MEMORANDUM OF UNDERSTANDING

33607

This Memorandum of Understanding ("MOU") is made and entered into on **November 1, 2014** by and between **Pioneer Provider Network, A Medical Group, Inc.** ("Group") and **City of Long Beach** ("Provider").

WHEREAS, Group and Provider desire to enter into an agreement whereby Provider agrees to provide Covered Services on behalf of Group to Enrollees of various health care coverage plans ("Plans") which contract with Group;

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

1.0 DEFINITIONS

1.1 "Covered Services" means those health care services and supplies which an Enrollee is entitled to receive under a Plan's benefit program and which are described and defined in the Plan's evidence of coverage and disclosure forms, subscriber and employer group contracts, and in a Plan's provider manual.

1.2 "Copayment or Deductible" means those charges for Covered Services which shall be collected directly by Provider for Enrollee as payment in addition to the fee paid by Group to Provider, in accordance with the Enrollee's Evidence of Coverage.

1.3 "Enrollee" means a person who is eligible to receive Covered Services under the Plans identified in Exhibit "B" attached hereto and incorporated herein (collectively referred to as "Plans").

1.4 "Payer" means the party that is contractually obligated to generate payment for authorized Covered Services. This party may consist of the Plan, group, hospital, or another party that is contracted with the Plan, Group, or hospital to generate payment for said services.

2.0 SERVICES TO BE PERFORMED BY PROVIDER

2.1 Scope of Services: Provider agrees to render Covered Services to Enrollees in the specialty of HIV/AIDS (which may be more fully described in Exhibit A hereto) to Enrollees assigned to and referred by Group subject to the availability of Provider's personnel and capacity. Provider shall only provide non-emergency Covered Services to an Enrollee upon receiving a prior written authorization from Group to provide specific Covered Services to the Enrollee. Failure of Provider to receive said prior written authorization might result, at Payer's option, in Payer's nonpayment of Provider for those Covered Services provided to the Enrollee.

2.2 Referral Procedure: Provider shall comply with those referral procedures, designed, established and implemented by Group prior to referring an enrollee to any professional or institutional health care provider for non-emergent services. Failure of Provider to follow said referral procedure may result in Group deducting the full amount of all monies due and owing Provider for said Covered Services in accordance with Paragraph 3.1 hereof.

3.0 COMPENSATION

3.1 Compensation Formula: Payer, as applicable, shall pay Provider those amounts set forth in Exhibit "A," for those Covered Services provided by Provider to Enrollees. Provider agrees to accept said payment, less all applicable copayments and deductibles, as payment in full for the Covered Services he/she provides Enrollees. Provider acknowledges and agrees that some Covered Services rendered to Enrollees of health care service plans licensed under the Knox-Keene Health Care Service Plan Act of 1975, may not be Group's financial responsibility under the specific terms of Group's agreement with such Plans ("HMO Agreements"); and that payment for such services may be made by the applicable Payer based on those fee-for-service rates and payment terms set forth in the applicable HMO Agreement. Such rates and terms may apply specifically to 1) out-of-network services rendered to Enrollees of point-of-service plans, 2) Enrollees not assigned to Group, 3) services rendered under transition-of-care provisions following termination of Group's HMO Agreement, 4) non-capitated services rendered to Group's assigned Enrollees, or 5) eligibility guarantee clauses in HMO Agreements.

3.2 Timing of Payment of Compensation: Payer shall pay Provider those amounts set forth in Paragraph 3.1 hereto within forty-five (45) days following Group's receipt of the CMS 1500 claim form, or other billing form, as approved by Group, provided by Provider to Group pursuant to Paragraph 3.3 hereof.

3.3 Billing Procedures: Provider shall bill Payer for all Covered Services rendered to an Enrollee by submitting to Payer a CMS 1500 or UB 04 claim form (or its successor form) within ninety (90) days following the provision of said Covered Services. Failure of Provider to submit said written claim within ninety (90) days of service delivery may, at Payer's option, result in Payer's nonpayment of Provider. Payer shall make reasonable exceptions to this ninety (90) day deadline due to circumstances beyond Provider's control (e.g., when Payer is the secondary payer under Coordination of Benefits rules).

3.3.1 Claim Appeals. If possible, Provider shall submit any appeals on payments or payment denials by Group and/or Payer within ninety (90) days following payment or denial date, not to exceed three hundred sixty-five (365) days. Neither Group nor Payer shall be under any obligation to process an appeal not submitted within three hundred sixty-five (365) days of payment or denial date.

3.3.2 Claim Overpayments: Provider shall notify Group within ten (10) days of becoming aware an overpayment has been made to Provider by Group. If Group determines that it has overpaid a claim, Group will notify Provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service(s) and a clear explanation of the basis upon which Group believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

If Provider contests Group's notice of overpayment of a claim, Provider, within thirty (30) working days of the receipt of the notice of overpayment of a claim, must send written notice to Group stating the basis upon which Provider believes that the claim was not overpaid. Group will process the contested notice in accordance with Group's Provider Dispute Resolution Process.
If Provider does not contest Group's notice of overpayment of a claim, Provider must reimburse Group within thirty (30) working days of the Provider's receipt of the notice of overpayment of a claim.

Group may offset an uncontested notice of overpayment of a claim against Provider's current claim submission if the Provider fails to reimburse Group within the timeframe set forth above. In the event that an overpayment of a claim or claims is offset against Provider's current claim or claims pursuant to this section, Group will provide Provider with a detailed written explanation identifying the specific overpayment(s) that have been offset against the specific current claim or claims.

3.4 Patient Billing: Provider shall look only to Payer for compensation for Covered Services and shall at no time seek, including but not limited to Payer's failure to pay Provider, compensation from Enrollees for Covered Services. No surcharge to any Enrollee shall be permitted. A surcharge shall, for purposes of this MOU, be deemed to be any additional fee not provided for in the Enrollee's Plan contract and Evidence of Coverage.

3.5 Patient Responsibility: Provider shall bill and collect all copayments or deductibles specifically permitted in an Enrollee Plan contract from an Enrollee for those Covered Services provided to an Enrollee.

3.6 Enrollee Eligibility: Provider understands that the eligibility of Group's Enrollees for coverage on the Plan or assignment to Group is subject to change at any time. While Group shall make its best efforts to verify current eligibility of Enrollees, Provider is advised that he/she should re-verify Enrollees' eligibility at the time of service. Should an Enrollee erroneously represented by a Plan as eligible for Covered Services be found not to be eligible under the Plan or with Group after having been referred to Provider for services, Provider will seek reimbursement from said referred Enrollee directly at the usual and customary rate. Provider will not seek or expect reimbursement through Group or Plan for any such ineligible Enrollee.

4.0 OBLIGATIONS OF PROVIDER

4.1 License: Provider warrants that he/she/it is duly licensed by the State of California to provide the medical or health care services that are the subject of this MOU and shall maintain such license for the duration of this MOU.

4.3 Credentialing: Provider agrees to cooperate with Group's peer review procedures, including credentialing and re-credentialing information requested by Group.

4.4 Utilization Management: Provider agrees to cooperate with Group's Utilization/Quality Management protocols, prior authorization, protocols and referral/admission and patient transfer procedures.

4.5 Malpractice Insurance: Provider agrees to maintain professional liability insurance in accordance with acceptable community standards.

5.0 MEDICAL RECORDS AND OTHER RECORDS

5.1 Medical Records: Provider shall maintain, with respect to each enrollee receiving Covered Services, a single standard medical record in such form, containing such information, and preserved for such time periods as are required by state and federal law. Records shall be accessible to state and federal agencies upon request.

5.2 Access to Records; Audits: It is understood that the Enrollees' medical records shall remain the property of Professional and shall not be removed or transferred from Professional except in accordance with applicable laws and regulations. Group shall have the right to inspect, review, to have copies made of such records to facilitate Group or Plan's obligation to conduct quality assurance, utilization monitoring and peer review activities. Professional agrees to comply with these requests with two (2) days prior written notice from Group. Professional agrees to permit Group, and its designated representatives, and designated representatives of local, State, and federal regulatory agencies having jurisdiction over Group or any Plan, to conduct site evaluations and inspections of Professional's offices and service locations. Additionally, except for Medicare Advantage Enrollees, Professional shall provide Group, Plans, and the Department of Managed Health Care, or their authorized designees, with reasonable access to Professional's records, both during and after the term of this Agreement, for a period of six (6) years after the record is created [records of a minor child shall be kept for at least one (1) year after the minor has reached the age of eighteen (18), but in no event less than six (6) years]. For Medicare Advantage Enrollees, Professional agrees to give the U.S. Department of Health and Human Services (HHS), and the General Accounting Office (GAO) or their designees the right to audit, evaluate, inspect books, contracts, medical records, patient care documentation, other records of subcontractors, or related entities until the later of a) ten (10) years from the end of the final contract period between CMS and the applicable Plan or b) ten (10) years from completion of any federal audit or investigation, unless a longer period is required pursuant to 42 CFR 422.504 (e) (4).

6.0 TERM AND TERMINATION

6.1 Term: This MOU shall be effective as of **November 1, 2014** and shall continue for a period of (1) year. Unless specifically renegotiated, superseded, or terminated, this MOU shall automatically renew from year to year under the same terms and conditions herein.

6.2 Termination with Notice: Either party may terminate this MOU with or without cause by providing ninety (90) days prior written notice to the other party.

6.3 Immediate Termination: Group may terminate this MOU immediately under any of the following circumstances: a) revocation of Professional's license to practice; b) reduction or expiration of any insurance coverage required hereunder; c) loss or reduction of Professional's hospital privileges; d) or any other material impediment to Professional's ability to provide Covered Services to Enrollees, as reasonably determined by Group.

6.4 Responsibility for Enrollees at Termination Following termination of this MOU, Professional agrees to continue to render Covered Services to Enrollees who are under Professional's care at the time of termination, until the later of a) completion of services covered by the rates set forth in Exhibit "A" hereto, or b) until Group can reasonably transition the Enrollees' care to another provider.

7.0 GENERAL PROVISIONS

7.1 Notices: Any notices required or permitted to be given hereunder by either party to the other may be given by personal delivery in writing or by registered or certified mail, postage prepaid, with return receipt requested. Notices shall be addressed to the parties at the addresses appearing below, but each party may change such party's address by written notice given in accordance with this paragraph. Notices delivered personally will be deemed communicated as of actual receipt; mailed notices will be deemed communicated as of as of three (3) days after mailing.

Group:	**Professional:**
Pioneer Provider Network / McKesson BPS	City of Long Beach
1901 N. Solar Dr. #265	2525 Grand Ave.
Oxnard, CA 93036	Long Beach, CA 90815
Attn. Contract Manager	Attn: City Health Officer

7.2 Amendment: No alteration of any term or condition of this MOU shall be binding unless reduced to writing and signed by both parties hereto.

7.3 Entire Agreement: This MOU supersedes any and all agreements or communications, either written or oral, between the parties hereto with respect to the subject matter contained herein and contains all of the covenants and agreements between the parties with respect to the rendering of and payment for Covered Services.

APPROVED AS TO FORM
10/22, 20 15
CHARLES PARKIN, City Attorney
By LINDA T. VU
DEPUTY CITY ATTORNEY

7.4 Non-Exclusivity: This MOU is non-exclusive. Either party may enter into agreements with any other party for the same scope of services. Group makes no guarantee of referrals to Professional nor any promise to market or otherwise offer Professional for elective referrals.

7.5 ~~Confidentiality: The parties agree to treat the terms of this MOU, including all payment rates and methodologies, as confidential and shall not disclose the terms of this MOU to any outside parties.~~Intentionally Omitted. CLB PPN

7.6 Governing Law: the laws of the State of California shall govern This MOU. All parties agree to abide by applicable federal or state laws and regulations, including but not limited to rules and regulations of the Medicare program, the Medi-Cal program, and the Knox Keene Health Care Service Plan Act of 1975.

7.7 Nondiscrimination: Professional agrees: (1) not to differentiate or discriminate in his/her/its provision of Covered Services to Enrollees because of race, color, ethnicity, national origin, ancestry, religion, gender, marital status, sexual orientation, age, physical or mental disability, medical condition or history (including conditions arising out of acts of domestic violence), cost of care, genetic information, health status, source or method of payment, evidence of insurability nor based on past complaints against Professional by said Enrollee, nor on any other basis prohibited by state or federal law or regulations; and (2) to render Covered Services to Enrollees in the same manner, in accordance with the same standards, and within the same time availability as offered to non-Plan patients consistent with existing medical ethical/legal requirements for providing continuity of care to any patient.

APPROVED AS TO FORM
10/22, 20 15
CHARLES PARKIN, City Attorney
By LINDA T. VU
DEPUTY CITY ATTORNEY

7.8 Dispute Resolution: ~~Professional shall have the right to pursue billing, payment or other disputes through Group's Provider Dispute Resolution Mechanism. A description of Group's Provider Dispute Resolution Mechanism is set forth in an Addendum to this MOU. Provider understands that this procedure may periodically be updated or modified by Group without notice to Provider. In addition, Professional and Group agree to meet and confer in good faith to resolve any problems or disputes that may arise under this MOU and that such negotiation shall be a condition precedent to the filing of any arbitration demand by either party, and no arbitration demand may be filed until the exhaustion of Group's Provider Dispute Resolution Mechanism.~~ A description of Group's Provider Dispute Resolution Mechanism is set forth~~m~~ in an Addendum to this MOU. Provider understands the process is available, but not required. CLB PPN

7.9 Arbitration: The parties agree that any controversy or claim arising out of or relating to this MOU or breach thereof shall be governed by the California Tort Claims Act (commencing with Government Code section 900)., ~~that is not resolved through the informal dispute resolution~~

~~processes referenced in Section 7.7, whether involving a claim in tort, contract or otherwise, shall be settled by final and binding arbitration in accordance with the provisions of the California Arbitration Act (California Code of Civil Procedure Sections 1280, *et seq.*). The parties waive their right to a jury or court trial.~~ CLB PPN

7.10 Assignment: This MOU, being intended to secure the unique services of Professional, may not be assigned, transferred or delegated by Professional without the prior written consent of Group. However, Group may assign, delegate, transfer, convey or sell its rights and/or obligations with respect to this MOU to a parent, subsidiary or affiliate or to an entity into which Group is merged or with which Group is consolidated or to a purchaser of all or substantially all of its assets or as part of a corporate reorganization, without prior written notice to Professional.

APPROVED AS TO FORM

10/22, 20 14

CHARLES PARKIN, City Attorney

By _____

LINDA T. VU
DEPUTY CITY ATTORNEY

IN WITNESS WHEREOF, Group and Professional have executed this MOU on the date and year first above written.

City of Long Beach	Pioneer Provider Network, A Medical Group, Inc.
("Professional")	("Group")
Patrick H. West, City Manager / Assistant City Manager	John M. Kirk, CEO
Print Name & Title	Name & Title
Signature	Signature
10-29-14	10/31/2014
Date	Date
2525 Grand Ave, Long Beach, CA 90815	1901 N. Solar Dr. #200 Oxnard, CA 93036
Primary Address	Address
562-570-4047	(805) 988-2280
Telephone #	Telephone #
562-570-4049	
Facsimile #	
mitchell.kushner@longbeach.gov	
Email	
95-6000733	
Federal Tax Identification Number	
1023116811	
National Provider Identification Number (NPIN)	
2525 Grand Ave, Long Beach, CA 90815	
Billing Address	
562.570-4341	
Billing Telephone #	

EXECUTED PURSUANT TO SECTION 301 OF THE CITY CHARTER.

APPROVED AS TO FORM

10/22, 20 14

CHARLES PARKIN, City Attorney

By _____

LINDA T. VU

DEPUTY CITY ATTORNEY

ADDENDUM
PROVIDER DISPUTE RESOLUTION MECHANISM

This Addendum informs Professional (a.k.a. herein "Provider") of Group's procedures for resolving written Provider Disputes (as indicated below) concerning claims, payment, billings or other contractual matters. Group's procedure may be amended from time to time by Group and shall conform to all applicable statutory, regulatory and accreditation standards governing Provider Disputes. Providers are not required to submit disputes in writing and may, alternatively, telephone Group with inquiries or concerns; in which case Group will respond to the inquiry or concern by following Group's standard customer service procedures, in lieu of the Provider Dispute Resolution Process outlined below.

Timeframes set forth in this procedure are intended to promote timely handling of provider disputes. Failure by Group to meet any of the specified timeframes, or to meet and confer with the provider (as envisioned in Section 12.4, Dispute Resolution, of this Agreement), shall not be construed to mean that the dispute has been resolved in the provider's favor; but rather shall be deemed an exhaustion of Group's internal appeals process, thus freeing the provider to proceed with other remedies available under this Agreement.

A Definition of Provider Dispute: A contracted provider dispute ("Provider Dispute") is a provider's written notice to Group challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested by Group; or seeking resolution of a Group billing determination or other contract dispute); or disputing a request from Group for reimbursement of an overpayment of a claim; or any other contract dispute. (For applicable timeframes concerning requests from Group for reimbursement of a claim overpayment, see Article 4.3.2 of the Agreement.)

Provider Disputes do not include Enrollee appeals or grievances, which must be processed by the Enrollee's health plan nor do they include re-submitted claims identified as "tracers." If Group has made a billing determination that a claim is the financial responsibility of the Plan, Group shall forward the claim to the plan, so notifying the provider, and the provider shall seek compensation from the Plan. The provider may not submit a dispute to Group for Plan-responsibility claims until and unless the Plan disagrees with this determination.

B. To qualify for this procedure, a Provider Dispute must contain, at a minimum the following information: provider's name; provider's identification number, provider's contact information, and:

(i) If the Provider Dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Group, the following must be provided: a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes that payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;

(ii) If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and

(iii) If the contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and provider's position on the dispute.

C. Submitting a Provider Dispute to Group: Provider Disputes must be sent to the attention of: **Provider Dispute Resolution / Pioneer Provider Network**, at the following addresses:

Via E-mail:	pdr@med3000.com
Via Mail:	1901 N. Solar Dr. #200 Oxnard, CA 93036
Via Delivery:	1901 N. Solar Dr. #265 Oxnard, CA 93036
Via Fax:	(805) 988-5161

D. Time Period for Submission of Provider Disputes:

(i) Provider Disputes must be received by Group within 365 days from Group's action that led to the dispute (or the most recent action if there are multiple disputes).

(ii) In the case of inaction, contracted provider disputes must be received by Group within 365 days after the time Group is allowed for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

(iii) Provider Disputes that do not include all required information as set forth above in Section A may be returned to the submitter for completion. An amended Provider Dispute, which includes the missing information may be submitted to Group within thirty (30) working days of your receipt of a returned incomplete Provider Dispute.

E. Acknowledgment of Provider Disputes: Group will acknowledge receipt of all Provider Disputes as follows:

(i) Group will acknowledge electronic contracted provider disputes within two (2) working days of the date of receipt by Group.
(ii) Group will acknowledge paper contracted provider disputes within fifteen (15) working days of the date of receipt by Group.

F. Contacting Group Regarding Provider Disputes: All inquiries regarding the status of a Provider Dispute that has been submitted, must be directed to Group one of the addresses shown in Section B, above or by telephoning the number below:

Via Telephone: (805) 604-3325

G. Instructions for Filing Substantially Similar Contracted Provider Disputes: Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

(i) Sort by Health Plan (each plan should be submitted separately)
(ii) Sort disputes by similar issue / type
(iii) Provide cover sheet for each batch
(iv) Number each cover sheet
(v) Provide a cover letter for the entire submission describing each Provider Dispute with references to the numbered coversheets.

H. Time Period for Resolution and Written Determination of Provider Dispute: Group will issue written determination stating the pertinent facts and explaining the reasons for its determination

within forty-five (45) working days after the date of receipt of the Provider Dispute or the amended Provider Dispute, as applicable.

I. Past Due Payments: If the Provider Dispute involves a claim and is determined in whole or in part in favor of the provider, Group will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

MEDICARE ADVANTAGE COMPLIANCE ADDENDUM

RECITALS

This Medicare Advantage Compliance Addendum ("Medicare Addendum) to the Agreement is intended to add to and consolidate contract language that is required by the Centers for Medicare and Medicaid Services ("CMS") for participation in the Medicare Advantage ("MA") program.

CMS requires that specific terms and conditions be incorporated into the Agreement and that all providers comply with the Medicare laws, regulations, and CMS instructions, including but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003. (Public Law 108-73) (MMA).

In the event that another provision in the Agreement is in conflict with this Medicare Addendum, this Medicare Addendum shall govern.

DEFINITIONS

Centers for Medicare and Medicaid Services ("CMS") means the agency within the Department of Health and Human Services that administers the Medicare program, formerly the Health Care Financing Administration (HCFA). All references to HCFA in the Agreement, if any, shall instead mean CMS.

Completion of Audit means completion of audit by the Department of Health and Human Services, the General Accounting Office, or their designees, of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Final Contract Period means final contract period between CMS and the Medicare Advantage Organization with whom the Group has entered into an Agreement.

Medicare Advantage ("MA") is an alternative program to traditional Medicare under which private MAOs (Plans) provide health care benefits that eligible Medicare beneficiaries would otherwise receive directly from the Medicare program. Such health care benefit programs for Medicare beneficiaries have been previously referred to variously as either Medicare Risk or Medicare + Choice which terms shall instead mean Medicare Advantage.

Medicare Advantage Organization ("MAO") means a Plan that has entered into a contract with CMS to provide services to Medicare beneficiaries under the Medicare Advantage program.

Medicare Enrollee means an individual eligible for Medicare who has enrolled in or elected coverage through a Medicare Advantage Organization. An Enrollee may also be known as a Member.

All other capitalized terms in this Addendum shall have the same meaning as set forth in the Agreement.

REQUIRED PROVISIONS

1. Retention and Access to Records. Provider agrees to retain and to grant the Department of Health and Human Services (HHS), the Comptroller General or their designees the right to inspect, evaluate, and audit any pertinent information, including books, contracts, medical records, patient care documentation, and records of subcontractors or related entities for a period of (10) years from the end of the Final Contract Period or Completion of Audit, whichever is later, for Enrollees of Medicare Advantage Organizations. This record retention period applies to all new records as well as to all records in existence as of January 1, 2006 [Citation: 42 Code of Federal Regulations (CFRs) 422.504 (e) (4)].

2. Confidentiality of Enrollees' Information. Provider agrees to abide by all Federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information, safeguard the privacy of the Medicare Enrollee's information, and maintain records and information in an accurate and timely manner. [Citation: 42 CFRs 422.118 and 422.504 (a)(13)].

3. Member (Enrollee) Hold Harmless. Provider agrees to hold harmless and protect Medicare Enrollees from incurring financial liabilities that are the legal obligation of the Medicare Advantage Organization or of Group or of any provider or other intermediary. In no event, including but not limited to nonpayment or breach of an agreement by the Medicare Advantage Organization, Group, any provider or other intermediary, or the insolvency of the Medicare Advantage Organization, Group, any provider, or other intermediary, shall Provider bill, charge, collect a deposit from or receive other compensation or remuneration from a Medicare Enrollee. Provider shall not take any recourse against the Enrollee, or a person acting on behalf of the Enrollee, for services provided. This provision does not prohibit collection of applicable coinsurance, deductibles, or co-payments, as specified in the Medicare Advantage Organization Evidence of Coverage. This provision also does not prohibit collection of fees for non-Covered Services, provided that, pursuant to CMS instructions, the Enrollee was informed in advance of the cost and elected to have non-Covered Services rendered. [Citation: 42 CFRs 422.504(g) and (i)(3)(i)].

4. Group's Contractual Obligations to MAOs. Provider agrees that its performance or other activity are consistent and comply with Group's contractual obligations with the Medicare Advantage Organization, which includes Group's agreement that its performance or other activity are consistent and comply with the Medicare Advantage Organization's contractual obligations with CMS. [Citation: 42 CFRs 422.504(i)(3)(iii) and 422.504(i)(4)].

5. Prompt Payment by Group. Group agrees to pay Provider's claims for provision of Covered Services promptly, as agreed to in the Agreement between Group and Provider, which claims payment turnaround time shall not exceed sixty (45) days from receipt of a clean claim, or such other period as may be specified by CMS at a future date. Group shall pay interest on late payments as required by law, regulation or CMS. [Citation: 42 CFR 422.520(b)].

6. Provider Reporting. Provider agrees to comply with CMS reporting requirements as specified in 42 CFR 422.310 (risk adjustment data) and 42 CFR 422.516 (informational data). [Citation: 42 CFR 422.504(a)(8)].

7. Compliance with Law, Regulation and CMS Instructions. Provider agrees to comply with all Medicare laws, regulations, and CMS instructions, including but not limited to, all CMS accountability provisions, which may be more fully documented in the Medicare Advantage Organization's policies and procedures. [Citation: 42 CFRs 422.504(i)(3)(ii) and 422.504(i)(4)(v)].

8. Dual Eligible Enrollees (Medi/Medi). Provider agrees that cost sharing for dual eligible Medicare Advantage Enrollees is limited to the Medicaid (including Medi-Cal) cost sharing limits; and that for those dual-eligible Enrollees Provider will accept the Medicare Advantage Organization or Group payment, as applicable, as payment-in-full or will separately bill the appropriate state source for any amounts above the Medicaid (or Medi-Cal) cost sharing. [Citation: 42 CFR §422.504(g) (l) (iii)].

Except as modified by this Addendum, all other provisions of the Agreement, not inconsistent herewith, shall remain in full force and effect. This Addendum shall remain in force as a separate but integral addition to such Agreement to ensure compliance with required CMS provisions, and shall continue concurrently with the term of the Agreement.

EXHIBIT "A"
COMPENSATION SCHEDULE

This Exhibit "A" contains the compensation payable to Professional for the performance of Covered Services as set forth below:

HIV/AIDS and Communicable Diseases

Payer shall compensate Professional, at the lesser of, the rate set forth in this Exhibit "A" or Professional's customary billed charge. Compensation shall be less any applicable copayment, coinsurance or deductible due from an Enrollee for those authorized Covered Services provided by Professional to such Enrollee. Professional is solely responsible for collecting the applicable copayment, coinsurance or deductible directly from Enrollee.

Professional must request a written authorization prior to rendering Covered Services to an Enrollee. Failure of Professional to receive said prior written authorization may result, at Payer's option, in Payer's nonpayment of Professional for those Covered Services provided to said Enrollee.

Compensation:

Professional Services and Drugs. Except as otherwise indicated below, Payer shall compensate Professional for those authorized Covered Services provided to Enrollees to which this Agreement pertains, based on the below fee schedules:

Commercial Enrollees: **One hundred percent (100%)** of the current Medicare Allowable fee schedule, as administered by the appropriate Medicare Carrier for Area 18 and as loaded to Group's system at the time the claim is processed. For authorized Covered Services not listed in the Medicare Fee Schedule, Group shall compensate Professional at a market rate reasonably determined by Group. Drugs shall be compensated at one hundred percent (100%) of the Medicare drugs and biologicals fee schedule.

Medicare Enrollees: **One hundred percent (100%)** of the current Medicare Fee Schedule, as administered by the appropriate Medicare Carrier for Area 18 and as loaded to Group's system at the time the claim is processed. For authorized Covered Services not listed in the Medicare Fee Schedule, Group shall compensate Professional at a market rate reasonably determined by Group. Drugs shall be compensated at one hundred percent (100%) of the Medicare drugs and biologicals fee schedule.

Medi-Cal and Healthy Families Enrollees: **One hundred percent (100%)** of the Medi-Cal allowable fee schedule, as administered by State of California, as loaded to Group's system at the time the claim is processed. For authorized Covered Services not listed in the Medi-Cal Fee Schedule, Group shall compensate Professional at a market rate reasonably determined by Group. Drugs shall be compensated at one hundred percent (100%) of the Medi-Cal drugs and biologicals fee schedule.

Payment Policies. Group's claim payment policies follow industry standards as defined by The Centers for Medicare and Medicaid Services (CMS). Group follows the Medicare Correct Coding Initiative and applies CMS guidelines to the re-bundling of procedure codes, as well as the application of modifiers for the payment of services involving multiple procedures, bilateral procedures, co-surgeons, and surgical global periods. In addition, for assistant surgeon services, Group multiplies the applicable contracted rate by an adjustment factor of twenty percent (20%). Group references the standard coding structure based on the AMA's Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding

System (HCPCS) for basic coding and description of services provided. Group shall use best efforts to update the coding structure on an annual basis. For payment of Evaluation and Management CPT codes above a level 3, Group requires Professional to submit chart documentation supporting the billed code. Group does not pay separately for casting materials billed with fracture care.

Compensation Adjustments: Group may increase or decrease the compensation amounts set forth above at any time upon providing Professional with thirty (30) days prior written notice of any such modification in compensation amounts.

Billing should be sent to: Pioneer Provider Network / McKesson BPS, 1901 N. Solar Dr. # 265, Oxnard, CA 93036

EXHIBIT "B"
HEALTH PLANS

The following is a list of Plans for which Group is currently responsible for provision or arrangement of Covered Medical Services:

Commercial Plans (HMO & POS):
Aetna
Anthem Blue Cross of California
Blue Shield of California
Cigna
Health Net
United Health Care

Medicare Advantage Plans:
Aetna
Anthem Blue Cross
Blue Shield
Health Net
LA Care
SCAN Health Plan
United Healthcare

Medi-Cal and Healthy Families:
Health Net
LA Care
Universal Care

Group may modify the list of Plans above from time to time and make best efforts to give thirty (30) days written notice to Professional of any additions or deletions.