as described in Section 3.6 of this Agreement and Section 6.5 of this Exhibit 2.1, for Covered Services provided to such individual from the date such individual becomes a Member; provided, however, that TPMG shall pay Contractor retroactively for such services only for a retroactive period not to exceed ninety (90) days. Contractor shall refund to the Member any amount collected from the individual from the date such individual became a Member, other than applicable Copayments.

5.2. Retroactive Termination. In the event Health Plan retroactively terminates the membership of a Member, and Contractor has provided services to such individual during the period of retroactive termination, TPMG shall compensate Contractor in accordance with Exhibit 2.2 and Exhibit 2.4 for Covered Services provided to such individual during such period; provided however, that TPMG shall pay Contractor retroactively for such services only for a retroactive period not to exceed ninety (90) days and provided, however, that Contractor has unsuccessfully billed the individual for such services through two (2) consecutive monthly billing cycles. Notwithstanding the foregoing, TPMG shall have no obligation to compensate Contractor hereunder for services provided to an individual retroactively terminated from membership in the event that such individual is covered during such period of retroactive termination by another health care service plan, insurer, or third party payor.

6. Other Compensation.

6.1. Newborn Dependents. TPMG shall reimburse Contractor for Covered Services provided to newborn dependents of Members' covered dependent children only on a fee-for-service basis in accordance with Exhibit 2.2. TPMG shall reimburse Contractor for Covered Services provided to newborn dependents of Members' covered dependent children only during such time as Health Plan is obligated to cover such dependents of dependents.

6.2. Workers' Compensation. TPMG shall pay Contractor for Covered Services provided to patients who are covered by the Workers' Compensation program at the lesser of the fee-for-service rates set forth in Exhibit 2.2 or an amount specified by the applicable Workers' Compensation fee schedule established by law or by regulation of the California Department of Industrial Relations or other appropriate state regulatory agency.

6.3. Copayments. TPMG shall notify of, or otherwise make available to, Contractor any Copayment requirements for each category of Member, and Contractor shall collect and retain such Copayments at the time Covered Services are rendered. Contractor shall not waive the Copayments required by Health Plan.

6.4. Call Coverage.

The parties agree that in the event call coverage is mutually agreed to by the parties in accordance with Section 1.4 of Exhibit 1.4, TPMG shall reimburse Contractor as follows. All payments made pursuant to this Section 6.4 may be subject to adjustment as described in Section 3.3 of this Agreement and to the Coordination of Benefits rules set forth in Section 3.6 of this Agreement. Contractor shall bill for such Covered Services in accordance with Exhibit 2.3:

(a) For Covered Services provided to unassigned Commercial Members, TPMG shall pay Contractor the lesser of billed charges, the rate(s) set forth on Exhibit 2.2.1, if listed, or one hundred forty percent (140%) of the RBRVS fee as of the date the Covered Services were rendered; provided, however, that if there is no assigned RBRVS fee for a Covered Service, then the applicable rate shall be fifty-five percent (55%) of the billed charge accepted by KP as usual, customary and reasonable for such Covered Service;

(b) For Covered Services provided to unassigned Medicare+Choice Members, TPMG shall pay Contractor the rates set forth in Section 1.2 of Exhibit 2.2;

(c) For Covered Services provided to unassigned Regular Medicare Members, TPMG shall pay Contractor the rates set forth in Section 1.3 of Exhibit 2.2;

(d) For Covered Services provided to unassigned Medi-Cal Members, TPMG shall pay Contractor the lesser of the rates set forth in Section 6.4(a) of this Exhibit 2.1 or the amount specified by the applicable Medi-Cal fee schedule established by law or by regulation of the California Department of Health Services or other appropriate state regulatory agency.

6.5. Non-facility-Based Services Provided to Unassigned Members. In the event Contractor provides primary care Covered Services to unassigned Members outside the hospital or skilled nursing facility setting, TPMG shall pay Contractor as follows. All payments made pursuant to this Section 6.5 may be subject to adjustment as described in Section 3.3 of this Agreement and to the Coordination of Benefits rules set forth in Section 3.6 of this Agreement:

(a) For Covered Services provided to unassigned Commercial Members, TPMG shall pay Contractor the lesser of billed charges, the rate(s) set forth on Exhibit 2.2.1, if listed, or one hundred thirty percent (130%) of the RBRVS fee as of the date the Covered Services were rendered; provided, however, that if there is no assigned RBRVS fee for a Covered Service, then the applicable rate shall be fifty-five percent (55%) of the billed charge accepted by KP as usual, customary and reasonable for such Covered Service;

(b) For Covered Services provided to unassigned Medicare+Choice Members, TPMG shall pay Contractor the rates set forth in Section 1.2 of Exhibit 2.2;

(c) For Covered Services provided to unassigned Regular Medicare Members, TPMG shall pay Contractor the rates set forth in Section 1.3 of Exhibit 2.2;

(d) For Covered Services provided to unassigned Medi-Cal Members, TPMG shall pay Contractor the lesser of the rates set forth in Section 6.5(a) of this Exhibit 2.1 or the amount specified by the applicable Medi-Cal fee schedule established by law or by regulation of the California Department of Health Services or other appropriate state regulatory agency.

6.6. Coordination of Benefits. Only TPMG has the right to seek coordination of benefits (COB) payments in connection with Group A Covered Services provided by Contractor to a Capitated Member hereunder. Contractor shall cooperate with TPMG in identifying such COB claims and in providing appropriate information to TPMG within the time frames set forth in the Provider Manual.

7. Services Provided to Other Non-Members. Except as required by this Agreement or the California Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations issued thereunder, services provided by Contractor to non-Members are not covered by the Agreement and shall not be reimbursed hereunder.

8. Additional Compensation Based on Performance Criteria. Contractor may be eligible for additional compensation based on compliance with certain performance criteria, as described in Exhibit 2.5.

EXHIBIT 2.2

FEE-FOR-SERVICE COMPENSATION

All capitalized terms used in Exhibit 2.2 which are not otherwise defined in the Agreement are defined as set forth in Exhibit 5.

1. Fee-For-Service Payments. TPMG shall pay fee-for-services payments to Contractor in accordance with this Exhibit 2.2 unless otherwise specified in this Agreement. All payments made pursuant to this Exhibit 2.2 may be subject to adjustment as described in Section 3.3 of this Agreement and to the Coordination of Benefits rules set forth in Section 3.6 of this Agreement. Contractor shall bill for such Covered Services in accordance with Exhibit 2.3.

1.1. Commercial Members. In consideration for the provision of Covered Services, other than Group A Covered Services provided by Contractor to Commercial Members who are Capitated Members, TPMG shall pay Contractor the lesser of billed charges, the rate(s) set forth on Exhibit 2.2.1, if listed, or one hundred percent (100%) of the RBRVS fee as of the date the Covered Services were rendered; provided, however, that if there is no assigned RBRVS fee for a Covered Service, then the applicable rate shall be fifty percent (50%) of the billed charge accepted by KP as usual, customary and reasonable for such Covered Service.

1.2. Medicare+Choice Members. In consideration for the provision of Covered Services, other than Group A Covered Services provided by Contractor to Commercial Members who are Capitated Members, TPMG shall pay Contractor in accordance with Section 1.1 of this Exhibit 2.2.

1.3. Regular Medicare Members. In consideration for the provision by Contractor to Regular Medicare Members of Covered Services, TPMG shall compensate Contractor in accordance with Section 3.5(b)(v) of this Agreement, except that to the extent a Covered Service is not a covered Medicare benefit, TPMG shall compensate Contractor one hundred percent (100%) of the RBRVS fee as of the date the Covered Service was rendered If there is no assigned RBRVS fee for a Covered Service, then the applicable rate will be fifty percent (50%) of the billed charges accepted by KP as usual, customary, and reasonable for such Covered Service.

1.4. Medi-Cal Members. TPMG shall pay Contractor for Covered Services provided by Contractor to Medi-Cal Members at the lesser of the fee-for-service rates set forth in Section 1.1 of this Exhibit 2.2 or the amount specified by the applicable Medi-Cal fee schedule established by law or by regulation of the California Department of Health Services or other appropriate state regulatory agency.

EXHIBIT 2.2.1

RATE SCHEDULE

All capitalized terms used in Exhibit 2.2.1 which are not otherwise defined in the Agreement are defined as set forth in Exhibit 5.

1. Procedure Code Rates. The following procedure code rates apply to Covered Services provided by Contractor as indicated on the invoice submitted by Contractor by the corresponding procedure code(s). TPMG may adjust the rate specified below when Contractor bills with a modifier code affecting the specific Covered Services provided.

Procedure Code	Rate

THERE ARE NO PROCEDURE CODE RATES

2. Case Rates. The following case rates apply to all Covered Services provided by Contractor to a specific Member related to a course of treatment for a diagnosis or group of related diagnoses during a course of treatment.

Description of Case Rate(s)	Identifying Procedure(s)	Rate

THERE ARE NO CASE RATES

3. Global Rate. A global rate is a single rate established to cover a series of or similar category of Covered Services provided to a Member. The global rate is applied each time such Covered Service is provided to a Member without variation due to the specific Member circumstances as follows:

Description of Global Rate(s)	Rate

THERE ARE NO GLOBAL RATES

4. Inclusive Rate. An inclusive rate applies to the primary Covered Service set forth as well as additional Covered Services ancillary to or related to the primary Covered Service. Payment for inclusive rate Covered Services is as follows:

Description of Inclusive Rate(s)	Rate
Well-woman examinations: as defined in Exhibit 1.2.2. The rate includes any specimens collected during the well-woman examination, including but not limited to pap smears.	$65.00 per exam

5. Changes in Codes. The parties acknowledge that the codes and ranges of codes set forth in this Exhibit 2.2.1 are updated periodically. Successor or replacement codes shall be automatically substituted for the codes and ranges of codes listed in this Exhibit 2.2.1 so long as the Covered Services described by the replacement codes remain substantially similar to those of the superseded codes.

EXHIBIT 2.3

FEE-FOR-SERVICE BILLING PROCEDURES AND ENCOUNTER DATA SUBMISSIONS

All capitalized terms used in Exhibit 2.3 which are not otherwise defined in the Agreement are defined as set forth in Exhibit 5.

1. Fee-For-Service Billing Procedures. Contractor shall submit invoices for Covered Services within thirty (30) days of the date of the Covered Service. Contractor shall comply with the following billing procedures in connection with the provision of all Covered Services to be reimbursed in accordance with Exhibit 2.2 and its subexhibits.

1.1. Invoice Information. Contractor shall submit invoices for Covered Services as indicated on the Authorization, and, if not indicated, to the facility referral coordinator at the referring KP medical center or as otherwise described in the Provider Manual.

(a) Contractor will submit invoices on billing form HCFA 1500, UB-92 or an equivalent uniform billing form, including complete CPT-4 procedure codes and any applicable modifiers, hospital revenue codes (if applicable) and ICD-9 diagnostic code. Such billing form will also include the following:

(i) Applicable Authorization number.

(ii) Medicare Provider Identification Number for the Participating Practitioner who actually delivered the itemized Services to the Member.

(iii) Member's Health Plan medical record number.

(iv) A unique invoice number to identify payments. TPMG will create a unique number if none is provided.

(v) Contractor's usual and customary billed charges.

(vi) An authorized signature and signature date.

(b) An invoice will cover only one Authorization. If a Member has multiple Authorizations, separate invoices for each Authorization number must be submitted. If no Authorization is required, the invoice will cover the Covered Services provided an individual Member related to the same episode or injury, within the same calendar year, and billed within the time frames set forth in this Agreement.

(c) If an invoice is lost or subsequently replaced by a copy, that copy will be marked "Duplicate Invoice" or "Tracer" in bold type.

(d) Statement invoicing, or "balance forward invoicing" and interim invoicing will not be used.

(e) An invoice must be accurate, complete and in the format as set forth in Section 1.1(a) of this Exhibit 2.3.

1.2. Additional Information. In addition to the invoice information set forth in Section 1.1 of this Exhibit 2.3, Contractor shall furnish, upon request and at no cost to TPMG, information required by TPMG to verify the Covered Services which were provided so that payment can be made.

2. Billing for Services Provided to Regular Medicare Members. Contractor shall bill TPMG for such Covered Services in accordance with Section 3.5(b)(v) of this Agreement and the Provider Manual. Contractor shall furnish,

upon request, information required by TPMG to verify the Covered Services which were provided so that payment can be made. Such information shall include a copy of the Explanation of Medicare Benefits ("EOMB").

3. Time Limit for Submission of Claims. Unless otherwise prohibited by law, TPMG may deny payment for any claims that are not submitted to TPMG by Contractor within ninety (90) days of the date of the Covered Service.

4. Other Billing Procedures. Billing procedures for circumstances not covered under this Exhibit 2.3 (including but not limited to the process for billing KP for certain Emergency Services) are set forth in the Provider Manual. In those circumstances, Contractor shall comply with the procedures set forth therein.

5. Coordination With Specialist Agreement. In the event that at any time during the term of this Agreement there is a separate agreement for specialist physician services in force and effect between the parties, Contractor shall not bill TPMG under the specialist physician services agreement for any services which are primary care Covered Services hereunder.

6. Encounter Data Information. Contractor shall furnish to TPMG encounter data related to the provision by Contractor of capitated Covered Services to Capitated Members within thirty (30) days of the date of such Covered Services. Such encounter data shall be submitted in the format set forth in the Provider Manual and shall include, at a minimum, the information listed in Section 1.1(a) of Exhibit 2.3.

EXHIBIT 2.4

COMPENSATION RELATED TO CAPITATED MEMBERS

All capitalized terms used in Exhibit 2.4 which are not otherwise defined in the Agreement are defined as set forth in Exhibit 5.

1. Capitation Payments. TPMG shall pay monthly Capitation Payments to Contractor in accordance with this Exhibit 2.4 for all Members who are Capitated Members as of the current month, as determined by TPMG. Capitation Payments shall be paid to Contractor by TPMG on the twentieth (20^{th}) day of each month for such Group A Covered Services provided during such month.

1.1. Commercial Member. Subject to the adjustments set forth in Section 1.1(a) of this Exhibit 2.4 and Section 2 of Exhibit 2.1, TPMG shall pay monthly Capitation Payments to Contractor in consideration for the provision of Group A Covered Services to Commercial Members who are Capitated Members in the amounts set forth in Section 1.1 of Exhibit 2.4.1.

(a) Quarterly Adjustments to Capitation Payments.

(i) On a quarterly basis, TPMG shall adjust the Base Capitation paid to Contractor in accordance with this Section 1.1(a). These adjustments will not begin until after the first six (6) months of the initial term of this Agreement.

(ii) In the event In-Network Utilization is less than eighty percent (80%), then TPMG will decrease the Base Capitation to be paid to Contractor by one percent (1%) for each percentage point that In-Network Utilization is under eighty percent (80%). In the event In-Network Utilization during the prior quarter exceeds ninety percent (90%), TPMG will increase the Base Capitation to be paid to Contractor by one percent (1%) for each percentage point that In-Network Utilization exceeds ninety percent (90%). There will be no adjustment to the Base Capitation if In-Network Utilization is eighty percent (80%), ninety percent (90%), or any percentage between eighty percent (80%) and ninety percent (90%). The calculation of the In-Network Utilization will round all fractions of a percentage point up to the next highest percentage point.

(iii) In the event In-Group Utilization exceeds ninety percent (90%), then TPMG will increase the Base Capitation to be paid to Contractor by one percent (1%) for each percentage point that such In-Group Utilization exceeds ninety percent (90%). The calculation of the In-Group Utilization will round all fractions of a percentage point up to the next highest percentage point.

(iv) TPMG may aggregate the Base Capitation adjustments calculated in accordance with the foregoing subparagraphs; provided, however, that the maximum increase in Capitation Payments that TPMG will pay Contractor pursuant to this Section 1.1(a) shall not exceed five percent (5%) of the Base Capitation. Once the aggregate In-Group Utilization and In-Network Utilization percentage has been determined, TPMG will adjust the Capitation Payments to be paid to Contractor for the second quarter after the quarter for which the aggregate In-Group Utilization and In-Network percentage has been determined in accordance with such aggregate amount.

(v) When calculating visits hereunder, visits to hospital-based urgent care facilities will be counted as two (2) visits.

(vi) Contractor shall provide to TPMG, promptly upon request, such information as may be required by TPMG to determine In-Network Utilization and In-Group Utilization in accordance with this Section 1.1(a).

1.2. Medicare+Choice Members. In the event Contractor has chosen to receive Capitation Payments in connection with the provision of Group A Covered Services to Medicare+Choice Members assigned to or selecting Contractor, in accordance with Exhibit 2.4.2, TPMG shall pay Contractor Capitation Payments in the amount set forth in Section 1.2 of Exhibit 2.4.1.

EXHIBIT 2.4.1

CAPITATION FORMULA

All capitalized terms used in Exhibit 2.4.1 which are not otherwise defined in the Agreement are defined as set forth in Exhibit 5.

1. Capitation Formula for Capitated Members.

1.1. For Commercial Members Who Are Capitated Members: The following amounts are Contractor's Initial Capitation.

	Age Bands	PMPM
Male	23 – 24	$5.47
	25 – 29	$6.88
	30 – 34	$7.75
	35 – 39	$8.62
	40 – 44	$9.74
	45 – 49	$11.14
	50 – 54	$13.29
	55 – 59	$17.32
	60 – 64	$22.69
	65+	$34.45
Female	23 – 24	$9.90
	25 – 29	$12.25
	30 – 34	$13.33
	35 – 39	$14.82
	40 – 44	$15.87
	45 – 49	$16.87
	50 – 54	$20.44
	55 – 59	$21.44
	60 – 64	$23.16
	65+	$33.27
Child	0 – 1	$36.97
	2 – 6	$11.42
	7 – 18	$8.30
	19 – 22	$7.65

(a) Annual Adjustments to Capitation Payments to Commercial Members. TPMG shall increase the Base Capitation paid in connection with Commercial Members by three percent (3%), to be effective (i) on July 1, 2002, for the year July 1, 2002 through June 30, 2003; (ii) July 1, 2003, for the year July 1, 2003 through June 30, 2004. Thereafter, the terms and conditions of Section 3.4 of this Agreement shall govern any increases in Capitation Payments.

1.2. For Medicare+Choice Members who are Capitated Members:

Seven and one-half percent (7.5%) of HCFA's base Annual Adjusted Per Capita Cost ("AAPCC") or any successor rate used by HCFA to determine the capitation paid by HCFA to health plans, that is applicable during the calendar year in which the Capitation Payments are made.

EXHIBIT 2.4.2

MEDICARE+CHOICE MEMBERS

All capitalized terms used in Exhibit 2.4.2 which are not otherwise defined in the Agreement are defined as set forth in Exhibit 5.

1. Acceptance of Capitation for Medicare+Choice Members.

1.1. Acceptance Upon Reaching Threshold.

(a) If Contractor, as of the Effective Date of this Agreement, already receives capitation from TPMG under the parties' prior agreement in consideration for the provision of Covered Services to Medicare+Choice Members assigned to or selecting Contractor, then Contractor, as of the Effective Date of this Agreement, shall be compensated for Group A Covered Services under this Agreement by Capitation Payments, in accordance with Section 1.2 of Exhibit 2.4.

(b) If Contractor does not already receive Capitation Payments pursuant to Section 1.1(a) of this Exhibit 2.4.2, and the number of Medicare+Choice Members assigned to or selecting Contractor equals or exceeds four hundred (400) (the "Threshold Number") prior to the Effective Date of this Agreement, Contractor may, at Contractor's option, request, within thirty (30) days after the execution of this Agreement, to receive Capitation Payments in connection with the provision of Group A Covered Services to such Medicare+Choice Members. Such request is subject to the approval of TPMG, which approval may be withheld, in TPMG's sole discretion. Contractor shall submit such request to TPMG in a format agreeable to TPMG and in accordance with the notice procedure set forth in Article IX of this Agreement. As of the first quarter following receipt of such notice, if such notice is received at least thirty (30) days prior to the beginning of such first quarter, TPMG shall begin to pay Contractor Capitation Payments in connection with Group A Covered Services provided to such Medicare+Choice Members in accordance with Section 1.2 of Exhibit 2.4. If the notice is not received at least thirty (30) days prior to the beginning of such quarter, such Capitation Payments shall begin in the second quarter after receipt of such notice. TPMG will pay Contractor in accordance with Exhibit 2.2 for all Covered Services provided to Medicare+Choice Members prior to the quarter the Capitation Payments begin. In the event the parties do not renegotiate rates at the end of the second term of this Agreement and on each anniversary thereafter, in accordance with Section 3.4 of this Agreement, then the right of Contractor to change from fee-for-service payments to Capitation Payments under this Section 1.1(b) will be unavailable until the parties have agreed upon new rates.

(c) If Contractor does not already receive Capitation Payments in accordance with Section 1.1(a) or 1.1(b) of this Exhibit 2.4.2, once the number of Medicare+Choice Members who have selected or been assigned to Contractor equals or exceeds the Threshold Number during the term of the Agreement, Contractor may request to be compensated by Capitation Payments in connection with the provision of Group A Covered Services to such Medicare+Choice Members by providing at least thirty (30) days' prior written notice to TPMG in a format agreeable to TPMG and in accordance with the notice procedure set forth in Article IX of this Agreement. Such request is subject to the approval of TPMG, which approval may be withheld, in TPMG's sole discretion. TPMG will notify Contractor of its approval/disapproval. As of the first quarter following approval by TPMG, TPMG shall begin to pay Contractor Capitation Payments in connection with Group A Covered Services provided to such Medicare+Choice Members in accordance with Section 1.2 of Exhibit 2.4.

1.2. Opting Out of Payment by Capitation. If, after Contractor has elected to receive Capitation Payments in connection with Group A Covered Services provided to Medicare+Choice Members assigned to or selecting Contractor, the number of Medicare+Choice Members who select or are assigned to Contractor declines to three hundred (300) or below, Contractor may request that TPMG compensate Contractor for Group A

Covered Services provided to such Medicare+Choice Members on a fee-for-service basis. This right will continue even if the number of Medicare+Choice Members increases above three hundred (300). Contractor shall provide at least thirty (30) days' prior written notice to TPMG of its intent to be paid fee-for-service payments in a format agreeable to TPMG and in accordance with the notice procedure set forth in Article IX of this Agreement. As of the first quarter following such request, if such request is provided by Contractor at least thirty (30) days prior to the beginning of such quarter, in lieu of Capitation Payments, TPMG shall compensate Contractor for all Covered Services, including Group A Covered Services and Group B Covered Services, provided to such Members on or after the first day of the quarter in accordance with Section 1.2 of Exhibit 2.2. If such notice is not provided at least thirty (30) days prior to the beginning of such quarter, then TPMG shall commence paying Contractor in accordance with Section 1.2 of Exhibit 2.2 beginning in the second quarter following receipt of such notice. Once Contractor has opted to be paid fee-for-service payments hereunder, Contractor may only accept Capitation Payments in consideration for the provision of Group A Covered Services provided to Medicare+Choice Members upon mutual agreement of the parties.

2. Medicare+Choice Members with End-Stage Renal Disease. Notwithstanding Section 1 of this Exhibit 2.4.2, Medicare+Choice Members who are classified as having End Stage Renal Disease will not be deemed to be Capitated Members under this Agreement. TPMG shall compensate Contractor for all Covered Services, including Group A Covered Services and Group B Covered Services, provided to such Medicare+Choice Members on a fee-for-service basis in accordance with the rates set forth in Section 1.2 of Exhibit 2.2.

EXHIBIT 2.5

ADDITIONAL COMPENSATION

All capitalized terms used in Exhibit 2.5 which are not otherwise defined in the Agreement are defined as set forth in Exhibit 5.

Contractor may be eligible for additional compensation in accordance with this Exhibit 2.5. Payout of such additional compensation shall be based on the following performance criteria, as amended from time to time in accordance with the provisions of this Exhibit 2.5, with performance aggregated over all eligible Core Medical Groups and PCPs and non-physician primary care practitioners who are Kaiser Providers in the Stanislaus Program.

TPMG will begin to measure compliance with the performance criteria described herein beginning in year 2001 for a measurement year or years as defined by KP ("Measurement Year"). Contractor acknowledges and agrees that because some of the criteria hereunder requires multiple-year measurements, KP may be required to evaluate data from years prior to the Effective Date of this Agreement. Additional compensation based on standards measured during the course of a Measurement Year shall be referred to as "Settlements". No additional compensation will be calculated hereunder for calendar year 2000.

Performance criteria will be measured against all Members assigned to or selecting Core Medical Group PCPs and non-physician primary care practitioners and PCPs and non-physician primary care practitioners who are Kaiser Providers in the Stanislaus Program. KP will fund the additional compensation available under this Exhibit 2.5. In the event the eligible Core Medical Group PCPs and non-physician primary care practitioners and PCPs and non-physician primary care practitioners who are Kaiser Providers in the Stanislaus Program meet the performance criteria, TPMG will pay Contractor the applicable additional compensation hereunder. Contractor may distribute such additional compensation to Contractor's Participating Practitioners and Subcontractors, in Contractor's own discretion. TPMG shall have no obligation to distribute additional compensation to Participating Practitioners or Subcontractors of Contractor. In the event the eligible Core Medical Group PCPs and non-physician primary care practitioners and PCPs and non-physician primary care practitioners who are Kaiser Providers in the Stanislaus Program, in the aggregate, do not meet the performance criteria set forth in this Exhibit 2.5 during any Measurement Year, Contractor will not receive the additional compensation set forth herein for that Settlement Year.

NO REDUCTION WILL BE MADE TO CONTRACTOR'S COMPENSATION FOR FAILURE TO MEET ANY OF THE PERFORMANCE CRITERIA.

The performance criteria are the approved criteria established by TPMG. TPMG will inform the Stanislaus Leadership Council of the approved criteria. The performance criteria will be subject to modification annually by TPMG. Upon request, TPMG will provide to Contractor specific details on methodologies, sample size, and statistics used in establishing the numerators and denominators used in actual calculations hereunder.

1. Performance Criteria. As of the Effective Date of this Agreement, KP is unable to measure this criterion in connection with the Stanislaus Program, and Contractor will not be penalized for failure to meet this criterion. Once the performance criterion is measurable, it will be included in the calculation under the incentive program. KP will share sampling methodologies with Contractor upon request. The current performance criteria are as follows:

a. Quality of Care Criteria

Fifty percent (50%) of the additional compensation available to Contractor hereunder will be based on compliance with the quality of care criteria described below.

The performance statistic (listed in the table below) is the actual rate of occurrence of a specified type of care or condition in the applicable target population. Each performance statistic will be compared to the applicable goal in the table below and will used to calculate additional compensation in accordance with this Exhibit 2.5.

Quality of Care Criteria

Performance Statistic	Target Population	Goal
Diabetic Retinopathy Screening	Members age 31 or older who received a dilated retinal exam during either (i) a 2-year period, if the Member had a diagnosis of "no retinopathy" or "retinopathy of level 21 or less", or (ii) a 1-year period, if the Member had a diagnosis of "retinopathy greater than level 21" or there is no stage of retinopathy information available.	70% of target population received a dilated retinal exam
Childhood immunization rates for the following immunizations: DPT, OPV, MMR, Hib, Hep B	Members less than age two during the study period with continuous membership enrollments beginning at 60 days old	90% of target population inoculated with all noted shots by second birth date
Hypertension Screening Rate	Members aged 20 to 80 years with at least two years' continuous membership enrollments	90% of target population is screened at least once for hypertension during two year period
Mammography Screening Rate	Female members aged 52 to 75 years with at least two years' continuous membership enrollments, without bilateral or two unilateral mastectomies	80% of target population is screened at least once for breast cancer using a mammogram during two year period
Cervical Cancer Screening: Pap Smear Rate	Female members aged 21 to 64 years with at least three years' continuous membership enrollments, without having had a total hysterectomy	80% of target population receives a pap smear at least once during a three year period
Prenatal Care in First trimester	Female Members (aged 10 to 49 years) with live births and continuous enrollment 12 months prior to delivery	90% of target population has an OB/GYN-related visit in the first trimester
LDL-C Assessment after Acute Cardiovascular Exam	Members age 18 or older who had an AMI, PTA, or CABG in the past year, who were discharged alive	90% of the target population had at least one LDL-C test within 60 to 365 days after discharge
Advising Smokers to Quit	Members age 18 or older who are current smokers or recent quitters, seen by a provider during the year	62% of the target population received advice from a provider to quit smoking

b. Member Satisfaction Criteria

Forty percent (40%) of such additional compensation will be based on compliance with the member satisfaction criteria described below.

The Performance Statistic (listed in the table below) is the percentage of the Sampled Population providing answers of "Excellent" or "Very Good" to specified questions on the KP Member & Patient Satisfaction Survey ("MPS").

Member Satisfaction Criteria

Performance Statistic	Sampled Population	Goal
Measured average performance for 2 questions from MPS: Survey Question #2 – How satisfied are you with the personal and responsive service you received; and Survey Question #3 – How satisfied are you with the convenient and easy access you received?	Members or KP patients that have visited a Stanislaus Network Provider subject to a sampling algorithm that randomly selects KP patients (based on visits) and non-utilizing Members up to quota for the Contractor. The algorithm maintains a split between patients and non-utilizing Members and excludes those previously surveyed (currently for one year)	Using the highest of either 4th quarter or YTD MPS ratings, must measure within one standard deviation below and 0.5 standard deviation above the average of KP competitors with those surveyed answering "excellent" or "very good" for the two questions.

c. Pre-authorization of Specialty Referrals Criteria

Ten percent (10%) of such additional compensation will be based on compliance with the specialty referral pre-authorization criteria described below.

The Performance Statistic listed below is the percentage of specialty Authorizations received by KP from the applicable PCP or non-physician primary care practitioners prior to the first date of service by a specialty provider.

Pre-authorization of Specialty Referrals

Performance Statistic	Target Population	Goal
Specialty referrals with Authorizations received by KP prior to the first date of service by the specialty provider	All Members	Retroactive authorization of specialty referrals shall be less than 25%

2. Performance Measurements.

Contractor acknowledges and agrees that KP, and/or KP's contracted survey firm, will collect and analyze the data required to determine compliance with the performance criteria. Contractor and KP acknowledge that the collection and analysis of data will require KP to exercise professional judgment, in determining, including, but not limited to, the appropriate sample size and statistical significance. The parties further acknowledge that due to statistical requirements, timely reporting requirements, and/or multi-year measures, KP may be required to use data from multiple years or time periods. KP will make efforts to minimize the impact of such timing differences so that the data sampled is representative of the Measurement Year in question. Additionally, the parties acknowledge that due to the structure of the Stanislaus Program and the design of some of the performance criteria, some Members may obtain care at either a KP or a Stanislaus site, and therefore some of the performance measures for Members may include data from providers other than those strictly associated with the Stanislaus Program.

Contractor shall provide to KP any information and records reasonably necessary for KP to determine the additional compensation hereunder. KP, at its expense, may audit any of the information/records so provided or any other Contractor records, including billing information, which is directly relevant to the settlement determinations hereunder.

KP staff will be made available to Contractor, upon written request to TPMG, to explain the results of analyses and to demonstrate to the reasonable satisfaction of Contractor that the analysis has been fairly conducted. Contractor personnel may be required to execute confidentiality agreements prior to any such discussions with KP. KP may issue a summary of the methodology to be used in measuring performance of the criteria and will notify Contractor of any significant changes in methodology. KP, in its discretion, may adjust the methodology as needed to accomplish the purposes of this Exhibit 2.5.

3. Determination of Additional Compensation.

TPMG will establish minimum and maximum payout parameters per Contractor PCP FTE. For purposes of this Section 3, Contractor's "PCP FTE" shall be calculated by dividing Contractor's annual average number of Capitated Members by two thousand (2000).

Each year, the Settlement to be paid to Contractor under this Exhibit 2.5 shall not exceed thirty percent (30%) of the total Capitation Payments paid to Contractor during the calendar year preceding the year in which such Settlement is paid.

4. Timing and Payout of Settlement. The additional compensation amount hereunder shall be calculated and paid to Contractor by June 30.

5. Review of Additional Compensation Program. Prior to the payout of Settlement, when data regarding performance hereunder becomes available, TPMG and the Stanislaus Leadership Council shall meet and confer in good faith to review the performance of the parties under this Exhibit 2.5.

EXHIBIT 3

KP UTILIZATION MANAGEMENT/QUALITY ASSURANCE

A Utilization Management/Quality Assurance Program assures that all medically necessary services are provided to Members in the most appropriate, and cost effective setting. This Program embraces all services provided to Members through referral review, preadmission certification review, concurrent inpatient review, and quality assurance.

The components of the Utilization Management/Quality Assurance Program are as follows:

a. REFERRAL REVIEW is a screening review of (1) all referrals initiated by TPMG Physicians and (2) all requests for additional service authorizations by Contractor. *It is the responsibility of Contractor to obtain prior authorizations as required by this Agreement for services provided to Members.* Prior written authorization is required for most non-emergent services. Exceptions to the prior–written–authorization requirement for self referral Services may be determined by contacting KP as provided in the Provider Manual.

b. PREADMISSION CERTIFICATION REVIEW is a detailed evaluation of requests for all hospital and facility based services. *Contractor must obtain prior authorization as required by this Agreement for hospital and facility-based services provided to Members.*

c. CONCURRENT INPATIENT SCREENING is conducted daily in Kaiser Foundation Hospitals and through telephone review or on-site visits at the non-Kaiser Permanente facilities to review a Member's record status and discuss discharge planning needs with Members and their families. The on-site review will be done by Utilization Review Nurses under the direction of TPMG Physicians, focusing on assessing care plans and progress towards discharge, identifying secondary referrals for review and authorization, and coordinating discharge planning. The Utilization Review Nurses will contact the attending physician, TPMG Physician, and/or TPMG Utilization Review Chief as is necessary.

d. QUALITY ASSURANCE is an integral part of the Program, which evaluates all services provided to Members in all settings. Contractor agrees to fully participate in recognized, approved and appropriate quality assurance activities and to develop review arrangements on a topic by topic basis. Quality Assurance activities may encompass retrospective review of Contractor's patient medical records.

All determinations as to the medical necessity for services and the appropriate setting for care are made by TPMG Physicians. Contractor has the right to appeal any decisions according to KP policy and procedures.

EXHIBIT 4

DELEGATED ACTIVITIES

No activities are delegated to Contractor.

EXHIBIT 5

DEFINITIONS

The capitalized terms in the Exhibits to this Agreement shall have the meanings described herein.

1. BASE CAPITATION means either the Initial Capitation or the Capitation Payment amounts adjusted in accordance with Section 1.1(a) of Exhibit 2.4.1.

2. CAPITATED MEMBER means an eligible Member of Health Plan, other than a Regular Medicare Member or Medi-Cal Member, who has selected or been assigned to Contractor as of the first day of the month for which the Capitation Payment is to be made. Notwithstanding the foregoing, a Medicare+Choice Member shall not be deemed a Capitated Member hereunder unless Contractor complied with Exhibit 2.4.2 addressing acceptance of Medicare+Choice Members as Capitated Members.

3. CAPITATION PAYMENT means the per Member per month payment paid to Contractor in exchange for Group A Covered Services (as listed in Exhibit 1.2.2) to be provided hereunder to Capitated Members.

4. CORE MEDICAL GROUP means each of the medical groups that are identified by TPMG, in its sole discretion, as Core Medical Groups.

5. GROUP A COVERED SERVICES means those Group A Services which are Covered Services. (Group A Covered Services provided to Capitated Members shall be compensated according to Exhibit 2.4 and its subexhibits.)

6. GROUP A SERVICES means those primary care services listed under the heading "Group A Services" in Exhibit 1.2.2.

7. GROUP B COVERED SERVICES means those Group B Services which are Covered Services. (Group B Covered Services shall be compensated according to Exhibit 2.2 and its subexhibits.)

8. GROUP B SERVICES means those primary care services listed under the heading "Group B Services" in Exhibit 1.2.2.

9. IN-GROUP PCPP VISIT means any visit by a Capitated Member to any PCPP employed by or contracting with Contractor.

10. IN-GROUP UTILIZATION means the ratio of In-Group PCPP Visits to the total number of visits by Capitated Members to Stanislaus primary care practitioners, including Contractor, calculated on a quarterly basis.

11. INITIAL CAPITATION means the Capitation Payment amounts listed in Section 1.1 of Exhibit 2.4.1.

12. IN-NETWORK PRIMARY CARE PRACTITIONER VISIT means any visit by a Capitated Member to a Stanislaus primary care practitioner.

13. IN-NETWORK UTILIZATION means the ratio of In-Network Primary Care Practitioner Visits to the sum of In-Network Primary Care Practitioner Visits plus Out-of-Network Primary Care Practitioner Visits, calculated on a quarterly basis.

14. KAISER PROVIDER means TPMG, KFH and the physicians, ancillary providers, facilities and other health care providers that have entered into contracts with KP to provide health care services to Members, including, but not limited to, Contractor and the Participating Practitioners identified in Exhibit 1.1.

15. MINIMUM AVERAGE MEMBERSHIP means an average of one thousand (1,000) assigned or selected Members per full-time Contractor PCP, as "full-time" is mutually defined by the parties.

16. NON-CONTRACTED PRIMARY CARE PRACTITIONER means a primary care practitioner that does not have a written contract with KP.

17. OPERATIONS MANUAL refers to a manual developed by TPMG and Health Plan, in consultation with the Stanislaus Leadership Council, which sets forth the operational rules and procedures in the Stanislaus Program, including, without limitation, rules regarding utilization management, quality assurance, billing, and credentialing requirements. TPMG and Health Plan, in consultation with the Stanislaus Leadership Council, may modify the Operations Manual from time to time by written notice to Contractor. The Operations Manual, as so amended, is incorporated herein by reference, and shall be complied with by Contractor. To the extent any conflict between this Agreement (including the Exhibits) and the Operations Manual exists, the terms of this Agreement shall govern.

18. OUT-OF-NETWORK PCPP VISIT means any visit for primary care services as defined in the Provider Manual by a Capitated Member to any of the following providers or as otherwise defined in the Provider Manual:

18.1. A TPMG practitioner; or

18.2. A Non-Contracted Primary Care Practitioner; or

18.3. A hospital-based urgent care facility contracted with KP.

19. PRIMARY CARE PARTICIPATING PRACTITIONER or PCPP means either a PCP or a non-physician primary care practitioner that is a Participating Practitioner.

20. PRIMARY CARE PHYSICIAN or PCP means a Kaiser Provider who is an internist, family physician or pediatrician or who is an OB/GYN identified by TPMG or Health Plan as a PCP.

21. PROVIDER MANUAL shall mean the Operations Manual.

22. RBRVS means the HCFA Resource-Based Relative Value Schedule, calculated as a product of the Relative Value Units (RVUs), a geographic adjustment factor based upon the location where Covered Services were provided, and the Conversion Factors (CFs) as published by HCFA for the date(s) on which Covered Services were rendered.

23. STANISLAUS ADVISORY MANAGEMENT TEAM refers to a committee composed of: (a) one (1) physician representative from each medical group which is a Core Medical Group; (b) the Medical Director for the Stanislaus Program, as designated by TPMG, (c) a Health Plan representative designated by Health Plan; (d) the Stanislaus Program network administrator, and (e) one hospital representative designated by an acute care hospital which is a Kaiser Provider located in Stanislaus County. Each member of the Stanislaus Advisory Management Team (the "Team") shall have one vote, and decisions shall be made by majority vote. Each party shall designate an alternate member of the Team to attend Team meetings in the absence of its representative. In the event a decrease in the number of Core Medical Groups would cause the number of Core Medical Group representatives on the Team to be fewer than the combined number of TPMG and Health Plan representatives, TPMG and the Core Medical Groups shall promptly meet and confer regarding revisions to the composition of the Team.

24. STANISLAUS LEADERSHIP COUNCIL means the committee composed of (a) one (1) physician representative from each medical group which has been designated as a Core Medical Group by TPMG; (b) the Medical Director in the Stanislaus Program, as designated by TPMG; and (c) a KP representative designated by TPMG.

25. STANISLAUS PCP means any PCP employed by or contracted with a Core Medical Group and any PCP associated with the Stanislaus Program.

26. STANISLAUS PROGRAM means the health care delivery system in and around Stanislaus County established by KP to service Members. The Stanislaus Program includes contracted hospitals and physicians, TPMG providers, ancillary providers and the Stanislaus Leadership Council.