

ARIZONA STATE PHYSICIAN ASSOCIATION

Provider Agreement

Effective Date: _____

*3030 North Central, Suite 1405, Phoenix, Arizona 85012
(602) 265-2524 FAX (602) 265-3289*

ARIZONA STATE PHYSICIAN ASSOCIATION

Provider Agreement

This Agreement is made and entered into as of the _____ day of _____, 201_ by and between **Arizona State Physicians Association**, an individual practice association incorporated under the laws of the state of Arizona (Association) and _____ a Provider licensed to practice medicine in the State of Arizona (Provider).

I. GENERAL

- 1.1 Provider intends to participate in Association for purposes of providing Health Care Services to members of contracted health maintenance organizations, preferred provider organizations, and other payor groups and programs. Provider may also participate in various Association-sponsored programs that are developed from time to time to create a benefit of membership or opportunity to satisfy a need for Provider and Association.
- 1.2 Provider's membership in Association does not guarantee or require that Provider participate in any or all Association-sponsored programs.
- 1.3 Nothing in this Agreement is intended to create, nor shall it be construed to create, any right of Association to intervene in any manner with the method by which Provider renders Health Care Services to his or her patients, whether or not they may be Members of any Association contracted entities.
- 1.4 Nothing herein is intended to interfere with the Provider's own interpretation of Provider's professional ethics.
- 1.5 Association and Provider agree that Patients to whom Health Care Services are provided by Provider and for which Provider is compensated hereunder shall not be third party beneficiaries of the rights and obligations assumed by either party hereto.

II. DEFINITIONS

- 2.1 **Credentialing Program:** A continuous process whereby Association seeks and maintains professional information on all Providers and other Association members in order to document the professional quality and integrity of the Association's health care service providers.
- 2.2 **Health Care Service:** The service to be provided through Association by Participating Providers and Providers and for which the Provider is duly licensed by state to provide.
- 2.3 **Health Care Service Organization (HCSO):** An organization, such as a health maintenance organization (HMO), licensed to conduct business in the State of Arizona.
- 2.4 **Member:** Any person and /or family dependent covered under a group or individual benefit agreement with any payor or any beneficiary of an agreement under Section 3.4.

- 2.5 Non-Participating Provider: A Provider or other health care service provider not under contract with Association or contracted payor.
- 2.6 Patient: A Member covered under a contracted health plan or Payor requiring Health Care Services.
- 2.7 "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
- a. in accordance with the generally accepted standards of medical practice;
 - b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
 - c. not primarily for the convenience of the patient or Provider, or other Provider; or other providers of care, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means:

- standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
- Provider Specialty Society recommendations;
- the views of Providers practicing in the relevant clinical area; and
- any other relevant factors.

Preventive care may be Medically Necessary but coverage for Medically Necessary preventive care is governed by terms of the applicable Plan Documents.

- 2.8 Participating Provider: Any Provider or other health care service provider of Health Care Services who has entered into a contract with Association for the provision of Health Care Services to Patients under a payor benefit agreement or an agreement under Section 3.4.
- 2.9 Payor: An entity such as an insurance company, HMO, PPO or other party, responsible for paying for Health Care Services and defined by a benefit program.
- 2.10 Third Party Administrator (TPA): An entity licensed by the State of Arizona to pay claims, collect premiums, and perform other functions involved in an administrative process for health insurance companies or self-funded employer groups.
- 2.11 Active ASPA Member: A member of ASPA, (Provider, provider, or facility) who has completed all requirements of credentialing, and is current with payment of ASPA annual dues.

III. ASSOCIATION PERFORMANCE PROVISIONS

- 3.1 Association shall cause Provider's name, address, phone number and areas of practice to be disseminated to Members and to other Providers, hospitals, and others associated with HCSOs, TPAs or other Payors in Section 3.4.
- 3.2 Association shall maintain and be responsible for administrative, accounting, enrollment and similar functions inherent in and appropriate for the provision of Health Care Services to Members in accordance with Association's agreements with contracted HCSOs, TPAs, or other Payors, under Section 3.4.
- 3.3 Association shall institute and maintain utilization management programs, peer review programs, and any other programs deemed necessary to promote quality, efficient health care and to monitor the cost and utilization of medical services rendered to Members whenever feasible.
- 3.4 It is agreed that Association, in an effort to promote a cost-effective practice of medicine, may establish (itself or through a duly designated independent agent) exclusive and preferred provider and other alternate delivery system relationships between its Affiliated Provider and contracted Payors under which Affiliated Provider may be rendering professional Health Care Services to individuals.

Provider's behalf. Association agrees that it will use (and will require any duly designated independent agent to use) its best efforts to seek out and secure such contracts for its Provider for the provision of professional Health Care Services with duly qualified Payors on terms and conditions advantageous to Provider and Association, Provider may select on a case-by-case basis with which Payors he or she wishes to become Participating Provider.
- 3.5 Association shall maintain professional information on Provider through Association's Credentialing Program. This information may be made available to contracting payors or state or federal agencies required by law to access such information.
- 3.6 Neither the Association or any of its officers, directors, shareholders, employees, agents, affiliates or other representatives shall be in any way liable or responsible to any party or person for any act or omission of Provider in connection with their rendering Health Care Services to Patients.

IV. PROVIDER PERFORMANCE PROVISIONS

- 4.1 Provider shall render Health Care Services to Patients in a reasonable, efficient, and professional manner, which shall be in accordance with the standards of the community, and within the same time availability as offered to Patients who are not Members.
- 4.2 Provider may not differentiate or discriminate in the treatment of Patients or in the quality of services delivered to Patients on the basis of race, color, national origin, sex, age, religion, ancestry, marital status, sexual orientation, place of residence, health status, or source of payment.
- 4.3 Provider may not refuse to provide Health Care Services to any Patient on the basis of the extent of such Member's requirements for Health Care Services, consistent with Provider's capabilities and resources.

- 4.4 Provider shall cooperate with Association to assure twenty-four (24) hour accessibility for Patients.
- 4.5 If Provider is unable to provide services to a Member, Provider agrees to refer such Member to another Participating Provider consistent with the terms and conditions of the agreement and Patient medical needs for which Provider is providing Health Care Services through Association. A copy of such referral terms and conditions shall be furnished to Affiliate Provider for each agreement under which Provider furnishes Health Care Services. Any emergency referral to a Non-Participating or unapproved Provider shall be subject to peer and utilization review by Association or contracted Payor.
- 4.6 Provider agrees, to the extent legally and reasonably possible and consistent with good patient care, to cooperate with Association programs designed to share medical records among Participating Providers who have contracted with Association.
- 4.7 Provider agrees to look solely to the entity designated by the Association for compensation for Health Care Services rendered to Members, and will not, under any circumstances (including nonpayment by an HCSO or other payor), assert any claim for compensation, other than for collection from Members of co-payments, payments for non-covered services, and if provided for in the applicable agreements any deductibles and coinsurance. This promise not to seek payment from the Member (except for applicable co-payments, payments for non-covered services, co-insurance and applicable deductibles) shall survive any termination of this Agreement with respect to services provided during the term of this Agreement pursuant to its terms and shall govern any agreement that Provider may have now or in the future with a Member during the term of this Agreement.
- 4.8 In presenting its claim for collection to Payors, Provider submit claims for payment within Ninety (90) days of the date of service or, if Patient is hospitalized, from the date of discharge. Claims submitted after Ninety (90) days may not be eligible for payment, unless otherwise specified in a specific Association/Payor contract.
- 4.9 Provider warrants that if Health Care Services are provided by a Non-Participating Provider who is providing practice coverage for Provider the Non-Participating Provider agrees to accept all payment and utilization management provisions set forth for Provider in this Agreement and shall hold Members harmless from any payment made in contravention of this Agreement.
- 4.10 Provider shall keep accurate and current medical files/records concerning Members seen pursuant to this Agreement. Medical records will be kept for the minimum time required by state and federal laws. Provider shall cooperate fully with any utilization review, peer review, and other programs that may be established by Association or contracted Payors to promote quality medical care and to monitor the cost and utilization of medical services. Provider agrees to allow Association or its designee to review all phases of Provider's patient-care activities, including, but not limited to, review and copying of medical records and inspection of Provider's facilities and practice management. Nothing in this section shall require Provider to reveal any confidential information of a Member without such Member's consent or be inconsistent with HIPAA regulations.
- 4.11 Provider shall establish and maintain procedures and controls so that no medical or enrollee information contained in Provider's records be used by or disclosed by Provider, Contractor Representatives, or Contractor's agents, officers, or employees except as provided in Section 1106 of the Social Security Act, as amended, and regulations prescribed there under.

- 4.12 Provider shall procure and shall maintain policies of general liability, professional liability with minimum coverage in the amount of \$1,000,000 per incident and \$3,000,000 aggregate, and any other insurance that is required by Association during the term of this Agreement and shall provide proof of such coverage upon request.
- 4.13 Provider shall comply with all policies and procedures and protocols as established and modified from time to time by Association or contracted Payors relating to the provision of Health Care Services to Patients, including, but not limited to, policies and procedures of the Board and the various advisory committees of Association and protocols related to precertification of hospital admissions, lengths of stays, referrals to Providers and other health care providers, purchase or rental of prosthesis and durable medical equipment, and use of non-emergency ambulance service as long as such agrees with community standards for the provision of medical care.
- 4.14 Provider hereby represents and warrants that Provider is currently and for the duration of this Agreement shall remain licensed to practice Provider's health care profession in the State of Arizona, and shall comply with all State and Federal laws and regulations pertinent to such practice. Provider shall immediately notify Association in the event of loss of license.
- 4.15 In the event that Provider changes the location in which Health Care Services are provided, Provider shall notify Association not less than thirty (30) days prior to such relocation.
- 4.16 Provider shall notify the Association within ten (10) calendar days of any of the following:
- (a) any action taken to restrict, suspend or revoke Provider's license to practice his or her health care profession in this state; or
 - (b) any action taken to restrict, suspend or revoke Provider's medical staff privileges; or
 - (c) any suit brought against Provider for malpractice and the final disposition of such action; or
 - (d) any other situation which might materially effect Provider's ability to carry out his/her duties under this Agreement.
- 4.17 Provider warrants that the statements set forth in his/her application for membership are true and may be relied upon by Association and will continue to be true throughout the term of this Agreement and any renewal thereof unless Provider notifies Association in writing that any such statements are no longer true.
- 4.18 Provider shall comply with all of the terms contained within Exhibit A to the Provider Agreement, "Required Contract Language in Support of Medicare Advantage Agreements" attached hereto and incorporated here by this reference.

V. PAYMENTS

- 5.1 Provider agrees that the fees payable to Provider, under the fee schedules for Health Care Services covered under the various Benefit Agreements between the Members and contracted Payors, are such fees as shall be specified by Association (or its duly designated agent) to Affiliated Provider from time to time for the various agreements for the provision of Health Care Services.
- 5.2 Provider shall be entitled to bill and collect from Patients those amounts for co-payment, non-covered services, and applicable deductibles or co-insurance identified to Provider by Association or contracted Payor under various agreements.

- 5.3 Provider shall obtain a valid assignment of benefits form from Patients annually and shall retain a copy of assignment in Patient's medical record. Provider may use its customary assignment form or a form furnished by Association. Provider's failure to obtain a valid assignment of benefits shall not negate the prohibition against Provider seeking from a Patient any payment for Health Care Services different from the amounts specified by Association from time to time under the various agreements.

VI. TERMS OF AGREEMENT

- 6.1 This Agreement shall be in full force and effect for a period of one year commencing on the date first written above, and shall continue in effect under identical terms and conditions for additional one year periods thereafter unless either party terminates this Agreement in accordance with the provisions of this Article VII.
- 6.2 Either party shall have the option of terminating this Agreement, without cause, upon providing at least ninety (90) days' prior written notice to the other party. Provider may also terminate as a Participating Provider with a Payor upon providing Association with ninety (90) days' prior written notice.
- 6.3 Except as provided otherwise in this Agreement, Provider shall have the right to terminate this Agreement upon providing thirty (30) days prior written notice to Association of a material breach of this Agreement. Remedy of such breach by Association within twenty (20) days of the receipt of such notice shall revive the Agreement in effect for the remainder of its term, subject to any other properly exercised rights of termination contained in this section, in any other provision of this Agreement, or in the rules and procedures, Articles of Incorporation or Bylaws of Association as in force at time of termination.
- 6.4 In addition to the right to terminate without cause in Section 7.2, Association shall have the right to terminate or not to renew this Agreement on the terms and conditions of the policies and procedures, Articles of Incorporation, and Bylaws of Association as then in force. This includes the non payment of ASPA Membership Dues.
- 6.5 Each party acknowledges the right and obligation of the other to inform Patients that this Agreement has been terminated. If a Patient is under active treatment by Provider on the date this Agreement terminates, Provider shall abide by all the laws and ethical principles against the abandonment of patients and will accept Association's reimbursement schedule for this patient during the course of treatment. Following any notice of termination, Provider shall fully cooperate in all matters relating to the orderly transfer of Patient care to other Participating Providers.
- 6.6 This Agreement shall automatically terminate upon the revocation or suspension of Provider's license.

VII. ARBITRATION

- 7.1 Before instituting arbitration under the terms of this Agreement, Provider must exhaust any and all administrative relief that is available under the Articles of Incorporation, Bylaws, or policies and procedures of Association then in force. The parties agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement.
- 7.2 If any dispute or controversy arising out of this Agreement is not covered by duly adopted policies and procedures of Association and cannot be informally settled by the parties, such controversy or dispute

shall be submitted to arbitration in Phoenix, Arizona, and for this purpose each party hereby expressly consents to such arbitration in such place. If the parties cannot mutually agree upon an arbitrator to settle their dispute or controversy, each party shall then select one arbitrator and the two arbitrators so selected shall select a third person who shall be the third arbitrator. The decision of the arbitrator shall be binding upon the parties hereto for all purposes, and judgment to enforce any such binding decision may be entered in Superior Court, Maricopa County, Arizona. For this purpose each party hereby expressly and irrevocably consents to the jurisdiction of said court. If either party fails to select any arbitrator within fifteen (15) days after written demand from the other party to do so, or if the two arbitrators selected fail to select a third person to serve as arbitrator within fifteen (15) days after the last of such selected arbitrators is appointed the then Presiding Civil Judge of the Maricopa County Superior Court shall select such arbitrator, or at the election of the parties hereto, the arbitrator shall be selected pursuant to the then-existing rules and regulations of the American Arbitration Association governing commercial transactions. At the request of either party, arbitration proceedings shall be conducted in utmost secrecy. In such case, all documents, testimony and records shall be received, heard, and maintained by the arbitrator in secrecy, available for inspection only by either party and by their attorneys and experts who shall agree, in advance and in writing, to receive all such information in secrecy. In all other respects, the arbitrator shall conduct all proceedings pursuant to the Uniform Arbitration Association governing commercial transactions to the extent such rules and regulations are not inconsistent with such Act or this Agreement.

- 7.3 Nothing contained herein is intended to create nor shall it be construed to create any right of any Patient to initiate independently the arbitration procedure specified in Section 8.2 above. This limitation shall also apply to Association and to Provider to prevent either or both parties from initiating such procedure in any representative capacity on behalf of a Patient.
- 7.4 Each party agrees to provide timely notice to each other if either party becomes aware of facts of circumstances which indicate a reasonable possibility of litigation with any third person or entity and which are relevant to any rights, obligations, or other responsibilities or duties provided for under this Agreement with respect to any party hereto. Each party further agrees not to counsel or encourage any third party or entity to pursue litigious action against the other party.

VIII. INDEPENDENT CONTRACTOR

- 8.1 Provider enters into this Agreement as an independent contractor and not otherwise and this Agreement does not make Provider or Association employees, agents, partners, or joint venturers of the other. Provider shall not publicize any relationship with Association without prior written permission. This Agreement in no way prevents Provider from participating in or contracting with any payor organization, other health care service organization or health care systems.
- 8.2 Provider agrees that, in the case of dual contracts with any Payor, the contract between Payor and Association will become the primary contract for Provider's services unless Provider notifies Association in writing of desire to act otherwise.
- 8.3 Nothing in this Agreement shall be construed or deemed to create, between the parties of this Agreement or Payors, a relationship of employer and employee or principal and agent, or any relationship other than that of independent parties contracting solely for the purpose of carrying out the provisions of this Agreement. Neither party shall be liable to third parties for acts or omissions of agents, representatives or employees of the other party.

IX. NOTICES

- 9.1 Any notice required to be given pursuant to the terms and provisions of this Agreement, unless otherwise indicated herein, shall be in writing and shall be sent by certified mail, return receipt requested, postage pre-paid, to Association and to Provider at the addresses appearing at the end of this Agreement. Notwithstanding the above, information pertaining to participation with new or existing Payors shall be sent via fax, e-mail or other electronic medium as determined appropriate by Association.
- 9.2 Notices shall be deemed received upon receipt by the addressee.

X. MODIFICATIONS

Association and Provider expressly intend that the terms of this totally integrated writing shall comprise the entire Agreement between the parties and shall not be subject to rescission, modification, or waiver except as defined in a subsequent written instrument executed by both parties hereto and, if required by applicable law, approved by the Arizona Department of Insurance.

XI. INVALIDITY OR UNENFORCEABILITY

The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability or any other term or provision.

XII. ATTORNEY'S FEES

If any action at law or in equity, including an action for declaratory relief, is brought to enforce or interpret the provisions of the Agreement, the prevailing party shall be entitled to recover reasonable attorney's fees and all court costs from the other party, which fees may be set by the court in the trial of such action or may be enforced in a separate action brought for that purpose, and which fees shall be in addition to any other relief which may be awarded.

XIII. MISCELLANEOUS

- 13.1 No waiver of any right hereunder shall be effective for any purpose unless it is in writing and signed by the party waiving such rights and shall not constitute waiver of any other right.
- 13.2 No right created under the provisions of this Agreement may be assigned and no duty hereunder may be delegated without the prior written consent of the other party.
- 13.3 Each party hereto agrees to perform all such acts as reasonably may be necessary to fulfill the purposes and intent of this Agreement. The toleration by either party of defective performance of any provision of this Agreement shall not be construed as a waiver of either the right to performance or the terms and conditions expressed in this Agreement.
- 13.4 The terms and provisions of this Agreement shall be construed in accordance with the laws of the State of Arizona, as they may exist from time to time.

EXECUTED on the day and year written above.

Provider

Arizona State Physicians Association Inc.

Signature

Director of Operations

Printed Name:

Date:

Printed Name

3030 N Central Avenue, Suite 1405
Phoenix, AZ 85012
602-265-2524

Date:

Address

City, State Zip Code

Telephone Number

PROVIDER AGREEMENT

REQUIRED CONTRACT LANGUAGE IN SUPPORT of ALL MEDICARE ADVANTAGE AGREEMENTS

WHEREAS, Arizona State Physicians Association, (“ASPA”) has or intends to contract directly with a Medicare Advantage Plan (“Contractor”) who in turn has or seeks to have a contract with the Center for Medicare and Medicaid Services (“CMS”) to provide, arrange for or administer the provision of health care services to Medicare beneficiaries; and

WHEREAS, ASPA has or obtains contracts with Providers, hospitals and other health care practitioners and entities (“Providers”) to provide, arrange for or administer at pre-determined rates, the delivery of such health care services; and

WHEREAS, ASPA and Contractor desire to effect a contract to allow Contractor to provide covered health care services to Medicare beneficiaries enrolled with Contractor; and

WHEREAS, Medicare Advantage Plan, Arizona State Providers Association and Providers have negotiated a Definitive Agreement (the “Definitive Agreement”)

NOW THEREFORE, in consideration of the mutual covenants and agreements herein, the parties hereto hereby agree as follows:

SECTION 1 DEFINITIONS

Centers for Medicare and Medicaid Services (CMS) means the agency within the Department of Health and Human services that administers the Medicare program

Medicare Advantage Plan means a health plan that has entered into a contract with CMS to provide services to Medicare beneficiaries under the Medicare Advantage Program.

Medicare Advantage is an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Member means an individual who has enrolled in or elected coverage through a Medicare Advantage Plan. A Member is also known as an enrollee.

SECTION 2 EFFECTIVE DATE; SCOPE

This Addendum A is effective as of the date first written in the **Definitive** agreement (“Effective Date”). This Addendum A shall only apply to the provision of covered Medicare Program health care services to Medicare beneficiaries enrolled with Contractor.

SECTION 3 FINANCIAL AGREEMENTS.

Contractor shall pay to Participating Providers and Participating Providers shall accept as payment in full from Contractor for services rendered to Contractor members. Contractor agrees that all “clean” claims are processed

and paid within thirty (30) days from date of receipt. Amounts to be agreed upon by the parties hereto. Participating Provider shall have the right to determine on a case-by-case basis with which Contractors he or she wishes to become a Participating Provider. [42 CFR 422.520 (b)].

SECTION 4 MEDICARE ADVANTAGE REQUIREMENTS

Provider agrees to comply with the requirements set forth in this addendum for Medicare Members.

- 1. Inspection and Audit of Records and Facilities.** Provider shall provide access at reasonable times upon demand by Provider and Government Agencies to periodically audit or inspect the facilities, offices, equipment, books, documents and records of Provider relating to the performance of the Addendum and the Medicare Covered Services provided to Medicare Members, including without limitation, all phases of professional and ancillary medical care provided or arranged for Medicare Members by Provider, Medicare Member medical records and financial records pertaining to the cost of operations and income received by Provider for Medicare Covered Services rendered to Medicare Members. Such access shall be limited to that necessary to perform the audit. Provider shall comply with any requirements or directives issued by Provider and Government Agencies as a result of such evaluation, inspection or audit of Provider. Provider shall retain the books and records described in this Section for at least ten (10) years and acknowledge that Government Agencies may have the right to inspect and audit Provider's books and records for ten (10) years beyond termination of the Addendum or until the conclusion of any governmental audit that may be initiated that pertains to such records, whichever is latest unless: (i) the CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies Contractor or Provider at least thirty (30) days before the normal disposition date; (ii) there has been a termination, dispute, or fraud or similar fault by Provider, in which case the retention may be extended to ten (10) years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or (iii) the CMS determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate, and audit Provider at any time. Without limiting the foregoing, following the commencement of any audit by a Government Agency, Provider shall retain its relevant books and records until completion of said audit. The provisions of this Section shall survive termination of the Addendum for the period of time required by State and Federal Law. [42 CFR 422.504 (e) (4) and 422.504(i)(2)(i) and (ii)]
- 2. Compliance.** Provider agrees to comply with Contractor's policies and procedures and all applicable Federal, State and local laws, rules and regulations, now or hereafter in effect, including but not limited to 42 CFR §422.118 and 422.504 (a)(13) regarding the performance of Provider's obligations hereunder, including without limitation, laws or regulations governing the record timeliness, adequacy and accuracy, Medicare Member and Beneficiary privacy and confidentiality along with the appeal and dispute resolution procedures related to Covered Services provided to a Medicare Member, to the extent that they directly or indirectly affect Provider, Provider's facilities or Contractor and bear upon the subject matter of this Addendum.
- 3. Applicable Federal Laws.** The compensation payable to Provider pursuant to the Addendum consists of Federal funds; accordingly, Provider acknowledges that Provider shall be required to comply with certain laws applicable to entities and individuals receiving Federal funds.
- 4. Nondiscrimination.** Provider understands that CMS requires compliance with the provision of this Section as a condition for participation in Medicare plans. Provider and Contractor Representatives shall comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. Section 200d et. seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C.

Section 794) and the regulation there under, Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Section 1681 et. seq.), the Age Discrimination Act of 1975, as amended (42 U.S.C. Section 6101 et. Seq.), Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended (42 U.S.C. Section 9849), the Americans With Disabilities Act (P.L. 101-365) and all implementing regulations, guidelines and standards as are now or may be lawfully adopted under the above statutes.

- 5. CMS Agreement Compliance and Delegation Requirements.** PROVIDER shall comply with all requirements in the CMS Agreement, which are applicable to Provider as a result of the Addendum. Without limiting the foregoing, Provider shall ensure that all provisions of the CMS Agreement, which are applicable to Provider and Providers representatives, are included in any of Contractor's subcontracts. A copy of the CMS Agreement shall be made available to Provider upon Provider's request. Provider shall comply with Title XVIII of the Social Security Act and the regulations adopted there under by CMS for the Medicare program. [42CFRs 422.504(i)(3)(iii) and 422.504(i)(4)]
- 6. Medicare Participation Standards.** Provider and Contractor Representatives shall 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 to provide Medicare Covered Services to Medicare Members shall comply with facility standards established by CMS.
- 7. Certification of Truth and Accuracy.** Provider is required to submit claims or other data to the contractor that includes a certification from the Provider, that such data is accurate, complete and true.
- 8. Submission of Claims.** Provider agrees to submit appropriate encounter to Contractor regardless of payment methodology.
- 9. No Billing of Medicare Members (Medicare Member Hold Harmless Provision).** Provider hereby agrees that in no event, including, without limitation, non-payment by Contractor, Contractor's insolvency or breach of the Agreement, shall Provider or any Participating Provider covering for Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Medicare Member or person, other than Contractor, acting on his or her behalf, for Medicare Covered Services provided pursuant to the Addendum. This provision shall not prohibit collection of deductibles, co-payments, co-insurance and/or non-Medicare Covered Services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Medicare Members in accordance with terms of the Medicare Member's Subscriber Agreement and Coverage Description.

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

service basis to Medicare Members provided that Provider has requested that a Medicare Member sign a waiver indicating the Medicare Member's financial responsibility for charges for non-Medicare Covered Services and as long as Medicare Member is informed by Provider that said services are non-Medicare Covered Services prior to being rendered and that Medicare Member signs such waiver prior to or at the time non-Medicare Covered Services are rendered. [422.504(g)(1)(i); 422.504(i)(3)(i)]

Provider agrees that cost sharing for dual eligible Member is limited to the Medicaid (including Medi Cal & AHCCCS) cost sharing limits and that for those dual eligible Members the Provider will accept the Medicare Advantage Plan payment as payment-in –full or will separately bill the appropriate state source for any amounts above the Medicaid (Medi Cal & AHCCCS) cost sharing. [422.504(g)(1)(iii)].

10. Accountability and Contractor Cooperation. Provider acknowledges and agrees that Contractor shall remain accountable to CMS for complying with its obligations under the CMS Agreement. Provider shall cooperate with Contractor in CMS required oversight activities.

11. Confidentiality of Medicare Member Records. Provider shall establish and maintain procedures and controls so that no medical or enrollee information contained in Provider's records be used by or disclosed by Provider, Contractor Representatives, or Contractor's agents, officers, or employees except as provided in Section 1106 of the Social Security Act, as amended, and regulations prescribed there under. [42CFRs 422.118 and 422.504 (a)(13)]

12. Compliance with Reporting Requirements. Provider shall cooperate with Contractor in submitting to the DHHS statistical and encounter data pertaining to Medicare Covered Services provided by Provider, and any other reports that DHHS may reasonably request to carry out its functions under the Medicare Advantage program as specified in Sec 422.310 (risk adjustment data) and Sec 422.516 (informational data). [42 CFR.504(a)(8)]

13. Compliance with Policies and Procedures. Provider shall comply with all Contractor policies and procedures.

14. Specific Provisions Pertaining to Benefits, Coverage and Beneficiary Protections. Without limiting any of Provider's other obligations under this Addendum, Provider specifically agrees to comply with the following policies and procedures:

- a. Contractor's policies pertaining to the collection of co-payments, which prohibit the collection of co-payments for routine injections, routine immunizations, flu immunizations, and the administration of pneumococcal/pneumonia vaccine.
- b. Contractor's policies pertaining to pre-certification which provide that Medicare Members may directly access a contracted provider for mammography and influenza vaccinations and women's health specialists for routine and preventative health care.
- c. Contractor'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. Contractor's policies pertaining to enrollment and assessment of new Medicare Members including requirements to conduct a health assessment of all new Medicare Members within ninety (90) days of the effective date of their enrollment.

15. Term of Addendum, Renewal and Termination.

- a. **Termination Without Cause.** This Addendum may be terminated at any time by either party without cause upon thirty (30) days prior written notice to the other party.
- b. **Termination of CMS Agreement.** In the event that CMS Agreement is not executed, or is terminated or not renewed, the provisions of this Addendum relating to the Medicare Members shall automatically terminate, unless otherwise specified by ASPA.
- c. **Medicare Advantage Termination** The termination provisions contained in this Addendum shall permit Contractor to terminate the Provider with respect to Medicare Members in accordance with the terms contained in the applicable provision. In the event Provider or Contractor terminates this Addendum with respect to Medicare Members, the Agreement shall not terminate with respect to non-Medicare Members.

16. Survival of Provisions following Termination. Provider agrees that the provisions of this Section and the obligations of Provider herein shall survive termination of this Addendum regardless of the cause giving rise to such termination, and shall be construed to be for the benefit of Medicare Members.

SECTION 5 NOTICE

Any notice required or permitted to be given pursuant to this Addendum shall be submitted in writing to the Arizona State Providers Association at the addresses below:

Arizona State Physician Association
3030 North Central Avenue, Suite 1405
Phoenix, AZ 85012
Attn: Executive Director

- 1. Medicare Participation.** Provider agrees to immediately notify ASPA if he/she is excluded from participation in Medicare.

SECTION 6 GENERAL PROVISIONS

- 1. Confidentiality.** The parties acknowledge that as a result of this Agreement, each may have access to certain trade secrets and other confidential and proprietary information of the other. Each party shall hold such trade secrets and other confidential and proprietary information, including the terms and conditions of this Agreement, in confidence and shall not disclose such information, either by publication or otherwise, to any person without the prior written consent of the other party except as may be required by law and except as may be required to fulfill the rights and obligations set forth in this Agreement.
- 2. Assignment and Delegation of Duties.** Neither party may assign duties, rights or interests under this Agreement unless the other party shall so approve by written consent.
- 3. Interpretation.** The validity, ability to enforce, and interpretation of this Agreement shall be governed by any applicable federal law and by the applicable laws of the state of Arizona.

4. Amendment.

- (a) This Addendum may not be amended without a written notice signed by both of the parties hereto.

- (b) In the event that state or federal law or regulation should change, alter or modify the present services, levels of payments, or standards of eligibility of Medicare members, such that the terms, benefits and conditions of this Agreement must be changed accordingly, then upon notice from Contractor, Provider shall continue to perform services under this Addendum as modified.

END OF ADDENDUM