PROVIDER SERVICES AGREEMENT BETWEEN TALBERT MEDICAL GROUP AND LONG BEACH PUBLIC HEALTH LABORATORY

30174

This Agreement is made and becomes effective this 1st of **March, 2007** between **Talbert Medical Group, Inc.,** a California professional corporation, ("TMG") and **Long Beach Public Health Laboratory** ("PROVIDER") to provide professional services Laboratory services ("Specialty").

The parties by their mutual covenants, agree as follows:

WHEREAS, TMG intends to enter into agreements with various payors of health care services, including entities licensed to provide prepaid health care pursuant to the Knox-Keene Health Care Service Plan Act of 1975, as amended ("Plans"), pursuant to which TMG will deliver care to enrollees of these Plans ("Enrollees");

WHEREAS, TMG will also provide services to non–Plan individuals (e.g., fee for service, indemnity patients, etc.) collectively referred to as "Patients";

WHEREAS, TMG will need the care of specialty providers for these Enrollees and Patients; and

WHEREAS, TMG and PROVIDER desire to enter into a contractual arrangement pursuant to which PROVIDER will provide certain Specialty medical services to Enrollees;

NOW, THEREFORE, in consideration of the mutual covenants and premises contained in this Agreement, the parties hereby agree as follows:

I. DEFINITIONS

1.1 **Agreement** means this Provider Services Agreement.

1.2 **Balanced Budget Act ("BBA")** means legislation as that contains specific requirements for the treatment of Medicare Program recipients as outlined in Section X, **BBA Requirements,** of this document.

1.3 **Copayment** means those charges for professional services which may be collected directly by PROVIDER from any Enrollee enrolled in a health insurance plan that permits the provider of services to charge a copayment in addition to the fees paid to PROVIDER by TMG, in accordance with the Enrollee's Plan's evidence of coverage. Copayments are deducted from the reimbursement due to PROVIDER from TMG.

1.4 **Covered Benefit** and/or **Covered Service** means benefits and services provided by and through various Plans, as set forth in the Enrollee's applicable evidence of coverage document ("Evidence of Coverage") or policy, including any

amendments, which is the document that sets out a summary of benefits or services to which each individual Enrollee is entitled.

1.5 **Covered Charges** means charges for services that are Covered Benefits and/or Covered Services that have been determined to be medically necessary by TMG's utilization management department.

1.6 **CPT-4** means Current Procedural Terminology, including subsequent updates.

1.7 **CRVS** means the 1974 California Relative Value Scale published by the California Medical Association, as amended.

1.8 **Disclosure** means the release, transfer, provision of access to, or divulging in any other manner, of Protected Health Information, outside Provider's organization, i.e., to anyone other than its employees who have a need to know or have access to the PHI.

1.9 **Emergency Services** means inpatient or outpatient Covered Services needed immediately because of an injury or the sudden unforeseen onset of an illness and the time required to reach TMG providers would mean risk of permanent damage to the Enrollee's health.

1.10 **Enrollee** means a person who is enrolled in a Plan, including enrolled dependents, and is entitled to receive Covered Services from TMG.

1.11 **Medicaid Plan** means a program offered by Plans to Enrollees having coverage of expenses for services pursuant to agreements between the State and the Plans which are acting as a Medicaid provider.

1.12 **HCFA** means the Health Care Financing Administration.

1.13 **HEDIS** means the Healthplan Employer Data and Information Set.

1.14 **HIPAA**. In connection with the performance of the Services, Provider may *receive from TMG or otherwise have access to certain information that is required* to be kept confidential in accordance with the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, as may be amended from time to time (collectively, "HIPAA"). Therefore, in consideration of the foregoing premises and the mutual covenants and conditions set forth below and in the Underlying Agreement, TMG and Business Associate, intending to be legally bound, agree to the terms and conditions set forth in this Agreement.

1.15 **Hospital** means any participating hospital unless otherwise designated by TMG.

1.16 **Medically Necessary** means medical or surgical treatment which an Enrollee requires as determined by TMG's or the Plan's utilization management department, in accordance with accepted medical and surgical practices and standards prevailing at the time of treatment and in conformity with the professional and technical standards adopted by TMG's or the Plan's utilization management committee.

1.17 **Medicare Fee Schedule** means the Medicare participating provider Fee Schedule based on the Resource Based Relative Value Scale ("RBRVS"), including annual revisions and updates for each specific Plan's geographic area and other Medicare Fee Schedules published annually by fiscal intermediaries.

1.18 **NCQA** means the National Committee for Quality Assurance.

1.19 **Participating Physician** means a physician, duly licensed to practice medicine or osteopathy in accordance with applicable State law, who has an employment contract with, or who has entered into an agreement with, TMG to provide Covered Services to Enrollees.

1.20 **Participating Provider** means an ancillary provider, participating hospital, or other licensed health facility or licensed health professional (other than a physician) which has entered into an agreement with TMG to provide Covered Services to Enrollees.

1.21 **Plan** means health care service plans or Federally–qualified health maintenance organizations which arrange for the provision of health care services to their Enrollees through TMG.

1.22 **Primary Care Physician or Primary Physician** means a Participating Physician selected by an Enrollee to render first contact medical care and to provide "primary care services" as that term is defined by TMG. Primary Physician or Primary Care Physician may include, as determined by TMG, internists, pediatricians, family practitioners, obstetricians/gynecologists and general practitioners.

1.23 **Protected Health Information or PHI** means information transmitted by or maintained in electronic media or any other form or medium, including demographic information collected from an individual, that (a) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; (b) individually identifies the individual or, with respect to which, there is a reasonable basis for believing that the information can be used to identify the individual; and (c) is received by Provider from or on behalf of TMG, or is created by Provider, or is made accessible to Provider by TMG.

1.24 **Referral** means the process by which the Participating Physician directs an Enrollee to seek and obtain Covered Services from a health professional, a hospital or any other provider of Covered Services.

1.25 **Secretary** means the Secretary of the United States Department of Health and Human Services or any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

1.26 **State** means the State of California.

1.27 **MA (Medicare Advantage) Programs(s)** means the health care service plan program(s) established by Talbert Health Plan approved by CMS and operating under the requirements of MMA.

1.28 **Use** (whether capitalized or not and including the other forms of the word) means, with respect to Protected Health Information, the sharing, employment, application, utilization, transmission, examination, or analysis of such information to, from or within Provider's organization.

II. PROVIDER SERVICES

2.1 PROVIDER Obligation to Deliver Covered Services. PROVIDER will provide Covered Services, including all diagnostic and therapeutic services as well as necessary materials and supplies, to Enrollees of each and every Plan with which TMG has contracted, on an as needed and Referral basis. If PROVIDER is unable to provide a specific service, PROVIDER will request authorization to refer Enrollee to an appropriate Participating Physician and will confer with Enrollee's Primary Care Physician regarding Enrollee's plan of care.

2.2 Address(es). PROVIDER shall ordinarily render all outpatient Covered Services to Enrollees at the address(es) set forth in Exhibit C - Provider Locations.

2.3 Service Report. PROVIDER agrees to submit a written and signed report to the Primary Care Physician and the referring physician having responsibility for the ongoing care of a particular Enrollee regarding the plan of treatment proposed by PROVIDER, including any proposed testing, hospitalization or surgery, within seven (7) days of examination of Enrollee, or sooner if necessary or if requested by the Primary Care Physician.

2.4 Covering Physician. If PROVIDER is unable to provide Covered Services when and as needed, PROVIDER may use the services of a qualified covering physician who will provide the Specialty Covered Services otherwise required of PROVIDER. The covering physician must be a physician approved by TMG to provide Covered Services to Enrollees. PROVIDER warrants the covering physician: (1) will accept reimbursement not to exceed the rate set forth in Exhibit A - Services Reimbursement of this Agreement; (2) shall accept TMG's peer review procedures; (3) shall not directly bill Enrollees for Covered Services

under any circumstances; (4) shall, prior to all elective testing, treatment and/or hospitalizations, obtain authorization from TMG's utilization management department; and (5) will fully comply with this Agreement.

III. PAYMENT-FOR SERVICES

3.1 Basis of Payment. Payment shall be made in accordance with Exhibit A – Services Reimbursement of this Agreement.

3.2 Submission of Payment Request Forms. Billings for Covered Charges must be submitted on a universal claim form with Enrollee's Plan number, date of birth, Date of Service, authorization number, discharge summary, and any other information required by TMG. Payment processing will not be initiated until all required documents are received by TMG. Billings must be submitted using the PROVIDER'S tax identification number set forth in this Agreement.

3.3 Claims Payment Denial. PROVIDER agrees to cooperate with TMG's and the Plan's utilization management and claims departments, which review the appropriateness, level of care, and services provided to Enrollees. If any of the services is deemed inappropriate, not medically necessary, or not a Covered Service, payment for those services will be denied. PROVIDER agrees that all charges for these services will be removed and neither TMG, Plan, Enrollee nor the State (for Medi–Cal Enrollees) will be billed for these services.

3.4 Claims Appeal. PROVIDER may request an appeal of a denial of payment of a claim to the TMG Medical Director or his/her designee. The decision of the TMG Medical Director or designee will be final.

3.5 Non–Covered/Not Medically Necessary Services. If an Enrollee requests services after being informed by TMG or PROVIDER, prior to the rendition of such services, that the services have been determined by TMG to be medically unnecessary or are not Covered Services, Enrollee shall be solely liable for payment. PROVIDER shall obtain written confirmation from Enrollee of this understanding prior to the rendition of services.

3.6 Copayments. PROVIDER shall collect and retain any applicable copayment and/or deductible from Enrollees for each outpatient visit. Copayments shall be calculated on the rates set forth in Exhibit A - Services Reimbursement of this Agreement.

3.7 Enrollee Billing. PROVIDER shall look only to TMG for compensation for Covered Services and shall at no time seek compensation from Enrollees for Covered Services, as is more fully set forth in Paragraph 7.4 of this Agreement. No surcharge to any Enrollee shall be permitted. A surcharge is, for purposes of this Agreement, any additional fee not provided for in the Enrollee's Evidence of Coverage.

3.8 Third Party Claims.

3.8–1 TMG as Secondary Payor. PROVIDER will make every attempt to identify other healthcare coverage and to provide that information to TMG. PROVIDER agrees to bill, where appropriate, any primary or other carrier for services rendered to Enrollees and shall advise TMG of any such payments recovered from the other payors. TMG's payment to PROVIDER shall be reduced by that amount received by PROVIDER from other carriers but in no case, will TMG's payment be such that would allow PROVIDER to receive more than the TMG rate set forth in Exhibit A.

3.8–2 TMG as Primary Payor. PROVIDER will make every attempt to identify other healthcare coverage and provide that information to TMG. PROVIDER will bill, where appropriate, any secondary or other carrier for services rendered to TMG Enrollees. PROVIDER may retain any recoveries made through this process.

IV. UTILIZATION MANAGEMENT

4.1 Policies and Procedures. PROVIDER agrees to comply with all TMG and Plan utilization management policies and procedures for both hospital–based and office-based care.

4.2 Prior Authorization Required. In order for PROVIDER to render service to Enrollees, authorization must be obtained from TMG, verbally or in writing, prior to the rendering of services. The purpose of prior authorization is to verify that the Enrollee is a current Enrollee, that the service to be provided is a Covered Service, and that it is appropriate for the service to be rendered by PROVIDER. An authorization number must be obtained from TMG utilization management for reimbursement for such services. During normal office hours, such services must be authorized by the TMG utilization Medical Director or Manager or the Primary Care Physician or his/her designee, and for after–hours emergencies, by the TMG on-call administrative physician. TMG will not be financially responsible for nonauthorized services.

4.3 Referrals by PROVIDER. PROVIDER shall not refer Enrollees to other consulting specialists or providers without prior authorization from the TMG utilization management department or the TMG Medical Director or his/her designee. TMG will not be financially responsible for unauthorized, non–emergent consultations. PROVIDER agrees to make referrals only to TMG approved or authorized providers.

4.4 Incentive Programs. Provider shall not have financial incentives based on under-utilization of Covered Services.

V. REIMBURSEMENT

5.1 Payment Requirements. Charges for services that require prior authorization shall be eligible for payment only if PROVIDER obtains prior authorization from TMG for such services. If such services are rendered without prior authorization or after prior authorization has been denied, TMG will not pay any claim for the service and PROVIDER shall not bill the Enrollee, TMG or Plan for the service.

5.2 Timing of Payments. TMG shall pay PROVIDER those amounts set forth in Exhibit A within forty-five (45) business days following TMG's receipt of clean, undisputed claims.

5.3 Payment Rates. Provider shall accept payment from TMG, Plan or other payor, and Enrollee when co-payment is required, as payment in full for Covered Services rendered to Enrollees eligible to received such services at the rates set forth in Exhibit A.

VI. QUALITY MANAGEMENT

6.1 Quality Management Program. As a provider of health care services to Enrollees, PROVIDER acknowledges the importance of quality management systems. PROVIDER agrees to comply with the TMG quality management program to ensure quality care and service. This includes but is not limited to random office review, medical record review, case specific review, and appropriate response to issues identified by TMG or governmental agencies.

6.2 Quality Management Compliance. TMG reserves the right to conduct periodic audits and/or site surveys for the purpose of evaluating compliance with quality management standards for TMG Enrollees. PROVIDER will respond appropriately to all quality issues addressed to the quality management committee within the requested time frame but not to exceed fourteen (14) days of receipt. Failure to comply with this requirement will be considered a material breach of this Agreement.

6.3 Clinical Practice Guidelines. PROVIDER shall incorporate into PROVIDER's practice nationally accepted clinical practice guidelines.

VII. OBLIGATIONS OF THE PROVIDER

7.1 Records.

7.2–1 Patient Chart. PROVIDER shall make available to the TMG Medical Director or designee at no charge to TMG, all information in an Enrollee's chart and shall promptly provide copies of any documents contained therein, if requested for the purpose of eligibility, liability, claim disputes, governmental agency requests or quality of care issues. TMG shall strictly maintain the

confidentiality of any such records and shall not disclose any information except as required by law.

7.2–2 Inspection and Retention of Records. PROVIDER agrees to allow TMG and other appropriate regulatory agencies to inspect, examine and copy PROVIDER's books and records pertaining to the products and services furnished to Enrollees under the terms of the Agreement, to the extent that such inspection may be required by law or regulation. PROVIDER will retain financial and medical records relating to Enrollees as required of TMG or Plan or by properly authorized governmental agencies for a period of the longer of ten (10) years from the termination of this Agreement or such time period as may be required by applicable law, regulation or customary practice.

7.2–3 Copying Records. When an Enrollee changes physicians, PROVIDER will furnish copies of all medical records, x–rays, laboratory reports or any other patient care data, within thirty (30) days, or sooner if necessary, to the Enrollee's new provider at no charge. PROVIDER shall provide copies of any necessary documents to TMG at no cost in matters involving claims or claims disputes.

7.3 In–Service Orientation. PROVIDER shall provide orientation time for in–service training by TMG, on an as needed basis.

7.4 No Billing of Enrollees.

7.4–1 No Charges. PROVIDER shall not impose any charges on Enrollees for Covered Services shall regard TMG's payment as payment in full for all Covered Services provided by PROVIDER under this Agreement. PROVIDER shall be entitled to receive payment for third party claims. PROVIDER will never, under any circumstances, including non–payment by TMG, the insolvency of TMG, or breach or termination of this Agreement, seek compensation from or have any recourse against any Enrollee, Plan or State (for Medi–Cal Enrollees) for Covered Services. If PROVIDER has billed or collected from an Enrollee for any Covered Service, TMG may refund that amount to Enrollee and may offset that amount from any payment to PROVIDER.

7.4–2 Survival of Covenants. PROVIDER agrees that these provisions shall survive the termination of this Agreement regardless of the cause–giving rise to termination and shall be construed for the benefit of Enrollee.

7.4–3 Collection of Copayments. These provisions shall not preclude PROVIDER from collecting copayments and/or deductibles that are specifically provided in Enrollee's Evidence of Coverage.

7.5 Hospital Privileges. Physicians associated with PROVIDER shall obtain and maintain the appropriate privileges at Hospital, have active medical staff status,

and be in good standing for the services covered under this Agreement during the initial and any succeeding term of this Agreement and shall admit all Enrollees to Hospital except in the case of an emergency or as prior authorized by TMG. If a Plan Hospital is changed during the term of this Agreement, TMG retains the right to request PROVIDER to provide Covered Services or to contract with other providers for Covered Services provided to Enrollees at those facilities.

7.6 Credentials. PROVIDER agrees that all Enrollees will be treated by physicians licensed to practice in the State, or by a qualified allied professional person legally acting under the supervision of a physician licensed to practice in the State. PROVIDER agrees that each physician treating Enrollees and other professionals who have the legal authority to practice independently of supervision and/or have supervisory authority over other health care practitioners, shall complete a TMG application in a timely manner and shall provide all other information including information on malpractice cases necessary for TMG to complete the credentialing/recredentialing process. Appropriate credentialing must be completed prior to PROVIDER rendering care to Enrollees. PROVIDER must be properly registered and certified under the Federal Clinical Laboratory Improvement Amendment and all other applicable state or federal regulatory agencies for any laboratory test performed in PROVIDER's office. A PROVIDER submitting claims for laboratory services shall provide evidence of his/her CLIA number and status.

7.7 Release of Information. PROVIDER authorizes the licensing bureaus, affiliations and/or persons to provide any and all necessary information regarding PROVIDER to TMG or its designee. PROVIDER authorizes TMG to release any information described in the TMG application to any purchaser of health care services or to any representative of local, State and federal government agencies. PROVIDER releases TMG, its employees and authorized agents from any liability for such disclosure or use and for any expenses incurred by PROVIDER resulting from the release of this information.

7.8 Notification of Changes. PROVIDER agrees to notify TMG within forty–eight (48) hours of any revisions, revocation, or limitation of his/her or of a group Enrollee's license to practice, narcotics license, or hospital/facility privileges or malpractice carrier change or termination. PROVIDER will notify TMG of any changes in the providers of the group who may treat Enrollees within forty–eight (48) hours. PROVIDER agrees to submit to TMG a completed TMG provider application within thirty (30) days of an agreement with any new physician/allied professional who will provide services to Enrollees so TMG may initiate the credentialing process.

7.9 Prescribing Practices. PROVIDER agrees to prescribe medication from the applicable Plan formulary and to obtain prior authorization from the appropriate TMG Medical Director or Plan for any pharmacy non-formulary medication.

7.10 Non–Solicitation of Enrollees. Subject to applicable State law, during the term of this Agreement and for a period of one (1) year following the date of termination of this Agreement, PROVIDER will not advise any Enrollee to disenroll from TMG or Enrollee's Plan and will not solicit any Enrollee or Enrollee's employer to become enrolled with any other health maintenance organization, provider organization, PROVIDER, or any other plan or insurance program.

7.11 Investigation and Resolution of Complaints. A report providing a summary of occurrence shall be made by PROVIDER for all unusual occurrences or events, including those events which may include, but are not limited to, those with a high potential for liability or which result in a ninety (90) day notice or legal claim being served. TMG's quality management department shall be sent a copy of the summary of occurrence report within forty–eight (48) hours of the discovery of the occurrence or event by PROVIDER. The information provided and developed shall be treated as confidential, under the applicable State statutes.

7.12 Service Standards. PROVIDER shall provide clean facilities and equipment; maintain adequate, consumer–oriented, and properly credentialed staff; maintain orderly and efficient systems for receiving patients; maintain orderly and efficient systems for the provision of patient services; and maintain proper medical records. PROVIDER will allow TMG's Medical Director, or his/her designee, to inspect PROVIDER's medical facilities, equipment and Enrollees' medical records, and to review all phases of professional care provided to Enrollees.

7.13 Reporting Requirements. PROVIDER shall provide TMG with all reports, contracts, or other information required by, or of, TMG by any Plan or regulatory agency, including without limitation, all information contained in HEDIS data fields applicable to PROVIDER services.

VIII. INSURANCE

8.1 Responsibility For Own Acts. Each party will be responsible for its own acts or omissions and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that party, its employees or representatives, in the performance or omission of any act or responsibility of that party under this Agreement. In the event that a claim is made against both parties, it is the intent of both parties to cooperate in the defense of such claim and to cause their insurers to do likewise. However both parties shall have the right to take any and all actions they believe necessary to protect their interest.

8.2 Liability Coverage. PROVIDER has and shall retain in effect during the term of this Agreement professional liability ("malpractice") insurance and primary general liability coverage in the minimum amount of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) annual aggregate and Workers' Compensation in the statutory amount at a minimum. If PROVIDER has a claims–made malpractice/professional liability insurance policy, then this policy shall be kept in effect for at least five (5) years past any termination of this Agreement or PROVIDER may purchase "tail" coverage. Said "tail" policy shall have the same policy limits as the primary professional liability policy.

8.3 Certificate of Insurance. PROVIDER will provide TMG with a certificate of insurance evidencing professional and general liability coverage at least thirty (30) days prior to the execution of this Agreement and annually thereafter. PROVIDER will require the insurance carrier to notify TMG of any change in coverage, including termination of the policy, at least thirty (30) days prior to any such change.

IX. TERM. TERMINATION, RENEWAL

9.1 Term. The term of this Agreement will begin on the effective date of this Agreement and continue for one (1) year unless otherwise terminated.

9.2 Automatic Renewal. This Agreement shall automatically renew for successive periods of one (1) year, without additions or modifications of its terms, unless one party notifies the other of its intent not to renew the Agreement. This notice must be given at least ninety (90) days prior to the renewal date of the Agreement.

9.3 Adverse Governmental Action. In the event any action of any department, branch, or bureau of the federal, State, or local government materially adversely affects either party, that party shall notify the other of the nature of this action, including a copy of the adverse action. The parties shall meet within thirty (30) days and shall, in good faith, attempt to negotiate a modification to this Agreement that minimizes the adverse affect. Should the parties be unsuccessful, then the parties can mutually agree to arbitration or either party may terminate this Agreement upon thirty (30) days prior written letter to the other party.

9.4 Material Breach and Termination. Notwithstanding any other provision of this Agreement, TMG shall have the right to terminate this Agreement upon thirty (30) days prior written notice to PROVIDER if TMG, in its sole and absolute discretion, determines that PROVIDER has committed a material breach of this Agreement. PROVIDER will have fifteen (15) days from receipt of the notice to correct the material breach. In the event PROVIDER fails to cure the material breach within the fifteen (15) day period, this Agreement shall automatically terminate upon completion of the thirty (30) day notice period, notwithstanding any other provision of this Agreement.

9.5 Termination Without Cause. This Agreement may be terminated by PROVIDER at any time, with or without cause, by giving ninety (90) days prior written notice to TMG. This Agreement may be terminated by TMG at any time, with or without cause, by giving ninety (90) days prior written notice to PROVIDER.

9.6 Effects of Termination. Upon termination of this Agreement, the following shall occur:

9.6–1 Responsibility for Enrollees at Termination. PROVIDER shall continue to provide Covered Services to Enrollees receiving Covered Services from PROVIDER on the effective termination date of this Agreement until the Covered Services being rendered to the Enrollees by PROVIDER are completed (consistent with existing medical ethical/legal requirements for providing continuity of care to a patient), unless TMG or Plan makes reasonable and medically appropriate provisions for the assumption of such Covered Services by another Participating Physician or provider.

9.6–2 Transfer of Medical Records. Upon receiving a signed request from Enrollee, PROVIDER agrees to furnish copies of all medical records, x–rays, laboratory reports or any other patient care data within thirty (30) days, or sooner if necessary, to Enrollee's new provider at no charge to Enrollee, the new Provider, Plan or TMG.

9.6–3 Payment for Services. TMG shall compensate PROVIDER for those Covered Services provided to an Enrollee pursuant to this paragraph 9.6 in accordance with Exhibit A of this Agreement.

9.7 No Contact With Enrollees. PROVIDER agrees not to contact Enrollees in any way about the termination of this Agreement, including those Enrollees who are receiving, or have received, services from PROVIDER. PROVIDER agrees to rely exclusively upon TMG's or Plan's communication to Enrollees concerning termination of this Agreement and agrees not to interfere in any way with the relationship between TMG, Plan and Enrollees. TMG shall notify Enrollees within 60 days of PROVIDER'S termination.

X. BBA REQUIREMENTS

10.1 To the extent, the foregoing BBA requirements are in conflict with or not addressed in the Agreement, the BBA requirement supersedes the provisions of the Agreement. These requirements only apply to enrollees applicable as deemed by BBA.

10.2 Access: Records and Facilities.

10.2-1 Provider must give the U.S. Department of Health and Human Services, the U.S. Government Accounting Office and their designees the right to audit, evaluate, and inspect their books, contracts, medical records, patient documentation and other relevant records. These rights will extend for six

years beyond termination of the Agreement and also until the conclusion of any governmental audit that may be initiated that pertain to such records. BBA Regulations 422.502(e)(2), (3) and (i)(2).

10.2-2 Provider must safeguard the privacy of any information that identifies a particular Enrollee and must maintain Enrollee records in an accurate and timely manner. BBA Regulations 422.188 and 422.502(a)(13).

10.3 Access: Benefits and Coverage.

10.3-1 Provider must not discriminate against Enrollees based on their health status. BBA Regulation 422.100(a).

10.3-2 The definitions of emergency services and urgently needed services are set forth at Section 10.10. BBA Regulation 422.2.

10.3-3 Provider shall comply with the following Plan policies and procedures:

a. Plan's policies pertaining to the collection of copayments which prohibit the collection of copayments for routine injections, routine immunizations, flu immunizations, and the administration of pneumococcal/pneumonia vaccine.

b. TMG's policies pertaining to pre-certification which provide that TMG Enrollees may directly access a provider for mammography and influenza vaccinations and women's health specialists for routine and preventative health cares.

c. TMG's policies pertaining to complex and serious conditions which provide for procedures to identify, assess and establish treatment plans for persons with complex or serious medical conditions.

d. Plan's pertaining to enrollment and assessment of new Plan Enrollees including requirements to conduct a health assessment of all new Enrollees within ninety (90) days of the effective date of their enrollment.

10.4 Enrollee Protections.

10.4–1 Provider shall provide all covered benefits in a manner consistent with professionally recognized standards of health care. BBA Regulation 422.502(a)(3)(iii). Provider shall require that all of its Participating Providers who provide services to TMG Enrollees meet the standards for participation and all applicable requirements for providers of health care services under the Medicare program. In addition, Provider shall require that all facilities and offices utilized by Provider and its Participating Providers to provide or arrange Covered Services to Plan Enrollees shall comply with facility standards established by HCFA.

10.4–2 Provider shall maintain the physician-patient relationship and nothing in the Agreement shall contain any provision that interferes with the physician-patient relationship. BBA Regulation 422.206.

10.4–3 Provider shall hold Enrollees harmless from any charges for which TMG is financially responsible in accordance with the terms of the following paragraph. BBA Regulation 422.502(g) and (i)(3)(i)(A).

With the exception of Copayments and charges for non-covered services delivered on a fee-for-service basis to Enrollees, Provider and its Participating Providers shall in no event, including, without limitation, non-payment by TMG's insolvency, or breach of the Agreement, bill, charge, collect a deposit from, seek compensation or remuneration or reimbursement from, or have any recourse against any Enrollee or any person acting on behalf on any Enrollee or attempt to do any of the foregoing for Covered Services provided or arranged pursuant to this Agreement.

Provider and its Participating Providers shall not maintain any action at law or equity against a Enrollee to collect sums owed by TMG to Provider. Upon notice of any such action, TMG may terminate this Agreement as provided above and take all other appropriate action consistent with the terms of this Agreement to eliminate such charges, including, without limitation, requiring Provider and its Participating Providers to return all sums collected as surcharges from Enrollees or their representatives. For purposes of this Agreement, "Surcharges" are additional fees for Covered Services which are not disclosed to Enrollees in the Subscriber Agreement, are not allowable Copayments and are not authorized by this Agreement. Nothing in this Agreement shall be construed to prevent Provider from providing non-Covered Services on a usual and customary fee-for-service basis to Enrollees.

10.4–4 Provider has certain continuity of care obligations in the event that the Agreement terminates or TMG becomes insolvent. The threshold requirement is that Enrollees continue to receive services through the period in which their HCFA payments have been made to Plan. Additionally, if the Enrollee is hospitalized, services must be provided until termination of HCFA's agreement with Plan or, in the event of Plan's insolvency, through the date of the Enrollee's discharge. BBA Regulation 422.502(g).

10.4–5 Provider must adhere to HCFA's appeals/expedited appeals procedures for Enrollees, including gathering and forwarding information on appeals to TMG as required. BBA Regulation 422.562(a).

10.5 Accountability and Delegation.

Where Provider performs managed care functions on behalf of TMG, the agreement contains specific provision pertaining to such delegated activities. TMG is accountable for these activities and oversees and monitors the activities on an ongoing basis. TMG retains all its legal remedies, including the right of revocation, if the activities are not performed satisfactorily. BBA Regulation 422.502(i)(3)(ii) to (4).

Consistent with the requirements of State and Federal Law, TMG shall be accountable for the performance of the following services: quality management and improvement, utilization management, credentialing, Enrollee rights and responsibilities, preventive health services, medical record review and payment and processing of claims. BBA Regulation 422.502(i)(3)(ii)(A).

10.6 Payment and Federal Funds.

10.6–1 Provider is advised that Provider will be receiving federal funds, and accordingly, Provider shall be subject to compliance with certain federal laws including applicable provisions of Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and other laws applicable to recipients of Federal funds. BBA Regulation 422.502(h).

10.7 Reporting and Disclosure/Encounter Data.

Provider shall submit all data and other information, including medical records, necessary to characterize the content and purpose of each encounter with an Enrollee and must be prepared to certify to the accuracy of such information. BBA Regulation 422.257, 422.502(a)(8) and (1)(3), and 422.516.

10.8 Quality Improvement.

Provider shall comply with the HCFA approved independent quality review and improvement organization for external review with respect to the provision of services to the Provider Review Organization (PRO review) applicable to TMG. BBA Regulation 422.154(a).

Provider shall comply with TMG's medical policy, quality assurance and medical management programs. These programs are to be developed in consultation with Provider. BBA Regulation 422.202(b).

10.9 Compliance.

10.9–1 TMG acknowledges that it is subject to certain requirements to notify Provider in writing of reasons for denial, suspension, and termination determinations that affect the health care professionals. BBA Regulation 422.204(c)(1).

10.9–2 The Agreement's without cause termination provisions, if any, shall provide for not less than ninety (90) days prior written notice (or such longer notice as currently provided by the Agreement). BBA Regulation 422.204(c)(4).

10.9–3 Neither TMG nor Provider shall contract with or employ individuals who have been excluded from participation in the Medicare Program. BBA Regulation 422.752(a)(8).

10.9–4 Provider's relationship with TMG shall terminate at such time as Provider files an affidavit with the Medicare Program promising to furnish Medicare-covered services to Medicare beneficiaries only through private (direct) contracts with such beneficiaries under Section 1802(b) of the Social Security Act. BBA Regulations 422.502(h).

10.9–5 Provider shall document all TMG Enrollee patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws. For purposes of this Agreement, and Advance Directive is a Enrollee's written instructions, recognized under State law, relating to the provision of health care when the Enrollee is not competent to make health care decisions as determined under State law. Examples of advanced Directives are living wills and durable powers of attorney for health care.

10.9–6 Provider shall comply with all applicable laws, including without limitation, laws and regulations and TMG's policies and procedures pertaining to the Medicare+ Advantage Programs. BBA Regulation 422.502(i)(4)(v).

10.10 Emergency and Urgently-Needed Services Definitions.

10.10–1 Emergency Services are Covered Services provided in a hospital emergency facility or comparable facility to evaluate, treat and stabilize a medical condition of a recent onset and severity, including, without limitation, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: (i) placing the Enrollee's health in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part; (iv) serious disfigurement; or (v) in the case of a pregnant woman, serious jeopardy to the health of the fetus. The final determination of whether Emergency Services were required shall be made by the medical director or designee, subject to appeal under the applicable Enrollee/TMG's appeals procedure.

10.10–2 Urgently Needed Services are Covered Services under a Managed Care Plan, which are required without delay in order to prevent the serious deterioration of an Enrollee's health as a result of an unforeseen illness or injury.

XI. GENERAL PROVISIONS

11.1 Relationship Between the Parties. TMG and PROVIDER are independent contractors. Nothing in this Agreement shall be construed to create a principal–agent, employer–employee, partnership, joint venture relationship, or any relationship other than that of independent parties contracting solely for the purpose of carrying out the provisions of this Agreement.

11.2 Non–Exclusive Agreement. PROVIDER agrees this is not an exclusive agreement and that TMG may contract with other providers to serve in the same capacity as PROVIDER and that PROVIDER may contract with others for his/her services.

11.3 Use of Names and Trademarks. TMG and PROVIDER each reserve the right to control the use of their name, symbols, trademarks, or other marks currently existing or later established. However, either party may use the other party's name, symbols, trademarks or other marks with the prior written approval of the other party. PROVIDER agrees that PROVIDER's name may be used in Plan or TMG provider directories without prior approval.

11.4 Use of TMG's Trade Secrets by PROVIDER. PROVIDER agrees not to use or divulge TMG's or Plan's trade secrets. A trade secret means information, including but not limited to, programs, methods, techniques and processes, that have independent economic value from not being generally known to either the public or to other persons who can obtain economic value from its disclosure or use. Examples of TMG and/or Plan trade secrets include, but are not limited to, actual and potential Enrollee lists, compiled information concerning Enrollees, key provider agreements, billing rates, and operations manuals. This paragraph shall not be applicable to information already in the public domain or that has been made available to the public by TMG or Plan.

11.5 Governing Law. This Agreement shall be governed by and construed in accordance with all current and future applicable California State, Federal and BBA laws, rules and regulations, as amended.

11.6 Interpretation. Neither TMG nor PROVIDER shall be deemed the drafter of this Agreement. If this Agreement is ever to be interpreted or construed by a court of law, both parties agree they are the drafters of the Agreement.

11.7 Non–Discrimination. PROVIDER agrees to render services pursuant to this Agreement without regard to race, age, sex, religion, creed, color, national origin or ancestry of any Enrollee. During the term of this Agreement, PROVIDER and any subcontractors shall not unlawfully discriminate because of race, religion,

color, national origin, ancestry, physical handicap, medical condition, sexual orientation, marital status, age or sex.

11.8 Assignment. The rights and/or obligations of this Agreement may not be assigned, delegated, transferred, conveyed or sold without the prior written consent of the other party, except that TMG may assign, delegate, transfer, convey or sell its rights and/or obligations to a parent, subsidiary or affiliate or to an entity into which TMG is merged or with which TMG is consolidated or to a purchaser of all or substantially all of its assets or as part of a corporate reorganization.

11.9 Sale of Business/Transfer of Assets. If PROVIDER desires to sell, transfer or convey its business or any substantial portion, or all, of its business assets to another entity, PROVIDER shall so advise TMG at least one hundred and twenty (120) days prior to the sale, transfer or conveyance date. PROVIDER warrants and covenants that this Agreement will be part of the transfer, conveyance or sale and will be assumed by the new entity.

11.10 Enforcement. If any action at law, in arbitration, or in equity is necessary to enforce or interpret the terms of this Agreement, the prevailing party shall be entitled to payment by the other party of reasonable attorneys' fees, costs and necessary disbursement and expenses in addition to any other relief to which the prevailing party may be entitled.

11.11 Severability. If any provision of this Agreement is deemed to be invalid or unenforceable by a court of competent jurisdiction or in arbitration, the same shall be deemed severable from the remainder of this Agreement and shall not cause the invalidity or unenforceability of the remainder of this Agreement.

11.12 Execution by TMG. This Agreement shall not be binding until executed by a person authorized to do so by TMG and an executed copy of this Agreement is delivered to PROVIDER.

11.13 Provisions Required by HCFA. If required of TMG by Plans, then PROVIDER shall comply with the following:

11.13–1 Ownership Information. PROVIDER shall provide TMG with full and complete information as to the ownership of PROVIDER and full and complete information as to any significant business transactions during the five–year period ending on the date of HCFA's or Plan's request to TMG for such information.

11.13–2 Disclosure of Information. PROVIDER agrees to establish and maintain procedures and controls so that no information contained in its records or obtained from HCFA or from others in carrying out the terms of this Agreement shall be used by or disclosed by PROVIDER, its agents, officers or employees except as provided in Section 1106 of the Social Security Act and Regulations promulgated thereunder, as amended.

11.14 Provider Incentives. Both TMG and PROVIDER understand and agree that any payments made directly or indirectly to PROVIDER under any PROVIDER incentive provisions (if any) set forth in this Agreement are not made as an inducement to reduce or limit medically necessary services and/or to affect care rendered to any Enrollee.

11.15 Appeals Process for Medicare Enrollees. PROVIDER shall follow the appeals process for Medicare Enrollees as set forth by federal law and regulation. PROVIDER shall be bound by any and all HCFA language requirements of any Plan's initial determination letters and other correspondence directed to Medicare Enrollees.

11.16 Notices. Any and all notices required to be given pursuant to the terms of this Agreement must be given by United States mail, postage prepaid, return receipt requested or may be telefaxed with proof of receipt, or hand delivered to the specific person listed below and at the following address:

If to TMG: Keith Wilson, M.D., President & CEO
Talbert Medical Group
1665 Scenic Avenue, Suite #100
Costa Mesa, CA 92626
(714) 436-4800

cc: Lillie Chambers, Director of Managed Care
Talbert Medical Group
1665 Scenic Avenue, Suite #100
Costa Mesa, CA 92626
(714) 436-4800

If to PROVIDER: Long Beach Public Health Laboratory
2525 Grand Ave, Room 260
Long Beach, CA 90815

11.17 Waiver. The waiver by either party of a failure to perform any covenant or condition set forth in this Agreement shall not act as a waiver of performance for a subsequent breach of the same or any other covenant or condition set forth in this Agreement.

11.18 Entire Agreement. This Agreement constitutes the entire understanding between the parties and shall bind and inure to the benefit of both parties and their successors and assigns. No change, amendment or alteration shall be effective unless in writing and signed by both parties. This Agreement shall supersede all prior written and/or oral agreements with PROVIDER that pertain to the subject of this Agreement, including any amendments, addendums, letters of understanding and any other documents relating thereto, and both TMG and

PROVIDER mutually agree to terminate any prior agreements pertaining to the subject of this Agreement on the effective date of this Agreement.

11.19 Plan Requirements. TMG and PROVIDER recognize and agree that TMG will be contracting with many Plans and each Plan may have slightly different requirements. Therefore, both parties agree to comply with any such Plan's requirements and should this Agreement need to be modified to conform to such Plan requirements, TMG shall so advise PROVIDER of the requirement and the necessary requisite change in the Agreement at least five (5) days prior to amending the Agreement. Should PROVIDER not be in agreement with the amendment, PROVIDER will comply with the change but shall advise TMG in writing of the disagreement and TMG and PROVIDER will attempt to resolve PROVIDER's concerns. Should this effort be unsuccessful, PROVIDER may terminate this Agreement on ten (10) days advance written notice, notwithstanding any other provision in this Agreement.

11.20 Confidentiality. The terms of this Agreement and in particular the provisions regarding payment for services, are confidential and shall not be disclosed except as necessary to the performance of this Agreement or as required by law. PROVIDER shall not disseminate or publish information developed under this Agreement or contained in reports to be furnished pursuant to this Agreement without prior written approval of TMG. PROVIDER acknowledges that a TMG Participating Physician or Provider may be responsible for payment for services rendered pursuant to this Agreement. PROVIDER agrees to TMG's disclosure of this Agreement's rate schedule, to a TMG Participating Physician or Provider to the extent necessary for determination of payment. PROVIDER acknowledges and agrees that any rate information about other TMG Participating Provider or Providers disclosed to PROVIDER by TMG for the performance of this Agreement is confidential and shall not be used by PROVIDER for any other purpose or disclosed by PROVIDER in any manner.

11.21 Exhibits. All exhibits attached to this Agreement, and referenced herein, are incorporated into and made part of this Agreement.

XII. HIPAA REQUIREMENTS

12.1 CONFIDENTIALITY OBLIGATIONS

12.1–1 Privacy, Security, and Confidentiality. Provider shall maintain the privacy, security, and confidentiality of all PHI, in accordance with HIPAA and this Addendum.

12.1–2 Use of PHI. Provider is authorized to use and disclose PHI only in accordance with the provisions of this Addendum, and only to the extent reasonably necessary (a) to provide the Covered Services; (b) for the proper management and administration of Covered Services; and (c) to

carry out the legal responsibilities of Provider's responsibilities as outlined in the Underlying Agreement.

12.1–3 Notice of Breach or Violation. Provider acknowledges that, under HIPAA, TMG could be deemed to be in violation of HIPAA if TMG knows of a pattern of activity or practice of Provider that constitutes a material breach or violation of Provider's obligations under this Addendum to maintain privacy, security, and confidentiality of PHI, unless TMG takes reasonable steps to cure the breach or end the violation; and, if such steps are unsuccessful, terminates the Underlying Agreement or reports the problem to the Secretary. Accordingly, Provider shall promptly notify TMG of any pattern of activity or practice of Provider that constitutes any such material breach or violation.

12.1–4 Additional Obligations. Provider shall:

a. Not use or further disclose PHI other than as permitted or required by the Underlying Agreement, this Addendum or as required by law.

b. Use appropriate safeguards to prevent use or disclosure of PHI other than as provided by the Underlying Agreement or this Addendum.

c. Mitigate, as much as possible, any harmful effect of which it is aware of any use or disclosure of PHI in violation of the Underlying Agreement or this Addendum.

d. Promptly report to TMG any use or disclosure of PHI not permitted by this Addendum of which Provider becomes aware.

e. Ensure that each of its agents and subcontractors to whom it provides PHI agrees in writing to the same restrictions and conditions that apply to Provider with respect to such information.

f. In accordance with the provisions of HIPAA, specifically 45 CFR ~164.524, provide access to PHI to individuals to whom the particular PHI pertains for the purposes of inspecting and obtaining a copy of such PHI.

g. In accordance with the provisions of HIPAA, specifically 45 CFR ~164.526, make available PHI for amendment as instructed by Business Associate.

h. In accordance with the provisions of HIPAA, specifically 45 CFR ~164.528, make available the information required to provide an accounting of disclosures of PHI.

i. Make its internal practices, books, and records (including the pertinent provisions of this Addendum and the Underlying Agreement), relating to the use and disclosure of PHI, available to the Secretary for the purposes of determining Business Associate's compliance with HIPAA.

j. Return to Business Associate, or destroy, Business Associate's PHI still in TMG's possession upon termination of the Underlying Agreement.

12.1–5 Disclosure Compelled by Law or Governmental Request. If Provider (a) becomes legally compelled by law, process, or order of any court or governmental agency to disclose PHI, or (b) receives a request from the Secretary to inspect Provider's books and records relating to the use and disclosure of PHI, TMG, to the extent it is not legally prohibited from so doing, shall promptly notify Provider and cooperate with TMG in connection with any reasonable and appropriate action TMG deems necessary with respect to such PHI.

12.2 OTHER PROVISIONS

12.2–1 Default. A breach under this Addendum shall be deemed to be a material default under the Underlying Agreement.

12.2–2 Obligations Upon Termination of Underlying Agreement. Upon the termination of the Underlying Agreement, Provider shall promptly return or destroy all PHI that Provider maintains in any form and retain no copies of such information. If the return or destruction of such PHI is not feasible, the obligations under this Addendum shall continue in effect for so long as Provider retains such information, and any further use or disclosure of such PHI shall be limited to those purposes that make the return or destruction of the PHI infeasible.

IN WITNESS WHEREOF, the parties hereby execute this Agreement.

For PROVIDER: City of Long Beach

By: Gerald R. Miller

Title City Manager

Signature: Christine F Shippey ASSISTANT Date: 4-26-07

Phone Number (562) 570-6916

Tax ID Number [redacted]

EXECUTED PURSUANT TO SECTION 301 OF THE CITY CHARTER.

For and on behalf of TMG:

By: Michael Gam

Title: Chief Financial Officer

Signature: Date: 5/14/07

APPROVED AS TO FORM

4/11, 2007

ROBERT E. SHANNON, City Attorney

By Lorna A Conway

DEPUTY

EXHIBIT A

Services Reimbursement

Provider agrees to bill GROUP for TMG eligible covered Enrollees at the most current standard CPT-4 codes and to accept the following reimbursement as payment in full:

A. Commercial & Medicare Advantage Enrollees, reimbursement will be as follow:

1. Total compensation to PROVIDER shall be the lesser of Provider's billed charges or 100% of the current participating Medicare Fee Schedule for the county of which services are rendered.

B. LA/Medi-Cal & LA/Healthy Families/Cal Optima Medi-Cal/Cal Optima Healthy Families Enrollees:

1. Total compensation to PROVIDER shall be the lesser of PROVIDER's billed charges or 100% of current Medi-Cal Fee Schedule.

C. Other Provisions

1. If not so provided, unit value(s) shall be determined by GROUP in its sole and absolute discretion based upon the report of the Provider. All claims filed BR/RNE shall be paid at a rate not to exceed 50% of usual & customary charges (not to exceed 120% of the highest reported RVS for that grouping.

2. Notwithstanding anything to the contrary contained herein GROUP shall have the right to retain coordination of benefits revenue collected. Provider shall be compensated as per this Exhibit A.

3. Provider agrees to apply the above reimbursement rates to all outstanding Enrollee claims.

4. Provider will bill Enrollees directly for any applicable copayment or deductible amounts and this amount will be deducted from the above reimbursement due to Provider from GROUP.

5. Authorized Injectable Medications will be reimbursed at the lesser of AWP –20% or Medicare Allowable.

6. PROVIDER agrees when submitting claims for payment to TMG to include the Enrollees name, date of birth, Date of Service, Enrollee's Plan number, and the authorization number on the claim. The tax identification number indicated below the signature line of this Agreement must be referenced on all claims submitted to TMG for services rendered to Enrollees. In addition a consultation report, discharge summary and/or any other information as may be required must also be included with the claim.

7. To be eligible for payment under the terms of this Agreement, all claims, including resubmitted rejected claims, must be submitted to TMG with documentation within ninety (90) days of the Date of Service or denial unless TMG agrees in writing to a later submission. TMG agrees to pay claims for (a) eligible enrollees at time of service, (b) when TMG is financially responsible for services rendered, (c) when services have been preauthorized and approved, (d) submitted by PROVIDER within ninety (90) calendar days from the date of receipt of the claim by TMG.

8. PROVIDER agrees to bill TMG within ninety (90) days from Date of Service, for services of TMG, and that enrollees will not be liable to the PROVIDER for payment of monies owed by TMG, and PROVIDER will not bill, collect or charge Enrollees of TMG for service rendered. Bills shall be submitted to:

TMG – Claims
P.O. Box 25074
Santa Ana, CA 92799-5074
(800) 241-4347

EXHIBIT B

Provider Data

Provider Name:
CA License #:
DEA #:

Provider Name:
CA License #:
DEA #:

Provider Name:
CA License #:
DEA #:

Provider Name:
CA License #:
DEA #:

Provider Name:
CA License #:
DEA #:

EXHIBIT C

Provider Location Information

Long Beach Public Health Laboratory

2525 Grand Ave, Room 260

Long Beach, Ca 90815

EXHIBIT D

PROVIDER AB 1455 NOTICE
CLAIMS SETTLEMENT PRACTICES & DISPUTE RESOLUTION MECHANISM

This Claims Settlement Practices and Dispute Resolution Mechanism shall become effective January 1, 2004 and shall be made a part of the PROVIDER SERVICES AGREEMENT.

Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care. This information notice is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for commercial HMO, POS, and, where applicable, PPO products where **Talbert Medical Group** is delegated to perform claims payment and provider dispute resolution processes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

I. Claim Submission Instructions

A. Sending Claims to **Talbert Medical Group**. Claims for services provided to members assigned to **Talbert Medical Group** must be sent to the following:

Via Mail:	**P.O. Box 25074** **Santa Ana, CA 92799-5074**
Via Physical Delivery:	**1665 Scenic Avenue, Suite #100** **Costa Mesa, CA 92626**

B. Calling **Talbert Medical Group** Regarding Claims. For claim filing requirements or status inquiries, you may contact **Claims Customer Service** by calling: **(800) 241-4347**.

C. Claim Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by **Talbert Medical Group**.

1. If Provider's "Provider Services Agreement" claims filling deadline to submit claims is less than 90 calendar days from the Date of Service, pursuant to the AB1455 Regulations, the new timeline will be 90 calendar days.

2. If Provider's "Provider Services Agreement" does not contain a specific filing deadline, Talbert Medical Group will follow a 90-calendar day timely filing requirement for all contracting provider claims.

3. Pursuant to Section 1300.71 (a)(10) of Tile 28 of the California Code of Regulations, Talbert Medical Group shall only request reasonably relevant information to determine the nature, cost and extent of the liability for the adjudication of claims.

4. If Provider's "Provider Services Agreement" deadline to submit requests for adjustments and appeals regarding claim payment or denial of claim to Talbert Medical Group is less than 365 calendar days after the date of the payment or denial of the claim to the Provider, pursuant to AB1455 regulations, the deadline shall be 365 calendar days.

5. If Provider's "Provider Services Agreement" does not contain a specific filing deadline for adjustments and appeals, Talbert Medical Group will follow a 365-calendar day timely filing requirement for all adjustment and appeals requests.

D. Claim Receipt Verification. For verification of claim receipt by **Talbert Medical Group**, please do the following:

1. Contact **Claims Customer Service** at **(800) 241-4347.**

II. Dispute Resolution Process for Contracted Providers

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to **Talbert Medical Group** and/or the member's applicable health plan 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 or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider's name; provider's identification number, provider's contact information, and:

1. If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from **Talbert Medical Group** to a contracted provider 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 the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;

2. 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

3. 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, and an enrollee's written authorization for provider to represent said enrollees.

B. Sending a Contracted Provider Dispute to **Talbert Medical Group**. Contracted provider disputes submitted to **Talbert Medical Group** must include the information listed in Section II.A., above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of **Claims Department** at the following:

Via Mail:	**P.O. Box 25074** **Santa Ana, CA 92799-5074**
Via Physical Delivery:	**1665 Scenic Avenue, Suite #100** **Costa Mesa, CA 92626**

C. Time Period for Submission of Provider Disputes.

1. Contracted provider disputes must be received by **Talbert Medical Group 365 days** from **Talbert Medical Group's** action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or

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

3. Contracted provider disputes that do not include all required information as set forth above in Section II.A. may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to **Talbert Medical Group** within **thirty (30) Working Days** of your receipt of a returned contracted provider dispute.

D. Acknowledgment of Contracted Provider Disputes. **Talbert Medical Group** will acknowledge receipt of all contracted provider disputes as follows:

1. Electronic contracted provider disputes will be acknowledged by **Talbert Medical Group** within **two (2) Working Days of the Date of Receipt by Talbert Medical Group.**

2. Paper contracted provider disputes will be acknowledged by **Talbert Medical Group** within **fifteen (15) Working Days of the Date of Receipt by Talbert Medical Group.**

E. Contact **Talbert Medical Group** Regarding Contracted Provider Disputes. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to **Talbert Medical Group** at:

1665 Scenic Avenue, Suite #100
Costa Mesa, CA 92626

F. 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:

1. Sort provider disputes by issue
2. Provide cover sheet for each issue
3. Number each cover sheet
4. Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheets
5. Include any back up documentation that supports Providers *dispute*

G. Time Period for Resolution and Written Determination of Contracted Provider Dispute. **Talbert Medical Group** will issue a 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 contracted provider dispute or the amended contracted provider dispute.

H. Past Due Payments. If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, **Talbert Medical 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.

III. Dispute Resolution Process for Non-Contracted Providers

A. Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider's written notice to **Talbert Medical Group** challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information, and:

1. If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from **Talbert Medical Group** to provider 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 the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect;

2. If the non-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, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

B. Dispute Resolution Process. The dispute resolution process for non-contracted Providers is the same as the process for contracted Providers as set forth in sections II.B., II.C., II.D., II.E., II.F., II.G., and II.H. above.

IV. Claim Overpayments

A. Notice of Overpayment of a Claim. If **Talbert Medical Group** determines that it has overpaid a claim, **Talbert Medical Group** will notify the 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 **Talbert Medical Group** believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

B. Contested Notice. If the provider contests **Talbert Medical Group's** notice of overpayment of a claim, the provider, within **thirty (30) Working Days** of the receipt of the notice of overpayment of a claim, must send written notice to **Talbert Medical Group** stating the basis upon which the provider believes that the claim was not overpaid. **Talbert Medical Group** will process the contested notice in accordance with **Talbert Medical Group's** contracted provider dispute resolution process described in Section II above.

C. No Contest. If the provider does not contest **Talbert Medical Group's** notice of overpayment of a claim, the provider must reimburse **Talbert Medical Group** within **thirty (30) Working Days** of the provider's receipt of the notice of overpayment of a claim.

D. Offsets to Payments. **Talbert Medical Group** may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse **Talbert Medical Group** within the timeframe set forth in Section IV.C., above, and (ii) **Talbert Medical Group's** contract with the provider specifically authorizes **Talbert Medical Group** to offset an uncontested notice of

overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, **Talbert Medical Group** will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

EXHIBIT E

H-ICE
MA Downstream Provider Contract Addendum
January 1, 2006

This ICE Downstream Provider Contract Addendum ("Addendum") is entered into by Talbert Medical Group ("First Tier Entity") and Long Beach Public Health Laboratory ("Downstream Provider") Effective January 1, 2006, in order to add contract language required by the Centers for Medicare and Medicaid Services, "(CMS") for participation in the Medicare Advantage ("MA") Program.

Whereas, CMS requires that specific terms and conditions be incorporated into sub contracts between a First Tier Entity and a Downstream Provider to comply with the provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. (Pub. L. 108-73) (MMA).

Whereas, Downstream Provider desires to provide services to Medicare beneficiaries who enroll in the Medicare Advantage Program; and

Whereas, First Tier Entity desires that Downstream Provider provide services to Medicare beneficiaries who enroll in the Medicare Advantage Program; and

Whereas, Downstream Provider agrees to comply with the terms and conditions specified by CMS in the form of this Addendum to the Agreement between Downstream Provider and First Tier Entity;

Whereas, Downstream Provider and First Tier Entity previously entered into a "ICE Downstream Provider Contract Addendum" for matters occurring on or after the date first written, this document supersedes and replaces the prior addendum in its entirety.

NOW, THEREFORE, the parties agree as follows:

DEFINITIONS

Agreement means the agreement between the First Tier Entity and Downstream Provider that specifies the contractual relationship between the First Tier Entity and Downstream Provider for the provision of services to Enrollees.

Downstream Provider means an entity or individual that is contracted by a First Tier Entity to provide services to Enrollees. A Downstream Provider includes, but is not limited to physicians, ancillary providers, and other health care providers.

First Tier Entity means the entity that contracts with a Medicare Advantage Organization, (MAO) to provide services to Enrollees. A First Tier Entity includes but is not limited to medical group, individual practice association ("IPA"), or hospital.

Centers for Medicare and Medicaid Services ("CMS") means the agency within the Department of Health and Human Services that administers the Medicare Program.

Completion of Audit means Completion of Audit by CMS of an MAO, MAO subcontractors or related entities.

Final Contract Period means Final Contract Period between CMS and the MAO with whom the First Tier Entity has entered into an Agreement.

Industry Collaboration Effort ("ICE") is a collaboration of health plans, providers and industry associations working on health care issues.

Medicare Advantage Organization ("MAO") means a Health Plan that has entered into an agreement with the CMS to provide services to Medicare beneficiaries under the Medicare Advantage Program.

Medicare Advantage ("MA") means the program offered by the federal government in which Medicare beneficiaries have several options to receive health care services.

Member means an individual who has enrolled in or elected coverage through an MAO. A Member is also known as an Enrollee.

OPL 77 REQUIRED PROVISIONS

Operational Policy Letter (OPL) 98.077 (revised) requires the Downstream Provider to comply with the following requirements:

1. Downstream Provider agrees to give the 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 for (10) years, or for periods exceeding ten (10) years, from the end of the Final Contract Period or Completion of Audit, whichever is later for reasons specified in the federal regulation, for Members enrolled in a MAO. 42 CFR 422.504 (e) (4). This increase in the duration of the record retention period applies to all new Records as well as to all Records required to be retained under the Prior Addendum as of the date first written above.

2. Downstream Provider agrees to comply with all confidentiality and Member record accuracy requirements. 42 CFRs 422.118 and 422.504. (a)(13).

3. Downstream Provider agrees to hold harmless and protect Members from incurring financial

liabilities that are the legal obligation of the MAO or First Tier Entity. In no event, including but not limited to, nonpayment or breach of an agreement by the MAO, First Tier Entity, or other intermediary, or the insolvency of the MAO, First Tier Entity, or other intermediary, shall Downstream Provider bill, charge, collect a deposit from or receive other compensation or remuneration from a Member. Downstream Provider shall not take any recourse against the Member, or a person acting on behalf of the Member, for services provided. This provision does not prohibit collection of applicable coinsurance, deductibles, or co-payments, as specified in the MAO Evidence of Coverage. This provision also does not prohibit collection of fees for non-covered services, provided the Member was informed in advance of the cost and elected to have non-covered services rendered. 42 CFRs 422.504(g) and (i)(3)(i).

4. Downstream Provider agrees to perform, if applicable, the functions that are delegated consistent with the First Tier Entity requirements, MAO requirements, and federal regulation. Downstream Provider also agrees to comply with any applicable delegation requirements and regulations between the MAO and First Tier Entity. 42 CFRs 422.504(i)(3)(iii) and 422.504(i)(4).

5. First Tier Entity agrees to pay Downstream Provider promptly according to CMS standards and comply with all payment provisions of law. 42 CFR 422.520(b).

6. Downstream Provider agrees to comply with CMS reporting requirements as specified in Sec 422.257 (encounter data) and Sec 422.516 (informational data). 42 CFR 422.504(a)(8).

7. Downstream Provider agrees to comply with CMS accountability provisions, including but not limited to the requirement to comply with Medicare laws, regulations, and CMS instructions, which are more fully documented in the MAO's policies and procedures. 42 CFRs 422.504(i)(3)(ii)(A) and 422.504(i)(4)(v).

Except as provided in this Addendum, all other provisions of the Agreement between Provider and First Tier Entity not inconsistent herein 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 such Agreement.