MEDICAL SERVICES AGREEMENT
FOR PRIMARY CARE

This Agreement ("Agreement") is made effective from the **1st** day of **July, 2023** ("Effective Date") by and between **Z Medical Center, Inc.**, ("Medical Services Entity"), and Polk County, a political subdivision of the State of Florida ("COUNTY") (Medical Services Entity and COUNTY shall be jointly referred to herein as the "Parties").

WITNESSETH:

WHEREAS, the County has an indigent health care plan, hereinafter known as the Polk HealthCare Plan (further defined herein and hereinafter referred to as the "Plan"), and wishes to arrange for the provision of medical services to certain eligible County residents ("Members");

WHEREAS, the Medical Services Entity is comprised of, or contracts with, one or more Qualified Providers (hereinafter defined) capable of meeting the credentialing criteria of the County;

WHEREAS, the County desires to engage the Medical Services Entity to deliver, or arrange for the delivery of medical services to the Members of its Plan; and

WHEREAS, the Medical Services Entity is willing to deliver or arrange for the delivery of such services on the terms specified herein.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, and other good and valuable consideration, the parties hereby agree as follows:

ARTICLE I
DEFINITIONS

1.1 Claim. A statement of services submitted to the County, or its designated third party administrator, by the Medical Services Entity following the provision of Covered Services to a Member that shall include the Member's demographics, diagnosis or diagnoses (ICD10 Codes), date(s) of service, CPT/HCPCS codes, place of service, authorization number if required, referring provider if applicable, treating provider and the member name, member address, member date of birth, Plan eleven-digit member identification number and Qualified Provider to be paid for services rendered to the Member submitted on an approved CMS 1500 Form.

1.2 Co-payment. A charge which may be collected directly by a Medical Services Entity or Medical Services Entity's designee from a Member in accordance with the Plan.

1.3 County. The designated division of the county government of Polk County, Florida, Polk HealthCare Plan, Health and Human Services Division or its authorized agent as applicable.

1.4 County Notice. A communication by the County to the Medical Services Entity informing the Medical Services Entity of the terms of the Plan, modifications to the Plan, and any other information relevant to the provision of Covered Services pursuant to this Agreement.

1.5 Covered Services. Health care services to be delivered by or through Medical Services Entity to Members pursuant to this Agreement, as further defined in ARTICLE II.

1.6 Emergent Care. Emergent conditions are those conditions where there is the potential for life-threatening or limb threatening complications, or where those complications are reasonably perceived by the member. The treatment of such perceived conditions should be severe enough that these could not have been treated in the Qualified Provider's office or urgent care setting.

1.7 Medical Management. The process by which the County, or its duly appointed and authorized third party administrator, together with the Medical Services Entity, will determine whether the Covered Services furnished to Members were Medically Necessary and the processes that will govern utilization, including concurrent review, case management, disease management, and all other processes affecting the medical care of Members. The Medical Services Entity may appeal any decision related to pre-service requests pursuant to Section 5.2 herein.

1.8 Medical Services Entity. An individual or group of Qualified Providers, who are capable of meeting the credentialing criteria of the Plan.

1.9 Medically Necessary. Health care services that a reasonably prudent Qualified Provider would deem necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a Member.

1.10 Payer. The entity or organization directly responsible for the payment of Covered Services to the Medical Services Entity under the Plan.

1.11 Polk HealthCare Plan (the "Plan"). A government assistance program to provide health care services, which is funded by a discretionary sales surtax (as authorized pursuant to F.S. 212.055(7)) and administered by the County for the benefit of Members, as it may be modified from time to time, and all the terms, conditions, limitations, exclusions, benefits, rights and obligations thereof to which County and Members are subject.

1.12 Polk HealthCare Plan Members. Any individual(s) who has/have been determined eligible by the County and is/are enrolled in the Plan.

1.13 Protected Health Information (PHI). Information that is (a) created or received by a Medical Services Entity; (b) relates to: (1) the past, present, or future physical or mental health or condition of an individual; (2) the provision of health care to an individual; or (3) the past, present, or future payment for the provision of health care to an individual; and (c) identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. PHI does not include information excluded from HIPAA's definition of "protected health information" in 45 C.F.R. 160.103.

1.14 Qualified Provider. A doctor of medicine, a doctor of osteopathy, or a doctor of optometry, certified nurse practitioner or physician assistant licensed to practice in the State of Florida, who possesses an unencumbered Florida license, and who provides Covered Services to Members as contemplated in this Agreement.

1.15 Routine Care /Well Care. Care provided to Members as follow-up to a previously treated condition or illness and care for the diagnosis and treatment of acute and chronic illnesses, as well as preventive treatment, including patient counseling/education.

1.16 Total Compensation. The total amount payable by Payer and Member for Covered Services furnished pursuant to this Agreement. The Total Compensation is defined herein pursuant to EXHIBIT A, attached hereto and incorporated into this Agreement by reference.

1.17 Urgent Care. Care provided to Members who have an injury or illness that is not life –threatening but could result in serious injury or disability unless medical attention is immediately received. These conditions are not serious enough to require a visit to the Emergency Room.

ARTICLE II
DELIVERY OF SERVICES

2.1 Covered Services. The Medical Services Entity shall provide or, through its Qualified Providers, arrange for the Members the provision of Covered Services that are identified in EXHIBIT B-1, attached hereto and made a part of this Agreement by reference. All Covered Services shall be provided in accordance with generally accepted clinical and legal standards, consistent with medical ethics governing the Qualified Provider. Covered Services requiring pre-certification are identified in EXHIBIT C, which may be adjusted from time to time by the County in its sole discretion. Non Covered Services identified in EXHIBIT B-2 are not reimbursable services under the Plan.

2.2 Verification of Members. Except in the case of emergency, in order to guarantee payment, the Medical Services Entity shall utilize a Member's identification card, which has been chosen by the County to verify and confirm that Member's eligibility for Covered Services prior to rendering any such Covered Services pursuant to the instructions provided in EXHIBIT D attached hereto and made a part of this Agreement by reference.

ARTICLE III
COMPENSATION AND RELATED TERMS

3.1 Compensation. The Medical Services Entity, or its designee, shall accept the Total Compensation as full payment for the provision of Covered Services.

3.2 Billing for Covered Services. The Medical Services Entity shall submit a Claim to the County or its third party administrator and, in the event the Claim is consistent with the compensation terms under EXHIBIT A, the County or its third party administrator shall pay the Medical Services Entity for Covered Services rendered to Members in accordance with the terms of this Agreement. The Medical Services Entity shall arrange for all Claims for Covered Services to be submitted to the County or its third party administrator within one hundred and eighty (180) days from the date of service. If additional information is required or needed by the County or its third party administrator to evaluate or validate the original Claim submitted by the Medical Services Entity for payment, the Medical Services Entity will have an additional ninety (90) days from the date of the initial claim denial to resubmit a corrected claim. The Medical Services Entity shall submit such claims on a billing form CMS-1500 or on any other form that the County directs the Medical Services Entity, in writing, to utilize. If the Medical Services Entity does not submit a Claim to the County or its third party administrator in a timely manner, the County or its third party administrator may, at its discretion, deny payment.

3.3 Co-payments to be Collected from Members. When the Plan requires Members to make Co-payments, such Co-payments shall be collected from the Member at the time the service is rendered by the Medical Services Entity or one of its Qualified Providers. The County shall inform or educate Members that Members must make a Co-payment at the time the service is rendered and that this practice is mandatory for all Members. At no time shall the Medical Services Entity bill a Member for any balance remaining in relation to a bill after the Total Compensation has been applied to the same.

3.4 Promptness of Payment. The County or its third party administrator shall remit to the Medical Services Entity the County's portion of the Total Compensation, as specified in EXHIBIT A, within forty-five (45) days of receipt of a Claim by the Medical Services Entity. This Claim shall be sufficient in detail so that the County or its third party administrator is able to reasonably determine the amount to be paid. If additional information is required or needed by the County or its third party administrator to evaluate or validate the original Claim submitted by the Medical Services Entity for payment, the Medical Services Entity will have an additional ninety (90) days from the date of the initial claim denial to resubmit a corrected claim.

The County or its third party administrator shall affirm and pay any valid claims within forty-five (45) days of receipt of such additional information. All payments to the Medical Services Entity shall be considered final unless adjustments are requested, in writing to the County or its third party administrator by the Medical Services Entity within ninety (90) days following receipt of the payment explanation from the Payer.

If payment has been made to the Medical Services Entity by the County or its third party administrator for a non-covered service, the Medical Services Entity shall promptly refund such payment provided written notice of payment for such non-covered service has been made by the County within ninety (90) days of receipt of the Medical Services Entity's Claim.

For purpose of payment, "prompt payment" may be defined as "within ninety (90) days." The Medical Services Entity agrees that it shall not bill and collect any amount pursuant to this Agreement for charges incurred by Members to the extent that such charges result from an error made by the Medical Services Entity. An error shall include, but not be limited to, duplicate billing for a Covered Service provided only once and any services which were not actually rendered. If the County or its third party administrator concludes that such an erroneous billing or collection has been made, the County or its third party administrator shall notify the Medical Services Entity of the error. Upon receipt of this notification, the Medical Services Entity shall promptly withdraw the billing or that part which is in error, or reimburse the County or its third party administrator for such amounts already paid to the Medical Services Entity pursuant to the erroneous billing.

3.5 Payer of Last Resort. Under no circumstances shall Medical Services Entity bill the Plan or the Plan pay any Member bill until and unless all other sources of other Member coverage have been billed and payment has been denied by the same. Should a Plan member be determined to have other coverage for services provided by Medical Services Entity under any other contractual or legal benefit, including, but not limited to, Medicaid, Medicare, worker's compensation insurance, motor vehicle insurance or a private group or indemnification program, Medical Services

Entity is expected to bill the said entity as the primary payer. If the Plan paid for services and other coverage is later discovered, the Medical Services Entity must reimburse the County or its third party administrator by recoup, refund or adjustments.

3.6 Sole Source of Payment. Only after other payer sources have been exhausted, Medical Services Entity will pursue payment of any Claim from the County or its third party administrator for Medically Necessary Covered Services of Members. Medical Services Entity shall make no charges or claims against the Plan Members for Covered Services except for Co-payments as previously authorized.

ARTICLE IV
MEDICAL SERVICES ENTITY'S OBLIGATION

4.1 Licensed/Good Standing. The Medical Services Entity represents that each of its Qualified Providers are and shall remain licensed and/or registered who possesses an unencumbered Florida license to practice medicine and, if such Medical Services Entity is an entity, such entity is registered and in good standing in the State of Florida. Failure to maintain licensure will be grounds for immediate termination of this Agreement under Section 8.2.

4.2 Nondiscrimination. The Medical Services Entity agrees that it and each of its Qualified Providers shall not differentiate or discriminate in its provision of Covered Services to Members because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, income, health status, disability or age. Further, the Medical Services Entity agrees that its Qualified Providers shall render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as such services are offered to patients not associated with the Plan and consistent with medical ethics and applicable legal requirements for providing continuity of care.

4.3 Standards. Covered Services provided by or arranged for by the Medical Services Entity shall be delivered only by professional personnel qualified by licensure, training or experience to discharge their responsibilities and operate their facilities in a manner that complies with generally accepted standards in the industry.

4.4 Credentialing of Qualified Providers. The Medical Services Entity acknowledges that the County may delegate to it, at the County's discretion, all credentialing responsibilities and authority with respect to Qualified Providers and/or other practitioners. This delegation will be accepted by the Medical Services Entity, if so directed by the County.

4.5 Employment Eligibility Verification (E-Verify)

a. For purposes of this section, the following terms shall have the meanings ascribed to them below, or as may otherwise be defined in Section 448.095, Florida Statutes, as amended from time to time:

(1) "Contractor" means a person or entity that has entered or is attempting to enter into a contract with a public employer to provide labor, supplies, or services to such employer in exchange for salary, wages, or other remuneration; and

(2) "E-Verify system" means an Internet-based system operated by the United States Department of Homeland Security that allows participating employers to electronically verify the employment eligibility of newly hired employees; and

(3) "Subcontractor" means a person or entity that provides labor, supplies, or services to or for a contractor or another subcontractor in exchange for salary, wages, or other remuneration.

b. Pursuant to Section 448.095(2)(a), Florida Statutes, effective January 1, 2021, public employers, contractors and subcontractors shall register with and use the E-Verify system in order to verify the work authorization status of all newly hired employees. The Contractor acknowledges and agrees to utilize the U.S. Department of Homeland Security's E-Verify System to verify the employment eligibility of:

(1) All persons employed by the Contractor to perform employment duties during the term of this contract; and

(2) All persons (including subvendors/subconsultants/subcontractors) assigned by the Contractor to perform work pursuant to this contract.

c. The Contractor acknowledges and agrees that use of the U.S. Department of Homeland Security's E-Verify System and compliance with all other terms of this section is an express condition of this contract, and the County may treat a failure to comply as a material breach of this contract. By entering into this contract, the Contractor becomes obligated to comply with the provisions of Section 448.095, Florida Statute, "Employment Eligibility," as amended from time to time. This includes but is not limited to utilization of the E-Verify System to verify the work authorization status of all newly hired employees, and requiring all subcontractors to provide an affidavit attesting that the subcontractor does not employ, contract with, or subcontract with, an unauthorized alien. The Contractor shall maintain a copy of such affidavit for the duration of the contract. Failure to comply will lead to termination of this contract, or if a subcontractor knowingly violates the statute, the subcontract must be terminated immediately. Any challenge to termination under this provision must be filed in the Tenth Judicial Circuit Court of Florida no later than 20 calendar days after the date of termination. If this contract is terminated for a violation of the statute by the Contractor, the Contractor may not be awarded a public contract for a period of 1 year after the date of termination. The Contractor shall be liable for any additional costs incurred by the County as a result of the termination of this contract. Nothing in this section shall be construed to allow intentional discrimination of any class protected by law.

4.6 Authority. The Medical Services Entity shall, and hereby does, represent and warrant that it has full legal power and authority to bind its Qualified Providers to the provisions of this Agreement. The Medical Services Entity shall communicate with its Qualified Providers regarding all matters relating to this Agreement and the services to be performed hereunder.

4.7 Administrative Procedures. The Medical Services Entity and each of its Qualified Providers shall comply with the policies and procedures established by the County and pursuant to the Plan, to the extent the Medical Services Entity has received notice of the same, consistent with the terms of this Agreement.

4.8 Use of Names for Marketing. The Medical Services Entity and each of its Qualified Providers shall permit the County to utilize the name, address, and telephone number of it or its Qualified Providers, in the County's list of Medical Services Entities, which will be distributed to Members. Such rights shall not extend to the listing of such Qualified Providers or Medical Services Entity in any newspaper, radio, or television advertising without receiving the prior written consent of said Medical Services Entity. Time is of the essence and approval will not be unreasonably withheld.

4.9 Provision of Covered Services. The Medical Services Entity agrees to provide or arrange for the provision of Covered Services, from Monday through Friday, 8:00 am to 5:00 pm. Covered Services include after-hours telephone access to a professional who is qualified to aid the Members in medical decision making regarding urgent/emergent care and to make any of the following recommendations to a Member who needs Emergency Care experiencing pain or other unusual symptoms: (a) treat pain or symptoms at home and come in to see the Medical Services Entity on the next day; (b) go to an urgent care center; (c) go to an emergency room.

4.10 Noninterference with Medical Care. Nothing in this Agreement is intended to create (nor shall be construed or deemed to create) any right of the County to intervene in any manner in the methods or means by which the Medical Services Entity renders health care services or provides health care supplies to Members. Nothing herein shall be construed to require the Medical Services Entity to take any action inconsistent with professional judgment concerning the medical care and treatment to be rendered to Members.

4.11 Best Efforts. The Medical Services Entity shall use best efforts to participate in such utilization review programs, medical necessity reviews, coordination of benefit activities, and cost containment activities, as are provided under the Plan.

4.12 Evaluation and Quality Management. The Medical Services Entity is expected to have its own quality management programs in place. These programs should include ongoing monitoring of quality of care, documentation, qualifications for professional staff and requirements for ongoing training of professional and support staff. The quality management process is expected to include annual satisfaction surveys of adults receiving primary care services.

4.13 Health Insurance Portability and Accountability Act (HIPAA). The Medical Services Entity warrants that it is in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the provisions of the Privacy and Security Rule adopted by the Department of Health and Human Services ("HHS").

ARTICLE V
COUNTY'S OBLIGATIONS

5.1 Deemed Notification. The County shall notify the Medical Services Entity in writing of all policies, procedures, rules, regulations, and schedules, that the County considers material to the performance of this Agreement and relevant amendments. Except in the event of emergency, or unless the County directs otherwise in writing, thirty (30) days from the date of notification will be considered sufficient notice to effect a change in policy under the Plan.

5.2 Appeal of a Pre-Service Denial. The Medical Services Entity or Qualified Provider shall have the right to appeal any denial by the County or its third party administrator of a pre-service request for authorization of services. There shall be a general appeals process for requested Covered Services of a routine nature, and an expedited appeals process for requested Covered Services of an urgent/emergent nature. The final decision of whether to expedite the appeal will be made by the County, in its sole discretion. There will be one level of appeal for denials made on a clinical basis. For clinical appeals, the Medical Services Entity will have sixty (60) days to appeal from the date of denial of the initial service request.

5.3 Appeal of a Claim Denial. For denial of payment of Claims, the Medical Services Entity will have sixty (60) days from the date of the final denial of a Claim to submit an appeal of the denial. "Final denial" of a Claim will occur upon the completion of the ninety (90) day period that a Medical Services Entity is afforded to resubmit a corrected Claim, if no corrected Claim is provided in such 90-day time period or if the corrected Claim is subsequently denied and an additional ninety (90) day period has elapsed without further corrected Claim submitted by the Medical Services Entity. The appeals decision whether to uphold or overturn a Claim appeal will be communicated to the Medical Services Entity within forty-five (45) days from the date the Medical Services Entity submitted the appeal using an Explanation of Payment form ("EOP").

5.4 Provider Grievances. The County shall establish and maintain systems to process and resolve any grievance a Qualified Provider has against the County.

5.5 Quality Management Monitors. As the Plan is committed to the quality of care provided to its Members, the Plan has identified preventive health services and certain medical conditions to be reviewed as quality indicators. These guidelines will be used to develop key indicators which will be monitored by the Plan for primary care and select specialty Qualified Providers. The Medical Services Entity, at the Plan's request, will furnish data to the Plan for review. The data will be analyzed and compared to peer and national standards. Any Medical Services Entity who falls outside the range for these indicators may be put on a corrective action plan by the Plan and monitored on a more rigorous basis. If the Medical Services Entity fails to show significant improvement, the Medical Services Entity may be terminated from the Plan.

5.6 Health Insurance Portability and Accountability Act (HIPAA). The County warrants that it is in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the provisions of the Privacy and Security Rule adopted by the Department of Health and Human Services ("HHS").

ARTICLE VI
INSURANCE

6.1 Medical Services Entity Insurance. The Medical Services Entity shall require each Qualified Provider to maintain, at all times, in limits and amounts as required by Florida law, a professional liability insurance policy and other insurance or other liability bond as shall be necessary to insure such Qualified Provider against any claim for damages arising directly or indirectly in connection with the performance or nonperformance of any services furnished to Members by such Qualified Provider. In the event that the Medical Services Entity discovers that such insurance coverage is not maintained, the Medical Services Entity shall immediately, upon making such discovery, ensure that such Qualified Provider discontinues the delivery of Covered Services to Members until such insurance is obtained and notify the Plan in writing of the same. A Certificate of Insurance, reflecting the minimal insurance coverage shall be provided to the County and Medical Services Entity prior to commencement of this Agreement.

ARTICLE VII
INDEMNIFICATION

7.1 Indemnification. The Medical Services Entity shall indemnify and hold harmless the County, its agents, officers, and employees, from all suits, actions, claims, demands, damages, losses, expenses, including attorney's fees, costs and judgments of every kind and description to which the County, its agents, officers, or employees may be subjected to by reason of injury to persons or death or property damage, resulting from or growing out of any action of commission, omission, negligence or fault of the Medical Services Entity, or its Qualified Providers committed in connection with this Agreement, the Medical Services Entity's performance hereof or any work performed hereunder. The Medical Services Entity shall indemnify and hold harmless the County, its agents, officers, and employees, from all suits, actions, claims, demands, damages, losses, expenses, including attorney's fees, costs and judgments of every kind and description arising from, based upon or growing out of the violation of any Federal, State, County or City law, ordinance, rule or regulation by the Medical Services Entity, or its Qualified Providers.

ARTICLE VIII
TERM AND TERMINATION

8.1 Term. This Agreement shall commence as of the Effective Date and shall be ongoing unless terminated upon sixty (60) days' prior written notice by either party to the other, or until terminated pursuant to this Article.

8.2 Termination for Cause. In the event either party shall fail to keep, observe or perform any covenant, term or provision of this Agreement applicable to such party, the other party shall give the defaulting party written notice that specifies the nature of said default. If the defaulting party fails to cure such default within thirty (30) days after receipt of such notice, the non-defaulting party may terminate this Agreement upon five (5) days' written notice. It shall be grounds for immediate termination if the County loses its ability to underwrite or administer the Plan or if any Qualified Provider suffers a loss or suspension of medical license, a conviction of a felony, or a loss of credentials for stated quality reasons under the Plan.

8.3 Voluntary Termination. At any time during the term of this Agreement, this Agreement may be terminated for any reason, with or without cause, by either party upon written notice given at least sixty (60) days in advance of the effective date of termination.

8.4 Termination for Failure to Satisfy Financial Obligations. If either party or a Payer is (a) more than sixty (60) days behind in its financial obligations to its creditors, or (b) files in any court of competent jurisdiction: (1) a petition in bankruptcy, (2) a petition for protection against creditors, (c) has such a petition filed against it that is not discharged within ninety (90) days, or (d) files or makes an assignment for the benefit of creditors, this Agreement may be terminated by the other party in its entirety or with respect to the Payer upon five (5) days' written notice.

8.5 Termination of Scrutinized Companies: This Contract may be terminated at the option of the County if the Medical Services Entity is found to have been placed on the Scrutinized Companies that Boycott Israel List or is engaged in a boycott of Israel. In addition, this Contract may be terminated at the option of County if the Medical Services Entity is found to have submitted a false certification as provided under Section 287.135(5), Florida Statutes; has been placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List; or has been engaged in business operations in Cuba or Syria.

8.6 Effect of Termination. This Agreement shall remain in full force and effect during the period between the date that notice of termination is given and the effective date of such termination. As of the date of termination of this Agreement, this Agreement shall be of no further force and effect, and each of the parties hereto shall be discharged from all rights, duties, and obligations under this Agreement, except that the County shall remain liable for Covered Services then being rendered by Qualified Providers to Members who retain eligibility under the applicable Plan or by operation of law until the episode of illness then being treated is completed and the obligation of the County to pay for Covered Services rendered pursuant to this Agreement is discharged. Payment for such services shall be made pursuant to the Total Compensation specified in EXHIBIT A.

ARTICLE IX
DISPUTE RESOLUTION

9.1 Initial Mediation of Dispute. In the event of a dispute between the parties to this Agreement, the following procedure shall be used to resolve the dispute prior to either party pursuing other remedies:

a. A meeting shall be held within seven (7) days at which all parties or party representatives will be present or represented by individuals (the "Initial Meeting").

b. If, within thirty (30) days following the Initial Meeting, the parties have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator mutually agreeable to the parties and not regularly contracted or employed by either of the parties ("Mediation"). Each party shall bear its proportionate share of the costs of Mediation, including the mediator's fee.

c. The parties agree to negotiate in good faith in the Initial Meeting and in Mediation.

9.2 Legal Remedies. If, after a period of sixty (60) days following commencement of Mediation, the parties are unable to resolve the dispute, either party may pursue all available legal and equitable remedies. Each party shall be responsible for its own attorneys' fees and costs, including attorneys' fees, costs, and expenses incurred for any appellate proceedings.

ARTICLE X
MISCELLANEOUS

10.1 Nature of Medical Services Entity. In the performance of the work, duties and obligations of the Medical Services Entity under this Agreement, it is mutually understood and agreed that the Medical Services Entity and each of its Qualified Providers are at all times acting and performing as independent Medical Service Entities, practicing medicine or providing for the delivery of medical services and under no circumstances shall the Medical Services Entity or any of its Qualified Providers be deemed employees of the County.

10.2 Public Entity Crimes. Medical Services Entity certifies compliance with Paragraph (2)(a) of Section 287.133, Florida Statutes, as amended from time to time, which provides that a "person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a bid, proposal, or reply on a contract to provide any goods or services to a public entity; may not submit a bid, proposal, or reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit bids, proposals, or replies on leases of real property to a public entity; may not be awarded or perform work as a Medical Service Entity, supplier, subMedical Service Entity, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, for CATEGORY TWO for a period of 36 months following the date of being placed on the convicted vendor list." The Medical Services Entity acknowledges that this Agreement shall be void if they have violated the above-referenced statute. Additionally, the Medical Services Entity shall ensure compliance with the U.S. Department of Health Office of Inspector General Medicare/Medicaid fraud, waste, and abuse requirements.

10.3 Public Meetings and Records.

a. The Medical Service Entity acknowledges the County's obligations under Article I, Section 24, of the Florida Constitution and under Chapter 119, Florida Statutes, to release public records to members of the public upon request and comply in the handling of the materials created under this Agreement. The Medical Service Entity further acknowledges that the constitutional and statutory provisions control over the terms of this Agreement. In association with its performance pursuant to this Agreement, the Medical Service Entity shall not release or otherwise disclose the content of any documents or information that is specifically exempt from disclosure pursuant to all applicable laws.

b. Without in any manner limiting the generality of the foregoing, to the extent applicable, the Medical Service Entity acknowledges its obligations to comply with Section 119.0701, Florida Statutes, with regard to public records, and shall:

(1) keep and maintain public records required by the County to perform the services required under this Agreement;

(2) upon request from the County's Custodian of Public Records or his/her designee, provide the County with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes, or as otherwise provided by law;

(3) ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the term of this Agreement and following completion of this Agreement if the Medical Service Entity does not transfer the records to the County; and

(4) upon completion of this Agreement, transfer, at no cost, to the County all public records in possession of the Medical Service Entity or keep and maintain public records required by the County to perform the service. If the Medical Service Entity transfers all public records to the County upon completion of this Agreement, the Medical Service Entity shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the Medical Service Entity keeps and maintains public records upon completion of this Agreement, the Medical Service Entity shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the County, upon request from the County's Custodian of Public Records, in a format that is compatible with the information technology systems of the County.

c. **IF THE MEDICAL SERVICE ENTITY HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE MEDICAL SERVICE ENTITY'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS AGREEMENT, CONTACT THE COUNTY'S CUSTODIAN OF PUBLIC RECORDS AT:**

RECORDS MANAGEMENT LIAISON OFFICER
POLK COUNTY
330 WEST CHURCH ST.
BARTOW, FL 33830
TELEPHONE: (863) 534-7527
EMAIL: RMLO@POLK-COUNTY.NET

10.4 Additional Assurances. The provisions of this Agreement shall be self-operative and shall require no further agreement by the parties except as may be specifically provided in this Agreement. However, at the request of either party, the other party shall execute such additional instruments and make such additional acts as may be reasonably requested in order to effectuate this Agreement. Additional instruments require agreement by both parties.

10.5 Governing Law. This Agreement shall be governed by and construed in accordance with the applicable Federal laws and regulations, laws of the State of Florida and local ordinance. Venue will be in Polk County, Florida, or in the United States District Court, Middle District of Florida located in Hillsborough County, Florida.

10.6 Assignment. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors, and assigns. The County may not assign this Agreement without the Medical Services Entity's prior written consent except that the County may assign this Agreement to an entity related to the County by ownership or control or to any successor organization without the Medical Services Entity's prior written consent. The Medical Services Entity may not assign this Agreement without the County's prior written consent, except that the Medical Services Entity may assign this Agreement to an entity related to the Medical Services Entity by ownership or control or to any successor organization without the County's prior written consent.

10.7 Waiver. No waiver by either party of any breach or violation of any provision of this Agreement shall operate as, or be construed to be, a waiver of any subsequent breach of the same or any other provisions.

10.8 Force Majeure. Neither party shall be liable for nor deemed to be in default for any delay or failure to perform under this Agreement deemed to result, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, failure of transportation, strikes or other work interruptions by either party's employees or any other cause beyond the reasonable control of either party.

10.9 Time is of the Essence. Time is of the essence in this Agreement. The parties shall perform their obligations within the time specified.

10.10 Notice. Any notice, demand or communication required, permitted or desired to be given pursuant to this Agreement shall be deemed effectively given when personally delivered or sent by fax with copy sent by overnight courier, addressed as follows:

MEDICAL SERVICES ENTITY:
Nauman Zaffar, MD, CEO
Z Medical Center, Inc.
7810 Lake Wilson Road
Davenport, FL 33896
Tel 863-420-7617

COUNTY:
Paula McGhee, Provider Services Manager
Health and Human Services Division
Polk HealthCare Plan
Polk County, Board of County Commissioners
2135 Marshall Edwards Drive
Bartow, FL 33830-6757
Tel 863-519-2003

or to such other address as such party has specified by notice in writing to the other party. Notice shall be deemed to have been duly given when: (a) received, if personally delivered; (b) the day after it is sent, if sent by recognized expedited delivery service; or (c) three (3) days after it is sent, if mailed, first class mail, postage prepaid.

10.11 Entire Agreement. This Agreement is the entire agreement between the parties, and it may not be modified or amended except by agreement in writing between the parties hereto.

10.12 Severability. The invalidity, illegality, or unenforceability of any provision of this Agreement, or the occurrence of any event rendering any portion or provision of this Agreement void, shall in no way affect the validity or enforceability of any other portion or provision of the Agreement; any void provision shall be deemed severed from the Agreement and the balance of the Agreement shall be construed and enforced as if the Agreement did not contain the particular provision held to be void. The parties further agree to reform the Agreement to replace any stricken provision with a valid provision that comes as close as possible to the intent of the stricken provision. The provisions of this section shall not prevent the entire Agreement from being void should a provision which is of the essence of the Agreement be determined to be void.

IN WITNESS WHEREOF, the parties hereto duly execute this Agreement as of the Effective Date.

MEDICAL SERVICES ENTITY
Z Medical Center, Inc.

BY: _____
Nauman Zaffar, MD, CEO

DATE: 5/4/23

_____
WITNESS

_____
WITNESS

POLK COUNTY, a political subdivision of the State of Florida

BY: _____
George M. Lindsey, III, Chairman

DATE: _____

ATTEST: Stacy M. Butterfield, Clerk

BY: _____
Deputy Clerk

Approved as to form and legal sufficiency:

_____
County Attorney's Office

EXHIBIT A
TOTAL COMPENSATION

Primary Care Provider Services

I. Provider Reimbursement:

a. The Plan shall compensate physicians for covered services at the rate of one hundred percent (100%) of the first Medicare rate published after January of each year, and as set forth in the Physician Fee Schedule, as published and updated by the Center for Medicare and Medicaid Services (CMS), plus the Plan Member copay.

b. Once the Medicare rates have been published in January of each year, there will be no adjustments to the fee schedule during the calendar year.

c. The Medical Services Entity or the Medical Services Entity's Designee shall collect a copay from the Member for each office visit. The co-payment amount will not be deducted from the compensation reimbursed by the Plan as defined below.

The following copays apply to Plan Members.

POLK HEALTHCARE PLAN
MEDICAL CARD

Essential Care Choices Card	Chronic Care Choices Card
$1.00 Office Visit	$1.00 Office Visit
$3.00 Radiology Services/X-rays	$3.00 Radiology Services/X-rays

EXHIBIT B-1
COVERED SERVICES

Allergy Services (does not include Allergy Testing or Injections)
Behavioral Health Services
Cardiology Services
Cardiothoracic Surgery
Dermatology Services
Diagnostic Services (at Plan contracted providers only)
Durable Medical Equipment
CT Scan
MRI
PET Scan
Ultrasound
X-ray
Ear, Nose, & Throat Services
Endocrinology Services
Gastroenterology Services
General/Vascular Surgery Services
Gynecology Services
Hematology/Oncology Services (limited services – does not include radiation or chemotherapy)
Hospital Services - Inpatient
Hospital Services - Outpatient
Hospital Services - Emergency Room
Infectious Disease Services (Inpatient only)
Joint Replacement
Laboratory Services (at Plan contracted laboratories only)
Nephrology Services
Neurology Services
Neurosurgery Services
Ophthalmology/Optometry Services (does not include eyeglasses, routine eye exams, corrective lenses or contacts)
Orthopedic Services
Pain Management Services
Physical Therapy/Occupational Therapy/Speech Therapy
Plastic Surgery (Non-Cosmetic Only)
Podiatry Services
Prescription Drugs (based on PHP Formulary)
Preventive Screening Services
Mammogram Screen
Bone Density DexaScan
Lipid Profile
Primary Care Services
Pulmonology Services
Rheumatology Services
Sleep Studies
Specialized Wound Care Services (Hospital Only)
Urology Services

EXHIBIT B-2
NON-COVERED SERVICES

Acupuncture, homeopathic or alternative medicine
Advanced oncology, chemotherapy, drug enhancers & radiation therapy
AIDS Services
Allergy Testing or Injections
Ambulance Services
Chiropractic Services
Cosmetic Surgery
Dental Services
Dialysis Services
Experimental/Investigational Procedures/Medicine
Hearing Aids
Screening Hearing Tests
Home Health Care Services
Hospice Services
Infertility Services
Inpatient Rehabilitation Services
Laser Therapy for Psoriasis
Long-term Institutional Care
Non-emergent services in Emergency Room setting
Nutritional Services by a Registered Dietitian (Routine Care)
Obstetrics/Pregnancy Care
Organ Transplants
Orthodontia (Braces, Retainers)
Outpatient Infusion Therapy
Paternity testing
Personal Care Items/Services
Procedures for Treatment of Obesity (Including surgery and meds)
Prosthetic Appliances and Braces
Reversal of Surgeries (Tubal ligation or vasectomy)
Self-inflicted/Self-induced injuries and illnesses
Skilled Nursing Facility Services
Temporomandibular Joint Disorder Services (TMJ)
Weight Management Services (Surgery and Medication)

EXHIBIT C
PRECERTIFICATION LIST

Precertification is only required for the following services:

Inpatient Admissions

Acute Inpatient medical & surgical admissions only

Outpatient – Surgery

Abdominoplasty
Autologous chondrocyte implantation, Caritcel
Back Surgeries
Blepharoplasty
Cervicoplasty (neck lift)
Facial skin lesions (MOHS, Photo therapy, laser therapy)
Hysterectomy (including prophylactic)
IDET (Thermal Intradiscal Procedures)
Liposuction/lipectomy
Mammoplasty, augmentation and reduction (includes removal of implant)
Mastectomy, gynecomastia and prophylactic
Orthognathic procedures (ex: Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
Osteochondral Allograft, knee
Otoplasty
Palatopharyngoplasty (UPPP for snoring)
Panniculectomy
Rhinoplasty
Rhytidectomy
Scar revisions
Septoplasty
Varicose vein surgery/sclerotherapy

A precert is a determination of medical necessity only; it is not a guarantee of benefits or payment for services rendered.

EXHIBIT D
INSTRUCTIONS FOR VERIFICATION OF ENROLLMENT

The following sources of enrollment verification shall be made when providing services to a Plan Member.

1. Each Member receives an identification card upon enrollment in the Plan. The card should always be presented to the Medical Services Entity when services are requested by Member and prior to receipt of services. The Medical Services Entity shall confirm eligibility by contacting the County or its third party administrator. It shall be the responsibility of the Medical Services Entity to confirm active enrollment prior to services being rendered.

2. If inpatient-admission certification is required for Member, the Medical Services Entity shall confirm admission certification approval, including contacting the County's representative or its third party administrator, when necessary.

Polk HealthCare Plan – Medical Card

FRONT OF CARD

POLK COUNTY

Indigent Health Care Division
Polk HealthCare Plan
Enrollment Card

Case #: _____ Worker Code: _____

Member Name: _____

Essential Care Choice

$1 Primary Care / $25 ER / Rx=$1 Generic / $5 Brand Name

OTHER COPAYS IDENTIFIED IN MEMBER SCHEDULE

Eligibility Period: _____ to _____

Primary Care Physician: _____

PCP Office Phone #: _____

BACK OF CARD

NOTICE TO MEMBER:

Carry this card with you at all times. To be used with contracted providers of the Polk HealthCare Plan, within Polk County, Florida. It must be presented each time you require any medical service. This card is not transferrable and is only valid for the eligibility period listed on the front. ***Do not alter or share this card with others as you will lose your governmental assistance provided by Polk County Indigent Health Care Tax.*** **Member Eligibility Appointments & Inquiries: Call (863) 533-1111.**

NOTICE TO PROVIDERS:

Only inpatient medical and surgery stays and certain outpatient services/ procedures require prior authorization. **Providers Call:**

Claims and Benefit Information
Ph: (888) 850-8222

AHH Pre-Certification
Fax (844) 241-9075

Paper Claim Submission
Meritain Health
PO Box 853921
Richardson, TX 75085-3921

Electronic Claim Submission
WebMD/Emdeon 41124
McKesson/Relay Health 1761

Polk HealthCare Plan – Medical Card

FRONT OF CARD

POLK COUNTY

Indigent Health Care Division
Polk HealthCare Plan
Enrollment Card

Case #: _____ Worker Code: _____

Member Name: _____

Chronic Care Choice

$1 Primary Care / $25 ER / Rx=$0 Generic / $3 Brand Name

OTHER COPAYS IDENTIFIED IN MEMBER SCHEDULE

Eligibility Period: _____ to _____

Primary Care Physician: _____

PCP Office Phone #: _____

BACK OF CARD

NOTICE TO MEMBER:

Carry this card with you at all times. To be used with contracted providers of the Polk HealthCare Plan, within Polk County, Florida. It must be presented each time you require any medical service. This card is not transferrable and is only valid for the eligibility period listed on the front. ***Do not alter or share this card with others as you will lose your governmental assistance provided by Polk County Indigent Health Care Tax.*** **Member Eligibility Appointments & Inquiries: Call (863) 533-1111.**

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Paper Claim Submission
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Richardson, TX 75085-3921

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McKesson/Relay Health 1761

DISCLAIMER: THIS VERSION OF THE CARD IS EFFECTIVE BEGINNING 12/15/16 AND MAY BE SUBJECT TO CHANGE. PLEASE WATCH THE POLK HEALTHCARE PLAN WEBSITE.