COUNTY MEDICAL SERVICES PROGRAM (CMSP)
PARTICIPATING PHYSICIAN, PHYSICIAN GROUP AND COMMUNITY HEALTH CENTER AGREEMENT

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COUNTY MEDICAL SERVICES PROGRAM (CMSP)
PARTICIPATING PHYSICIAN, PHYSICIAN GROUP AND COMMUNITY HEALTH CENTER AGREEMENT
CONTRACT # SP118

This Agreement is made and entered into the first day of the month following execution of all necessary signatures between the County Medical Services Program Governing Board (hereafter "Governing Board") and County of Shasta and/or entity(ies) identified in Exhibit A to this agreement, attached and incorporated herein ("Provider").

1. RECITALS

1.1 Governing Board is a public agency formed pursuant to California Welfare and Institutions Code Section 16809 *et seq.*, which governs the County Medical Services Program ("CMSP") and provides policy direction for CMSP. Governing Board through CMSP provides health care services to indigent adults in thirty-five (35) rural and semi-rural California counties.

1.2 Governing Board may from time to time contract with third party administrators for the administration of CMSP, and currently contracts with Advanced Medical Management, Inc. to administer CMSP ("Third Party Administrator"). Governing Board may change the Third Party Administrator at any time within its sole discretion. For purposes of this Agreement, the Third Party Administrator is a duly authorized representative acting on behalf of Governing Board, and the Third Party Administrator may perform certain obligations of the Governing Board under the terms of this Agreement.

1.3 Provider is in the business of providing the health care services. Further, Provider is a California corporation duly licensed by the California Department of Health Services or otherwise licensed, certified or qualified to provide Medical Services for Members in compliance with all federal, state and local laws.

1.4 Provider is eligible to participate in and is certified to provide health care services under the Medicare program and the California Medi-Cal Program and meets applicable requirements under Titles XVIII and XIX of the Social Security Act and substantially complies with all applicable federal, state and local laws.

1.5 Governing Board intends by entering into this Agreement to make available quality health care to Members by contracting with Provider. Provider intends to provide such quality health care in a cost-efficient manner.

2. DEFINITIONS

2.1 "Benefit Plan" refers to documents prepared by and distributed by Governing Board that describe and explain the health care benefits for CMSP that Governing Board administers for Members. Governing Board retains the unilateral right to modify the benefit structure of CMSP at any time.

2.2 "County Medical Services Program" or "CMSP" means the program governed by the Governing Board to provide health care services to medically indigent adults that are eligible for CMSP.

2.3 "Emergency" means a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including without limitation, severe pain) such that the patient may reasonably believe that the absence of immediate medical attention could reasonably result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; (c) other medical consequences, or (d) serious and/or permanent dysfunction of any bodily organ or part.

2.4 "Hospital Services" means those Medically Necessary acute care hospital inpatient and hospital outpatient services that are covered by the Benefit Plan. Hospital Services does not include long-term non-acute care.

2.5 "Medical Services" means those Medically Necessary services provided by Participating Physician as determined by Governing Board that are covered by the Benefit Plan.

2.6 "Medically Necessary" means procedures, supplies, equipment or services that Governing Board determines to be:

(a) Appropriate for the symptoms, diagnosis or treatment of the medical condition, illness or injury, and

(b) Provided for the diagnosis or direct care and treatment of the medical condition, illness or injury, and

(c) Within standards of good medical practice within the organized medical community, and

(d) Not primarily for the convenience of the Member, the Member's family members, Member's physician or any other provider, and

(e) Supported by valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit without a disproportionately greater risk of harm or complications for the Member with the particular medical condition being treated than other alternatives, and

(f) Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable, and

(g) For inpatient hospital stays, necessary due to the kind of services the Member is receiving or the severity of the medical condition, and safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

2.7 "Member(s)" means a person who is eligible to receive Medical Services pursuant to the Benefit Plan.

2.8 "Participating Hospital" means a hospital which has entered into an agreement with Governing Board to provide Hospital Services as a Participating Provider.

2.9 "Participating Physician" means a physician who has entered into an agreement, directly or indirectly, with Governing Board to provide Medical Services to Members as a Participating Provider and who is a "licensee" as that term is defined in California Business and Professions Code Section 2041.

2.10 "Participating Provider" means a hospital, other health facility, community clinic, physician or other health professional which has entered into an agreement, directly or indirectly, with Governing Board to provide health care services to Members.

2.11 "Provider Operations Manual" means the compilation of policies, procedures, standards and specific documents pertaining to the Benefit Plan that has been compiled by Governing Board for the use and instruction of Provider, and to which Provider must adhere. The Provider Operations Manual may be unilaterally amended or modified from time to time by Governing Board.

2.12 "Rate" means the amount(s) as shown in Exhibit B to this Agreement, attached hereto and incorporated herein, that Provider agrees to accept as full payment for Medical Services rendered to Members under the Benefit Plan.

2.13 "Utilization Management" means a function, including case management, performed by Governing Board for the Benefit Plan, or an entity acting on behalf of Governing Board, to review and determine whether Medical Services provided, or to be provided, are Medically Necessary.

2.14 "Utilization Management Procedures" means those procedures described in Article 6 of this Agreement.

2.15 "Working Day" means any day, Monday through Friday, excluding legal holidays.

3. PROVIDER OBLIGATIONS

3.1 Provision of Medical Services. Provider shall provide Medical Services to Members when such services are Medically Necessary and are in accordance with the Benefit Plan and this Agreement.

3.2 Standard of Care and Location of Services. Provider shall provide Medical Services to Members with the same degree of care and skill as customarily provided to Provider's patients who are not Members, according to generally accepted standards of medical practice. Such services shall be provided at the locations and under the tax identification numbers listed on Exhibit A. Provider's practice must be readily accessible to Members. Further, Provider shall provide for the availability of emergency services twenty-four (24) hours a day, seven (7) days a week and to arrange for coverage by another provider if Provider's illness, vacation or other absence from Provider's practice, and, if such covering Provider is not a

Participating Provider, use Provider's best efforts to cause such covering provider to abide by the terms of this Agreement.

3.3 Licenses and Certifications. Provider has and shall maintain in good standing, all licenses, certifications, permits, accreditations and other prerequisites required by Governing Board and federal, state and local law to provide Medical Services, including but not limited eligibility to participate in and certification to provide health care services under the California Medi-Cal Program. Copies of such licenses, certifications, permits, evidence of accreditations or other prerequisites are attached as Exhibit C to this Agreement, attached hereto and incorporated herein. Provider agrees to provide copies of such licenses, certifications, permits, evidence of accreditations or other prerequisites to Governing Board each year they are issued, and upon written request.

3.4 Compliance with Policies and Provider Operations Manual. Provider agrees to comply with all Benefit Plan policies and procedures, as may be modified from time to time by Governing Board in its sole discretion. Provider further agrees to comply with all operational processes, claims administration and utilization management and other requirements contained in the Provider Operations Manual for the Benefit Plan. Provider agrees to cooperate with Governing Board administration of the Benefit Plan quality improvement program, internal quality of care review and appeals/grievance resolution procedures, including its Member grievance process, and agrees to provide all pertinent information and requested records. Both parties agree that the cost of the provision of records associated with these provisions will be borne by the Provider.

3.5 Utilization Management. Provider agrees to participate in the Utilization Management provided in Article 6 and to abide by decisions resulting from that review subject to rights of review and arbitration provided in Section 6.5.

3.6 Evidence of Assignment. Provider shall, to the extent possible, seek, accept and maintain evidence of assignment for the payment of Medical Services provided to Members by Provider, under the Benefit Plan.

3.7 Reports. Provider shall submit all reports required by Governing Board necessary to comply with requirements for the Benefit Plan.

3.8 Notification. Provider shall promptly notify Governing Board, in accordance with Section 12.6, of:

(a) any change in its business ownership;

(b) any change in business address or change of the address of locations at which services are provided by Provider;

(c) any legal or government action initiated against Provider, including but not limited to an action (a) for professional negligence; (b) for violation of the law; or (c) against any license, permit, accreditation or other prerequisite; which, if successful, would materially impair the ability of Provider to carry out the duties and obligations under this Agreement;

(d) Any other problem or situation that will materially impair the ability of Provider to carry out the duties and obligations under this Agreement;

(e) Any consistent inability to initiate care to the Member within 24 hours of referral or discharge to the hospital, as applicable;

(f) Any change in status of license, status as a Medi-Cal provider or accreditation;

(g) Of each separate tax identification number under which Provider received compensation.

3.9 Compliance with Law. Provider shall comply with all applicable state and federal laws and regulations relating to the delivery of Medical Services.

3.10 Certification Regarding Service Providers. Provider certifies that none of its employees or agents providing service under this Agreement ("Service Providers") have been convicted of a criminal offense related to health care, nor are any listed by any federal or state agency as debarred, excluded or otherwise ineligible for participation in Medicare, Medi-Cal, or any other federal or state funded health care program. Provider certifies that it has performed an appropriate screening of Service Providers prior to making this certification, that it will screen all new Service Providers, and that it will monitor the status of existing Service Providers. Provider certifies that it and Service Providers possess all required licenses, that such licenses are in good standing, and that in providing these contract services, it and its Service Providers are operating within any and all limitations or restrictions of these licenses. Provider further certifies that none of its directors, managing employees, and owners of five percent interest, or more, in Provider's business have been convicted of any health care related offenses nor excluded from Medicare, Medi-Cal, or any other federal or state funded health care program.

3.11 No Discrimination. Provider agrees that Members shall not be subject to discrimination regardless of race, creed, color, religion, language, gender, age, health status, mental or physical disability, physical/mental handicap, sexual orientation, marital status or national origin/ancestry. Provider agrees to see and schedule Members for Medical Services on a similar basis to Medi-Cal beneficiaries and/or Provider's other patients.

3.12 Credentialing. Provider agrees to comply with all credentialing processes and requirements for the Benefit Plan as set forth in the Provider Operations Manual and this Agreement.

3.13 Member Eligibility Verification. Provider shall confirm each Member's eligibility status prior to providing Medical Services. Provider acknowledges that a patient's identification card confers no right to service or other benefits. Provider understands and agrees that it is Provider's responsibility to confirm or verify each Member's eligibility status prior to providing Medical Services whether or not a patient informs Provider of the patient's eligibility status. Provider understands and agrees that Provider shall not be reimbursed for Medical Services provided to Members if Provider has not timely confirmed eligibility status in accordance with this Agreement. Provider agrees that Provider shall not submit a claim for any

amount for Medical Services provided to Members or patients where Provider has not timely confirmed eligibility status in accordance with this Agreement.

Provider shall confirm that the person presenting the CMSP identification card and/or a State of California Beneficiary Identification Card is the Member or covered person named on the card. Governing Board shall not be responsible for the fraudulent or deceptive use of either identification card.

3.14 Formulary. Provider agrees to use the pharmaceutical formulary approved by Governing Board and administered by the contracted pharmacy benefit manager, unless otherwise notified by Governing Board.

3.15 Participating Hospitals. Providers agree to admit or arrange for the admission of Members only to Participating Hospitals unless otherwise determined by Provider and agreed to in writing by Governing Board. In the case of an Emergency, as that term is defined in this Agreement, Provider agrees to use a Participating Hospital whenever possible. Other exceptions to the use of non-Participating Hospitals shall be approved pursuant to the provisions of Article 6.

3.16 Referrals to Participating Providers. Provider agrees to refer Members to other Participating Providers unless otherwise determined by Provider and agreed to in writing by Governing Board.

3.17 Non-Participating Providers. If Provider, in any case other than an Emergency, admits or arranges for the admission of a Member to a non-Participating Hospital or refers a Member to a non-Participating Provider, Provider will obtain authorization from Governing Board Utilization Review Program as set forth in the Provider Operations Manual. Provider shall use Provider's best efforts to require any non-Participating Provider to whom a Member is referred to abide by the terms of this Agreement.

3.18 Hospital Privileges. Provider agrees that if Provider does not maintain active hospital privileges at a Participating Hospital, Provider must provide an acceptable arrangement, or agree to work with Governing Board to establish and maintain a plan that ensures continuity of care at all times including after-hours, weekend and hospital coverage.

3.19 Allied Health Personnel. Provider agrees to have policies in place for utilization of allied health personnel, including nurse practitioners, physician assistants and medical assistance, if such personnel is utilized in Provider's business.

3.20 Relationship with Member. Governing Board and Provider agree that Provider shall be maintain a provider/patient relationship with each Member that Provider treats. Provider shall be responsible solely to that Member for treatment and medical care.

3.21 Provider Communication with Members. Provider agrees to communicate results of all Utilization Review pre-service review decisions to the Member. Provider may freely communicate with Members regarding the treatment options available to them, including medication treatment options (when appropriate) regardless of benefit coverage limitations. Nothing in this Agreement is intended to be construed as encouraging Provider to restrict

Medically Necessary covered Medical Services or to limit the clinical dialogue between Providers and Members.

3.22 Medi-Cal Provider. In order to submit claims and receive reimbursement, Provider is, and shall remain, for the term of this Agreement an approved Medi-Cal provider. For the term of this Agreement, Provider shall remain in good standing with the Medi-Cal program.

4. GOVERNING BOARD OBLIGATIONS

4.1 Status as Participating Provider. Governing Board shall grant Provider the status of "Participating Provider", identify Provider as a Participating Provider on informational materials to Members and direct Members as appropriate to Provider.

4.2 Provider Information. Governing Board shall provide Provider with a list of all Participating Physicians, Participating CMSP Hospitals and other Participating Providers in Provider's geographic area as well as the Provider Operations Manual for the Benefit Plan.

4.3 Member Cards. Governing Board shall provide appropriate identification cards to its Members. Provider acknowledges that a patient's identification card confers no right to service or other benefits, and Provider shall verify Member's eligibility in accordance with Section 3.13 of this Agreement.

5. COMPENSATION AND BILLING

5.1 Compensation Generally. Governing Board shall pay Provider in accordance with the provisions of this Agreement. Provider shall seek payment only from Governing Board for the provision of Medical Services except as provided in Section 5.2. The payment from Governing Board shall be limited to the Rates referred to in Section 5.7.

5.2 Coordination of Benefits. Except as permitted under Section 5.3, Provider may also seek payment for the provision of Medical Services from other sources only as available pursuant to the coordination of benefits provisions of the Benefit Plan and Section 5.4.

5.3 No Billing of Members. Provider agrees that the only charges for which a Member may be liable and may be billed by Provider shall be for Medical Services not covered by the Benefit Plan and as provided in Section 5.9. If Provider receives any additional surcharge from a Member in excess of the applicable share-of-cost, Governing Board shall require that Provider promptly refund the amount thereof to the Member.

5.4 CMSP Payer of Last Resort. Provider expressly acknowledges that if a Member has other health coverage, CMSP shall be the payer of last resort.

5.5 Payment Requirements. Provider shall bill Governing Board on forms and in a manner acceptable to Governing Board within one hundred fifty (150) days from the date of Medical Service or Governing Board may refuse payment. Provider shall furnish, on request, all information reasonably required by Governing Board to verify and substantiate the provision of Medical Services and the charges for such services. Governing Board reserves the right to

review all statements submitted by Provider when necessary and in accordance with this Agreement.

Provider understands and agrees that Provider shall not be reimbursed for Medical Services provided to Members if Provider has not timely billed Governing Board in accordance with this Agreement. Further, Provider understands and agrees that Provider's non-submission of a timely bill to Governing Board is not excused by reason of Provider's not timely confirming eligibility status as provided in Section 3.13. Provider agrees that Provider shall not submit a claim for any amount for Medical Services provided to Members where Provider has not timely billed Governing Board in accordance with this Agreement.

5.6 Compensation. Governing Board shall pay Provider within sixty (60) Working Days of receipt of statements which are accurate, complete and otherwise in accordance with Section 5.5, unless the claim, or portion thereof, is contested by Governing Board, in which case Provider shall be notified in writing within thirty (30) Working Days. The term "contested" in this Section has the same meaning as in the California Health and Safety Code, Section 1371.

5.7 Full and Final Payment. Full and final payment, including share of cost amounts for Medical Services provided to Members, shall be the lesser of the Rate(s) set forth in Exhibit B or Provider's billed charges for Medical Services. The Rate(s) listed in Exhibit B shall apply to claims submitted for services provided during the term of the Agreement.

5.8 Right to Adjust Payments. Pursuant to Welfare and Institutions Code Section 16809 *et seq*, the Governing Board retains the right to adjust payment amounts at any time in order to remain within its budgetary allowance. Provider will receive notification of any such adjustment prior to its implementation.

5.9 No Charge to Members. Provider shall not charge Members for Medical Services denied as not being Medically Necessary under Article 6, unless Provider has obtained a written waiver from that Member or an individual legally responsible for Member. The waiver, except in Emergency situations, must be obtained in advance of rendering services and shall specify those services which Governing Board has denied as not being Medically Necessary and shall clearly state that the Member, or individual legally responsible for the Member, shall be responsible for payment of Medical Services denied by Governing Board.

5.10 Requirements for Claims for Members Retroactively Eligible for Medi-Cal. If a Member is determined retroactively eligible for Medi-Cal for a period in which Provider billed Governing Board for Medical Services under this Agreement, Provider shall resubmit the claim(s) to Medi-Cal and refund to Governing Board any amounts paid by Governing Board under this Agreement or any share-of-cost paid by the Member.

5.11 Overpayments. Any amount paid by Governing Board to Provider under this Agreement determined subsequently by Governing Board to have been an overpayment will be considered indebtedness of Provider to Governing Board. Such indebtedness may include any payments made by Governing Board for a Member who is subsequently determined to be eligible for Medi-Cal or any other benefit covering the same time period. Governing Board shall have a first lien in the amount of such indebtedness and may request a refund from Provider, or

after notice, recover such indebtedness by deducting from and setting off any amount or amounts due and payable from Governing Board to Provider at any time under this Agreement or any other agreement between Governing Board and Provider, or for any reason, an amount or amounts equal to such indebtedness of Provider. Provider agrees, upon request by Governing Board, to execute any financing statement and/or other documents required by Governing Board to perfect its lien under any state Uniform Commercial Code or similar law.

6. UTILIZATION MANAGEMENT

6.1 Utilization Management Program. Governing Board has established a Utilization Management program which is designed to assure that Hospital Services or Medical Services provided to Members are Medically Necessary. Provider shall comply with the Utilization Management program, which is set forth in the Provider Operations Manual and incorporated herein. The scope of the Utilization Management program may be changed at the discretion of Governing Board upon prior written notice to Provider.

6.2 Program Components. Utilization Management for Medical Services may include:

(a) "Pre-admission Review" or "Pre-service Review" to determine whether a scheduled inpatient admission or a scheduled treatment is Medically Necessary. Preadmission review procedures and pre-service review procedures are provided in the Provider Operations Manual;

(b) "Admission Review" to determine whether an unscheduled inpatient admission or an admission not subject to preadmission review is Medically Necessary;

(c) "Concurrent Review" to determine whether a continued hospital stay or treatment is Medically Necessary;

(d) "Retrospective Review" to determine whether inpatient Medical Services or treatments were Medically Necessary.

Provider agrees that it will provide adequate and accurate information in a timely manner, in accordance with applicable standards, in order to carry out effective Utilization Management on all Medical Services, specialist referrals or other authorized services as determined by Governing Board.

6.3 Pre-Referral Review. Governing Board may conduct pre-referral review with regard to referrals for specialty services.

6.4 Retroactive Denial. Governing Board shall not retrospectively deny as not Medically Necessary any inpatient hospital stay approved under Section 6.2 (a), (b) or (c), provided that the information given by Provider to Governing Board is substantially true and accurate regarding the medical condition of Member.

6.5 Appeal. Provider may appeal a Utilization Management decision. Any appeal shall be in accordance with the procedures set forth in the Provider Operations Manual and this

Agreement. If after completion of these procedures Provider continues not to be satisfied, its sole remedy to appeal a Utilization Management decision is the dispute resolution provisions as provided in Article 10 of this Agreement.

7. RECORDS MAINTENANCE, AVAILABILITY, INSPECTION AND AUDIT

7.1 Records Maintenance. Provider shall prepare and maintain books, records of account, medical records, billing records, reports and papers, including encounter data and records pertaining to Members receiving Medical Services at Provider, or to this Agreement in accordance with general standards applicable to such bookkeeping and recordkeeping and as is required by Provider's license, certification, permit, by applicable laws and by any applicable accreditation body. All records shall be maintained in a system that permits prompt retrieval of information. Medical records are to be legible, documented accurately in a timely manner and readily accessible.

7.2 Availability, Inspection and Audit. Provider agrees that Governing Board or its authorized representative may review, audit, and duplicate data and other records maintained by Provider concerning Members and this Agreement, including but not limited to medical records or other records relating to billing, payment and assignment, to the extent permitted by law. Governing Board and their auditors shall have access (which includes inspection, examination and copying) at reasonable times upon demand to the books, records and papers of Provider, at Provider's office or such other mutually agreeable location in California relating to the services Provider provides to Members, to the cost thereof, and to payments Provider receives from Members or others on their behalf, and shall be subject to all applicable laws and regulations concerning the confidentiality of such data or records. Provider shall maintain such records and provide such information to Governing Board as may be necessary for Governing Board's compliance with the requirements of any applicable law or regulation. Provider shall maintain such records in a system that permits prompt retrieval of information for at least five (5) years from the termination of this Agreement, and such obligations shall not be terminated upon a termination of this Agreement, whether by rescission or otherwise. Governing Board maintains the right to audit such records to determine the appropriateness of payments made. Governing Board's audit policy is described in the Provider Operations Manual for the Benefit Plan.

Subject to applicable laws relating to privacy, confidentiality, and privileged documents and communications, Provider shall only make a Member's information, including but not limited to medical records, available upon reasonable request to each physician or practitioner treating the Member, for Utilization Review purposes, and to Governing Board or as consented by the Member or an authorized representative of the Member.

This Section shall not be construed to prevent Provider from releasing information which Provider has taken from such medical records to organizations or individuals taking part in research, experimental, educational or similar programs, if no Member identifiable information is released and such release complies with all applicable laws.

7.3 Member Information. Subject to all applicable laws relating to privacy, confidentiality, and privileged documents and communications, Provider shall only make a Member's information including but not limited to medical records available upon reasonable

request to each physician or practitioner treating the Member, for Utilization Review and/or Quality Management purposes, and to Governing Board or as consented by the Member or an authorized representative of the Member.

7.4 Member Records. Ownership and access to records of Members shall be controlled by applicable laws.

8. LIABILITY, INDEMNITY AND INSURANCE

8.1 No Third Party Liability. Neither Governing Board nor Provider nor any of their respective agents or employees shall be liable to third parties for any act or omission of the other party.

8.2 Insurance. Provider, at its sole expense, agrees to maintain adequate insurance for professional liability and comprehensive general liability in an amount no less than: (a) professional liability insurance at a minimum level of $3,000,000 per claim/$5,000,000 annual aggregate; (b) comprehensive general liability insurance at a minimum level of $3,000,000 per claim/$5,000,000 annual aggregate; and (c) director and officer liability coverage for Provider's directors, officers, trustees and managers in the minimum amount of $5,000,000. Such insurance coverage shall cover the acts and omissions of Provider as well as those of Provider's agents and employees. Provider shall also maintain other insurance as shall be necessary to insure Provider and its employees against any event or loss which would impair the ability of Provider to carry out the terms of this Agreement. Such other insurance shall cover any event or loss that Provider would protect itself against in absence of this Agreement. In lieu of any insurance, Provider shall maintain the ability to respond to any and all damages which would be covered by such insurance.

8.3 Evidence of Insurance. Upon request by Governing Board, Provider shall provide Governing Board with copies of insurance policies or evidence of the ability to respond to any and all damages, as provided in Section 8.2.

8.4 Indemnity. Governing Board shall indemnify and save Provider harmless for any claim, demand, loss, lawsuit, settlement, judgment, or other liability, and all related expenses which may accrue, arising from or in connection with a claim of a third party arising from a negligent or otherwise wrongful act or omission of Governing Board, its agents or employees.

Provider agrees to indemnify and save Governing Board harmless from any claim, demand, loss, lawsuit, settlement, judgment, or other liability, and all related expenses which may accrue, arising from or in connection with a claim of a third party arising from a negligent or otherwise wrongful act or omission of Provider, its agents or employees.

If each party claims and is entitled to indemnity from the other, the liability of each to the other shall be determined according to principles of comparative fault.

Indemnity shall include damages, reasonable costs, reasonable expense, and reasonable attorney's fees as incurred by the party indemnified. Any disputes concerning indemnity as provided in this Agreement shall be brought in accordance with the dispute

resolution provisions set forth in Article 10. The foregoing indemnification provision will remain in effect following the termination of this Agreement.

9. MARKETING, ADVERTISING AND PUBLICITY

9.1 Use of Name. Governing Board shall have the right to use the name of Provider for purposes of informing Members and prospective Members of the identity of Participating CMSP Providers and otherwise carrying out the terms of this Agreement.

9.2 Right to Control Names and Marks. Except as provided in Section 9.1, Governing Board and Provider each reserves the right to control the use of its name, symbols, trademarks, or service marks presently existing or later established. In addition, except as provided in Section 9.2, neither Governing Board nor Provider shall use the other's name, symbols, trademarks or service marks in advertising or promotional materials or otherwise without the prior written consent of that party and shall cease any such usage immediately upon written notice of the party or upon termination of this Agreement, whichever is sooner.

10. DISPUTE RESOLUTION

10.1 Provider Operations Manual. Provider shall comply with the procedures set forth in the Provider Operations Manual for the Benefit Plan in bringing any difference or dispute concerning matters described therein. If after completion of these procedures Provider continues to not be satisfied with the resolution of the difference or dispute, its sole remedy to pursue a resolution is the dispute resolution provisions in this Article 10.

10.2 Dispute Resolution and Binding Arbitration Process. Unless otherwise mutually agreed in writing by Governing Board and Provider, if the Governing Board and Provider cannot reach an amicable understanding regarding a difference or dispute and Provider has complied with Sections 10.1 and 10.2 of this Agreement, Governing Board and Provider agree that any such problem or dispute concerning the terms of this Agreement that are not satisfactorily resolved shall be resolved in accordance with the procedures set forth in Exhibit D to this Agreement, attached hereto and incorporated herein. Nothing in this Agreement shall relieve Provider from compliance with California Welfare and Institutions Code Section 16809.4(f) and the Government Claims Act (California Government Code Section 900, *et seq.*) with respect to any dispute or controversy arising out of or in any way relating to this Agreement or the subject matter of this Agreement.

11. TERM AND TERMINATION

11.1 Term. When executed by both parties, this Agreement shall become effective as of the date noted on page one (1) and shall continue in effect for two (2) years ("Initial Term"). Thereafter, this Agreement shall continue in effect until terminated as specified below.

11.2 Without Cause Termination. Either party may terminate this Agreement after the expiration of the Initial Term, without cause, by giving at least ninety (90) days' prior written notice.

11.3 For Cause Termination. Either party may terminate this Agreement for cause effective upon written notice of termination describing in detail the circumstances giving rise to cause of termination. Cause for termination includes, but is not be limited to, material breach of any term or condition of the Agreement. Nothing in this Agreement shall be construed to limit either party's other lawful remedies in the event of a material breach of this Agreement. In the event of a material breach by Provider, Governing Board, in addition to any other available remedy, may require that Provider promptly prepare and submit for Governing Board's approval a corrective action plan that addresses the material breach. Provider shall immediately implement such approved corrective action plan and provide Governing Board with periodic status reports, as requested by Governing Board.

11.4 Immediate Termination by Governing Board. Governing Board may immediately terminate this Agreement upon notification or discovery of the probation, suspension or revocation of Provider's license, certification or accreditation, or other condition that limits Provider's ability to render Medical Services.

11.5 Upon Termination. After the effective date of termination, this Agreement shall remain in effect for the resolution of all matters unresolved as of that date. Without limiting the foregoing, if this Agreement is terminated, Provider shall continue to provide and be compensated for Medical Services under the terms of this Agreement for Medical Services provided to Members who are under the care of Provider at the time of that termination, until (a) the Medical Services being rendered to the Member are completed, or (b) Governing Board makes reasonable and medically appropriate provisions for the assumption of such Medical Services by another Participating Provider. In the event of termination, Provider agrees to follow the Member notification procedures as set forth in the Provider Operations Manual. In addition, in the event of termination of this Agreement, Provider shall not make any representation to Members that Provider is a Participating Provider.

11.6 Access to Records. Notwithstanding any termination, Governing Board shall continue to have access to records for five (5) years from the date of provision of Medical Services to which the records refer. The records shall be available in accordance with Article 7, to the extent permitted by law and as necessary to fulfill the terms of this Agreement.

11.7 Assistance After Termination. In the event this Agreement is terminated, Provider agrees to assist Governing Board in the transfer of Member medical care including making available to Governing Board copies of medical records, patient files, and any other pertinent information held by Provider necessary for efficient case management of Members, as determined by Governing Board. The parties acknowledge that the cost of reproduction required by this provision will not be billed to Members.

11.8 Interruption of Medical Services. In the event that the Provider Services provided by Provider are substantially interrupted by acts of war, fire, labor strike, insurrection, riots, earthquakes or other acts of nature, Governing Board shall have the right to terminate this Agreement upon thirty (30) days' prior written notice to Provider. Such termination shall be canceled if Governing Board, in its judgment, determines that the Medical Services can be performed in spite of the event or because the interruption has ended. Governing Board shall not unreasonably refuse to cancel such termination. If the operations of Provider's facilities are

substantially interrupted by such an event that is not the fault of Provider or is beyond reasonable control of Provider, and Governing Board does not terminate this Agreement as set forth above, then Provider shall be relieved of its obligations only as to those affected operations and only as to those affected portions of this Agreement for the duration of such interruption.

12. GENERAL PROVISIONS

12.1 Relationship of the Parties. Governing Board and Provider are independent entities. Nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee or principal and agent or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement. Nothing in this Agreement is intended to be construed or be deemed to create any rights or remedies in any third party, including but not limited to a Member or a Participating Provider other than Provider.

12.2 Assignment. No assignment of the rights, duties or obligations of this Agreement shall be made by Provider without the expressed written approval of a duly authorized representative of Governing Board. Any attempted assignment in violation of this provision shall be void as to Governing Board.

12.3 Binding on Successors in Interest. Subject to Section 12.2, the provisions of this Agreement and obligations arising hereunder shall extend to and be binding upon the parties hereto and their respective successors and assigns and shall inure to the benefit of the parties hereto and their respective successors and assigns.

12.4 Subcontracting. Provider shall not subcontract this Agreement or any portion of it without the prior written consent of Governing Board if the subcontract requires a Member to occupy an inpatient bed or receive Medical Services at locations other than those listed in Exhibit A. Such consent shall not be unreasonably withheld. Provider agrees to maintain and make available to Governing Board, upon request, copies of all subcontracts and to ensure that all subcontracts shall be in writing and require that the subcontractor shall comply with Article 7 herein.

12.5 Waiver of Breach. No delay or failure to require performance of any provision of this Agreement will constitute a waiver of that provision as to that or any other instance. Any waiver granted by a party must be in writing and will apply to the specific instance expressly stated.

12.6 Notices. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing, postage prepaid, and shall be sent by certified or registered mail, return receipt requested, to Governing Board or Provider at the address below. The notice shall be effective on the date indicated on the return receipt.

To Governing Board at:	County Medical Services Program Governing Board c/o Advanced Medical Management, Inc. 5000 Airport Plaza Drive, Suite 150 Long Beach, CA 90815-1260 Phone: (877) 589-6807 Fax: (562) 766-2006
to Provider at:	County of Shasta Director of Adult Services Branch Attn: Contracts Unit P.O. Box 496005, Redding, CA 96049-6005 Phone: (530) 225-5900 Fax: (530) 225-5977

12.7 Severability. In the event any provision of this Agreement is rendered invalid or unenforceable by any valid Act of Congress or of the California Legislature or by any regulation duly promulgated by officers of the United States or the State of California acting in accordance with law, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of this Agreement shall, subject to Section 12.8, remain in full force and effect.

12.8 Effect of Severable Provision. In the event that a provision of this Agreement is rendered invalid or unenforceable or declared null and void as provided in Section 12.7 and its removal has the effect of materially altering the obligations of either Governing Board or Provider in such a manner as, in the judgment of the party affected, (a) will cause serious financial hardship to such party; or (b) will cause such party to act in violation of its corporate Articles or Bylaws, the party so affected shall have the right to terminate this Agreement upon thirty (30) days' prior written notice to the other party. The provisions of Article 11 shall apply to such termination.

12.9 Entire Agreement. This Agreement, together with exhibits, contains the entire agreement between Governing Board and Provider relating to the rights granted and the obligations assumed by the parties concerning the provision of Medical Services to Members. Any prior agreements, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

12.10 Amendment. This Agreement or any part or section of it may be amended at any time during the term of the Agreement by mutual written consent of duly authorized representatives of Governing Board and Provider. Notwithstanding the foregoing, Governing Board may amend this Agreement or any part or section of it by providing written notice to Provider at least thirty (30) business days prior to the effective date of such amendment which shall become effective upon the effective date, unless Provider objects in writing to such amendment within fifteen (15) business days of receipt of such notice. Amendments required due to legislative, regulatory or other legal authority do not require the prior approval of Provider and shall be deemed effective immediately upon Provider's receipt of notice.

12.11 Attorneys' Fees. If either Governing Board or Provider institutes any action, suit or arbitration proceeding to enforce the provisions of this Agreement, each party shall pay one-half of the arbitration costs and otherwise pay its own attorneys' fees and other costs.

Notwithstanding the foregoing, should Governing Board prevail in any action, suit or arbitration instituted by Provider to contest the denial of any claim submitted to Governing Board or its designated agent for CMSP where any such claim was denied solely because either (a) Provider did not timely confirm eligibility status in accordance with this Agreement, or (b) Provider has not timely billed Governing Board in accordance with this Agreement, the Provider shall pay all of Governing Board's and its designated agent's costs associated with the action, suit or arbitration, which costs include, without limitation, attorneys' fees, statutory costs, expert witness fees and the fees of the arbitrator.

12.12 Headings. The headings of articles and sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

12.13 Governing Law. This Agreement shall be construed, regulated and administered under the laws of the State of California without regard to conflict of law principles that would result in the application of another jurisdiction, except as otherwise specifically required by federal law. The venue for any action or arbitration under this Agreement shall be the County of Sacramento in the State of California.

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

12.15 Force Majeure. The parties shall not be liable for any failure to meet any of the obligations or provide any of the services specified or required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of a party, its employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed by such party, its employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations, whether valid or invalid.

12.16 No Third Party Beneficiaries. The obligations created by this Agreement shall be enforceable only by the parties hereto, and no provision of this Agreement is intended to, nor shall it be construed to, create any rights for the benefit of or be enforceable by any third party.

GOVERNING BOARD	COUNTY OF SHASTA
By:_____	By:_____
Name:_____	Name: DAVID A. KEHOE
Title:_____	Title: Chairman, Board of Supervisors
Date:_____	Date:_____

RISK MANAGEMENT APPROVAL
BY: _____
12/6/2017

APPROVED AS TO FORM
SHASTA COUNTY COUNSEL
Alan B. Cox
Deputy County Counsel
12/4/17

EXHIBIT A

PROVIDER INFORMATION AND ADDRESSES WHERE MEDICAL SERVICES ARE PROVIDED
For: County of Shasta

In accordance with Sections 3.1 and 3.2 of the Agreement, Provider provides, or arranges for, services at the locations listed below. Use one or more pages as necessary when multiple providers under common ownership (the Provider is signing on behalf of all of them) are expected to bill Governing Board under more than one TIN and/or billing address. Please enter "N/A" for the following if not applicable or not available:

Provider Name	Shepard Greene M.D.	Billing Address: Shasta County Mental Health 2640 Breslauer Way Redding, CA 96001 Billing Contact:
Telephone No.		
Facsimile No.		
Email Address		
Tax I.D. No.		Physical Address (if different than above):
License No.	A51910	
NPI (or UPIN if NPI not yet designated)	NPI: 1639204357 Clinic NPI: 1881692390	
DEA No.	BG3384841	
Hours		Mid-Level Practitioners Supervised:
Languages Spoken	By Staff: By Provider:	

Provider Name	Leonora Petty	Billing Address: Shasta County Mental Health 2640 Breslauer Way Redding, CA 96001 Billing Contact:
Telephone No.		
Facsimile No.		
Email Address		
Tax I.D. No.		Physical Address (if different than above):
License No.	C38026	
NPI (or UPIN if NPI not yet designated)	NPI: 1194778894 Clinic NPI: 1881692390	
DEA No.	FP4133372	
Hours		Mid-Level Practitioners Supervised:
Languages Spoken	By Staff: By Provider:	

EXHIBIT A (continued)

PROVIDER INFORMATION AND ADDRESSES WHERE MEDICAL SERVICES ARE PROVIDED

Provider Name	Divya Krishnamoorthy	Billing Address: Shasta County Mental Health 2640 Breslauer Way Redding, CA 96001 Billing Contact:
Telephone No.	(206)965-0030	
Facsimile No.		
Email Address		
Tax I.D. No.		Physical Address (if different than above):
License No.	54901	
NPI (or UPIN if NPI not yet designated)	NPI: 1194742825 Clinic NPI: 1881692390	
DEA No.	FK3832056	
Hours		Mid-Level Practitioners Supervised:
Languages Spoken	By Staff: By Provider:	

Provider Name	Jonathan Sy	Billing Address: Shasta County Mental Health 2640 Breslauer Way Redding, CA 96001 Billing Contact:
Telephone No.	(808)304-0406	
Facsimile No.		
Email Address		
Tax I.D. No.		Physical Address (if different than above):
License No.	141653	
NPI (or UPIN if NPI not yet designated)	NPI: 1629339148 Clinic NPI: 1881692390	
DEA No.		
Hours		Mid-Level Practitioners Supervised:
Languages Spoken	By Staff: By Provider:	

EXHIBIT A (continued)

PROVIDER INFORMATION AND ADDRESSES WHERE MEDICAL SERVICES ARE PROVIDED

Provider Name	Shari Muir	Billing Address: Shasta County Mental Health 2640 Breslauer Way Redding, CA 96001 Billing Contact:
Telephone No.	(949) 735-9473	
Facsimile No.		
Email Address	_____	
Tax I.D. No.		Physical Address (if different than above): _____ _____ _____ _____
License No.	97068	
NPI (or UPIN if NPI not yet designated)	NPI: 1598883233 Clinic NPI 1881692390	
DEA No.		
Hours	_____	Mid-Level Practitioners Supervised: _____ _____
Languages Spoken	By Staff: _____ By Provider:	

Provider Name	Andrew Deckert	Billing Address: Shasta County Public Health 2650 Breslauer Way Redding, CA 96001 Billing Contact:
Telephone No.		
Facsimile No.		
Email Address	_____	
Tax I.D. No.		Physical Address (if different than above): _____ _____ _____
License No.	G57867	
NPI (or UPIN if NPI not yet designated)	NPI:1750416541 Clinic NPI 1588709182 Lab NPI 1063547131	
DEA No.	MW2970425	
Hours	_____	Mid-Level Practitioners Supervised: _____ _____
Languages Spoken	By Staff: _____ By Provider:	

EXHIBIT A (continued)

PROVIDER INFORMATION AND ADDRESSES WHERE MEDICAL SERVICES ARE PROVIDED

Provider Name	Tammy White	Billing Address:
Telephone No.		Shasta County Mental Health
Facsimile No.		2640 Breslauer Way
Email Address	_____	Redding, CA 96001 Billing Contact:
Tax I.D. No.		Physical Address (if different than above):
License No.		_____
NPI (or UPIN if NPI not yet designated)	NPI: 1891968459_____ Clinic NPI 1881692390	_____ _____ _____
DEA No.	MW2970425	
Hours	_____	Mid-Level Practitioners Supervised: _____
Languages Spoken	By Staff: _____ By Provider:	

Provider Name		Billing Address:
Telephone No.		_____
Facsimile No.		_____
Email Address	_____	_____ Billing Contact:
Tax I.D. No.		Physical Address (if different than above):
License No.		_____
NPI (or UPIN if NPI not yet designated)	_____ UPIN: _____	_____ _____ _____
DEA No.		
Hours	_____	Mid-Level Practitioners Supervised:
Languages Spoken	By Staff: _____ By Provider:	

EXHIBIT B

COMPENSATION RATES

County of Shasta
CONTRACT # SP118

Provider agrees that it shall accept the Rates below as payment in full for Medical Services pursuant to Article 5.

Physicians and Physician Groups Not Affiliated with Community Health Centers

For Providers that are Physicians and Physician Groups Not Affiliated with Community Health Centers, reimbursement for each Medical Service rendered to Members under this Agreement shall be at the lesser of Provider's charge for such Medical Service or the Medi-Cal rates for such services in effect on July 1, 2007, plus twenty percent (20%). Such rate shall be adjusted annually by the Medicare Economic Index (MEI) adjustment approved for Federally Qualified Health Centers.

EXHIBIT C

COPIES OF LICENSES AND CERTIFICATIONS

Provider to attach copies of the following documents:

1. Current license, certification, permit or other accreditation, and
2. Evidence of participation in Medi-Cal program; and.
3. Copy of W-9 Form.

EXHIBIT D

DISPUTE RESOLUTION AND BINDING ARBITRATION PROCESS

1. **Overall Scope**. The provisions for binding arbitration set forth in this Exhibit D shall apply to all disputes between the Provider and Governing Board (whether stated in tort, contract or otherwise) ("Disputes") which exceed the jurisdictional limit of Small Claims Court. Any Disputes that are within the jurisdictional limit of Small Claims Court shall be filed in such Court. Provider and Governing Board may individually be referred to herein as a "Party" and collectively be referred to herein as "Parties."

2. **Meet and Confer.**

2.1 **Initiate/Information**. The Parties agree to meet and confer within thirty (30) days of a written request by either Party in an effort to settle any Dispute arising under this Administrative Services Agreement. Throughout the meet and confer process, the Parties shall exchange information which is sufficiently detailed to enable each Party to understand and effectively evaluate the other Party's position.

2.2 **Authority**. At each meet and confer meeting, each Party shall be represented by persons with authority to settle the Dispute. If a Party's representative does not have such authority, the other Party may elect to terminate the meet and confer process and, at its option, proceed directly to arbitration.

2.3 **Confidentiality and Limited Use**. All documents created for the purpose of and exchanged during the meet and confer process and all meet and confer discussions, negotiations and proceedings shall be treated as compromise and settlement negotiations and subject to Section 1152 of the California Evidence Code. To the extent that the Parties produce or exchange documents otherwise subject to the attorney work product doctrine, the Parties agree that such production or exchange shall not waive the protected nature of those documents and shall not otherwise affect their inadmissibility as evidence in any subsequent proceeding. The Parties shall each endeavor to label any such documents as protected under Section 1152, but their failure to do so shall not be deemed a waiver of protections set forth in this Exhibit D, Section 2.3.

3. **Agreement to Arbitrate**. If the Parties cannot resolve their Dispute(s) through the meet and confer process, the Parties shall submit the Dispute(s) to binding arbitration in lieu of any form of litigation in any court.

4. **Initiating Arbitration.**

4.1 **Arbitration Demand**. Upon the conclusion of the thirty (30)-day meet and confer period, either Party may initiate the arbitration process by serving on the other Party a written Arbitration Demand setting forth separately a clear statement of each Dispute, the ultimate facts underlying each Dispute, the closest approximation reasonably possible of the amount of money believed to be at issue and how that amount was calculated.

4.2 **Choose Arbitrator.** Upon receipt of the Arbitration Demand, the Parties shall promptly meet and confer to choose an arbitrator ("Arbitrator"), who meets the qualifications outlined in Exhibit F, Section 5.3. If the Parties are unable to agree on the Arbitrator within ten (10) business days of the date the Arbitration Demand is served (unless the Parties agree to extend this time period), the Arbitration Demand may be filed with the AAA and an Arbitrator will be chosen from the AAA panel of arbitrators in accordance with the AAA rules applicable to commercial arbitrations (the "AAA Rules"). If the Parties are able to agree on an Arbitrator, the moving Party will file the Arbitration Demand with the dispute resolution service used by that Arbitrator. The Parties shall each advance one-half of the Arbitrator's fees.

5. **Arbitration Rules and Process.**

5.1 **Identification of Disputes / Rules.** The Parties shall consolidate in a single arbitration all Disputes arising from the same set of facts and circumstances. All arbitration shall be conducted in accordance with the provisions of this Exhibit D and the rules of the dispute resolution service used by the Arbitrator, unless the Parties and the Arbitrator mutually agree to a different service. The provisions of this Exhibit D shall control in the event of a conflict between this Exhibit D and the arbitration service rules.

5.2 **Joinder of Interested Parties.** The Parties agree that any party with an interest in the matter may join or be joined in the arbitration, but the Parties agree to proceed with the arbitration of all Disputes between them even if other parties refuse to participate. This arbitration agreement set forth in this Exhibit shall be enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

5.3 **Arbitrator Qualifications.** The Parties prefer that the arbitrator ("Arbitrator") be a retired judge of the California (Superior Court or above) or United States courts (the "Arbitrator") or an attorney with at least, fifteen (15) years of experience.

5.4 **Early Pre-Hearing Conference.** The Parties acknowledge and agree that Disputes based on contract interpretation or performance arise, or are likely to arise, in the ordinary course of business. As soon as possible after the Arbitrator is chosen, s/he shall schedule an early pre-hearing conference (the "Pre-Hearing Conference") to address and resolve procedural matters (including the appropriateness of bifurcation, consolidation, coordination and severance), confidentiality issues (see Section 5.5 below), arrange for the exchange of discovery information, and narrow the issues to the extent possible.

5.5 **Confidentiality and Protective Orders.** The Parties agree to enter into such protective orders (including creating a category of discovery documents "for attorney's eyes only" to the extent this is feasible given the nature of the evidence and the Dispute) as are, or may become, necessary to assure that neither Party obtains access to proprietary business information that would adversely affect the disclosing Party's legitimate business interests. All discovery information shall be used solely and exclusively for arbitration of the Disputes between the Parties. After the arbitration award becomes final, each Party shall return or destroy all attorneys' eyes only and highly confidential documents obtained from the other Party during the course of the arbitration, and within thirty (30) days of such date shall provide to the other Party an officer's certificate signed under penalty of perjury indicating that all such information

has been returned or if the return is not feasible, destroyed. Nothing herein is intended as a modification to or waiver of any privileges or protections from discovery that might otherwise exist.

5.6 **Discovery**. The Parties shall be allowed the following limited discovery: Each Party shall be entitled to receive reasonably relevant documents and take one fact witness deposition. Each Party shall also be entitled to take the depositions of all of the opposing Party's experts. Any further discovery shall be allowed only by order of the Arbitrator upon a showing that it is necessary to the presentation of a Party's claims or defenses and is consistent with the goals set forth in this Exhibit D. All fact discovery shall be completed thirty (30) days prior to the arbitration hearing. All expert discovery shall be completed fifteen (15) days prior to the arbitration hearing.

5.7 **Arbitration Hearing**. The Arbitrator may require, and the Parties shall provide, briefing of legal issues or presentation of additional evidence. Copies of documents may be used in lieu of originals, absent a showing by an objecting Party that the copy is unlike the original in some substantive way. In putting on its case, each Party may choose whether to use declarations of witnesses in lieu of live testimony. Witnesses under the control of one Party, including third party witnesses whose declarations are being offered at the arbitration, shall be made available to give live testimony at the request of the other Party.

5.8 **Arbitrator's Final Decision**. The Arbitrator shall have the power to grant all legal and equitable remedies, except only that punitive damages, penalties or forfeitures shall not be awarded. The Arbitrator shall issue a binding decision within thirty (30) days of the conclusion of the arbitration, or, if the arbitration involves multiple Disputes that the Arbitrator determines are separate and severable, then within thirty (30) days of the last day of arbitration on each such separate and severable Dispute. The Arbitrator will apply state and federal law and regulations, and will issue a written, reasoned decision setting forth the basis of the award. The arbitrator's decision shall be conclusive and binding, and it may be confirmed thereafter as a judgment by the Superior Court of the State of California, subject *only to* challenge as set forth in the California Arbitration Act (Cal. C.C.P. § 1281 *et seq.*).

5.9 **Arbitration Costs and Arbitrator's Fees**. The costs of the arbitration service and the arbitrator's fees shall be split equally among the Parties regardless of the outcome of the case; provided however, that the Cal. C.C.P. § 998 procedure and the award of costs thereunder shall be available in arbitration.

5.10 **Venue**. The arbitration shall be conducted in Sacramento, California, or such other venue as the Parties mutually agree.

6. **Waiver of Rights**. By agreeing to binding arbitration as set forth in this Exhibit D, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a Dispute between them were determined by litigation in a court, including without limitation the right to seek or obtain the remedies referenced in Section 5.8 above, the right to a jury trial, and certain rights of appeal.