Desert Physician Association

PHYSICIAN SERVICE AGREEMENT
PHYSICIAN INFORMATION

Physician Printed Name _____

Practice Name _____

Address _____

City _____ County _____ State AZ Zip _____

Phone _____ Fax _____ E-mail _____

Website _____

Organization: Sole Practitioner, Partnership, Corporation, Other (Specify)_____

Tax ID _____

Contact Person _____ Phone _____

Billing Address _____ Phone _____

Address _____

City _____ County _____ State _____ Zip _____

Other locations.

Address _____

City _____ County _____ State AZ Zip _____

Phone _____ Fax _____

Attach list of additional locations

PHYSICIAN SERVICE AGREEMENT

This Agreement is made and entered into as of the ___day of _____, 2013, by all the party(ies) designated on the Cover Sheet as “Physician” and Desert Physician Association (“IPA”), an Arizona corporation. ("Physician" and other capitalized terms shall have the meanings in Attachment A.)

RECITALS:

Physician wishes to contract with various Health Plans to provide medical services to patients for capitation or fee-for-service payments. IPA desires to arrange for and administer such contracts.

Physician is willing to participate in IPA and to permit IPA to arrange and administer Health Plan contracts for Physician on the terms set forth herein. Physician agrees that IPA may arrange for and administer Health Plan contracts which do not require the services of Physician and which IPA may not offer to Physician.

NOW, THEREFORE, in consideration of their respective promises and undertakings and for other good and valuable consideration, whose receipt and sufficiency are hereby acknowledged, the parties agree as follows:

1 SCOPE OF AGREEMENT

1.1 This agreement sets forth the rights, responsibilities, terms and conditions governing IPA and Physician’s status as a participating physician of IPA as it pertains to IPA’s Health Plan agreements, medical services to be provided to covered individuals designated by Health Plans, including individuals covered under Health Plan’s commercial plans, Medicare HMO plans, and other plans.

1.2 Physician (and, by signature, each individual Physician who will provide Physician Services under this Agreement) warrants that each member, independent contractor and employee who will provide Physician Services under this Agreement shall abide by the terms and conditions of this Agreement.

1.3 In performing the Agreement and in any services rendered or performed for Enrollees by either party, it is agreed that IPA and Physician are at all times acting and performing as independent contractors and that neither IPA nor Physician shall be considered the agent, servant, or employee of or joint venturer with the other or any Health Plan. With the exception of Section 6, this Agreement is not intended to benefit any third parties.

2 DEFINITIONS (See Attachment A)

3 REPRESENTATIONS AND WARRANTIES

3.1 Physician. Physician represents and warrants to IPA, and IPA shall rely thereon in contracting with Health Plans, that Physician: (i) is and shall remain, during the term of this Agreement, in good standing under applicable laws and regulations governing Physician’s practice; (ii) has any and all licenses or certifications required to perform Physician’s duties hereunder; and (iii) has not and shall not discriminate in the selection or retention of employees on the basis of gender, race, age, religion, national origin or any other grounds prohibited by law. Physician (including each individual Physician) further represents and warrants (i) that no proceeding, action or investigation that could lead to the revision, revocation, suspension, limitation or voluntary relinquishment of any such license or certification, or that could impair materially Physician’s ability to carry out Physician’s obligations under this Agreement, is pending or has been threatened, and (ii) that executing and performing Physician’s obligations under this Agreement shall not cause Physician to violate any term or covenant of any other agreement or arrangement existing or hereafter executed.

Physician herein grants IPA power of attorney to enter into health plan contracts and bind Physician to participation in such contracts unless Physician provides notification to IPA of their decision not to participate in a health plan contract entered into by IPA within 10-days of announcement of the contract by IPA.

3.2 Qualified Personnel. Physician warrants and shall require that all personnel employed by, associated with or under contract with Physician (i) are and shall remain licensed or certified and

supervised (when and as required by law), and qualified by education, training and experience to perform their professional duties, and (ii) are and shall be acting within the scope of their licensure or certification.

3.3 IPA. IPA represents and warrants to Physician that it is in good standing under applicable laws and regulations governing its existence and operations and that this Agreement has been executed by its duly authorized representative.

3.4 Audit. IPA, Physician and Health Plans may audit compliance with this section on notice.

4 PROVISION OF PHYSICIAN SERVICES

4.1 Provision of Covered Services. Physician agrees to provide all Medically Necessary Physician Services to contracted Health Plan Enrollees in accordance with generally accepted community professional standards and this Agreement. Physician shall provide or arrange for the provision of Covered Services in accordance with IPA Policies and Procedures and the requirements of the applicable Health Plan. If designated as a Primary Care Physician by IPA and the applicable Health Plan, Physician agrees to provide medical services to Enrollees selecting or assigned to Physician, regardless of whether Physician has previously seen or treated the Enrollee.

4.2 Availability of Physician Services. Physician shall render Physician Services to Enrollees within a reasonable time after an Enrollee requests an appointment and in accordance with applicable Health Plan contracts, as may be modified from time to time. Such modifications are not, and shall not be deemed to be, amendments to this Agreement and shall be effective on notice to Physician. Physician shall keep reasonable office hours and call schedules. Physician shall ensure that Physician Services are available twenty-four (24) hours per day, seven (7) days per week, including coverage, consistent with IPA and the applicable Health Plan Provider Manual, after Physician's regular office hours or when Physician is otherwise unavailable. Physician shall ensure that covering Providers do not under any circumstances bill Enrollees (except for applicable Copayments, Coinsurance and Deductibles) for any Covered Services.

4.3 New Patients. Subject to any limitations imposed by the Medicare program, Physician may decline to accept Health Plan Enrollees as new patients upon thirty (30) days written notice to IPA and any required notice to IPA Health Plans. Physician understands that Physician shall not accept Enrollees as new patients again without written approval from the applicable Health Plans.

4.4 Non-Discrimination. Physician shall not discriminate against Enrollees on the basis of their status as Enrollee, source of payment, gender, race, age, religion, national origin, mental or physical disability, health status, the cost or extent of Covered Services required, or any other grounds prohibited by law (including, under Public Law 105-33, Title VI of the Civil Rights Act of 1964, Age Discrimination Act of 1975, and Americans with Disabilities Act) or this Agreement. Physician shall provide services to Enrollees with at least the same degree of care and skill as Physician customarily provides to patients who are not IPA contracted Health Plan Enrollees.

4.5 Medical Records. Physician shall maintain and retain usual and customary and timely and accurate medical records for each Enrollee for whom Physician provides or arranges Covered Services and safeguard the privacy of any patient identifying information as required by law. Such information includes, but is not limited to, the provision of Physician Services, the cost of said services, and payments received by Physician from IPA or Enrollee (or from others on Enrollee's behalf) as required by applicable state and federal laws, licensing and reimbursement entities, or contracted Health Plans, and in accordance with accepted medical standards applicable to such records. Physician will make such records available to other medical providers, subject to applicable confidentiality requirements, when such with all applicable law, Physician shall implement and maintain procedures for maintaining the confidentiality of Enrollee medical records and treatment. Subject to applicable law and to standards on confidentiality and patient authorization, IPA, Health Plans, payors and plan sponsors, state and federal regulators, and their respective agents and representatives shall have the right to inspect, evaluate and audit, make copies and prepare abstracts of Enrollee medical records, books, contracts, patient care documentation, and other relevant records during regular business hours on prior notice to Physician, and Physician shall provide copies of such records to IPA, Health Plan, payors and plan sponsors at no cost promptly on written request. . Subject to applicable law and to standards on confidentiality and patient authorization, Physician shall cooperate in the orderly transfer of Enrollees medical records when requested by Health Plan, an Enrollee or Enrollee's authorized representative.

4.6 Admissions. Physician shall admit Enrollees requiring Hospital Services only to **Participating Hospitals designated by IPA or the applicable Heath Plan**, unless the necessary Hospital Services are not available from a designated Participating Hospital or in the case of an emergency. Physician shall seek prior authorization from IPA or the applicable Health Plan except in the case of an emergency, when admitting Enrollees to a Hospital. Physician shall notify IPA no later than the next working day following an emergency admission or such other time as specified by the applicable Health Plan.

4.7 Referrals. Physician shall refer Enrollees only to other **IPA or applicable Health Plan Participating Providers** unless required medical services are unavailable through an IPA or Health Plan Participating Provider. Physician shall seek prior authorization from IPA (or from the appropriate Health Plan as specified in the Health Plan agreement with IPA) before referring Enrollee to a non-Medical IPA Provider, and/or from Health Plan before referring Enrollee to Non-Participating Physician except in the case of an emergency. Physician agrees to notify IPA or appropriate Health Plan no later than the next working day following an emergency referral.

4.8 Reciprocity. Physician shall arrange for the provision of Covered Services in a manner consistent with this Agreement to any Enrollee whose usual place of residence is outside the area in which Physician customarily practices. Health Plan may direct Payors to pay, and Physician shall accept as compensation in full for those services (except for applicable Copayments, Coinsurance or Deductibles), fee-for-service payments based on Health Plan's then prevailing fee schedule.

5 COMPLIANCE WITH POLICIES AND PROCEDURES

5.1 Compliance with IPA Policies and Procedures, Rules and Regulations. Physician agrees to comply with and abide by all quality review and improvement, peer review, pre-authorization, utilization review, credentialing, medical, administrative and other policies and procedures relating to the delivery of medical services, and also comply with all applicable State and Federal laws and regulations and policies, manuals and procedures relating to Medicare, Medicare Advantage, Medicaid (AHCCCS) and contracted Health Insurance Organizations including the Balanced Budget Act of 1997 (Public Law 105-33) and any laws, regulations or requirements passed by federal or state governments and any related agency and CMS. Physician also agrees to be bound by all of the provisions of the Administrative and Utilization Review and Quality Management Policies and Procedures of IPA and the respective Health Plans, CMS and IPA's Rules & Regulations. Physician recognizes that provisions in said documents may be amended from time to time. These amendments are not, and shall not be deemed to be, amendments to this Agreement. Such modifications shall be effective on notice to Physician, and Physician agrees to be bound by such amendments.

5.1.1 As required by the Medicare program and coordinated by IPA, Physician shall provide direct access to mammography screening and influenza vaccination, not impose cost-sharing for influenza vaccine or pneumococcal vaccine, follow procedures to identify, assess and establish treatment plans for persons with complex or serious medical conditions, conduct a health assessment of all new enrollees with 90 days of the effective date of enrollment, and agree to serve plan members for the period of time specified by the plan.

5.1.2 Physician understands that and agrees to comply with Medicare plan agreements which shall specify delegation requirements, require payment and incentive arrangements be disclosed, insertion of prompt payment provisions to which Physician agrees, and application of laws affecting persons receiving Federal funds and notice thereof.

5.1.3 As required by applicable law, Physician shall not employ or contract with persons excluded from participation in the Medicare program under Sections 1128 or 1128A of the Social Security Act.

5.2 Prior Authorizations and Referral Policy.

5.2.1 Referral Policy. Subject to the Enrollee's Health Benefit Program and IPA Provider Manual, if applicable, Physician shall refer an Enrollee to, and arrange for Covered Services from, Health Plan Participating Providers who have contracts with IPA. Upon notice from IPA that IPA or Health Plan has contracted with a vendor to provide Enrollees with outpatient services, supplies or goods, Physician shall refer an Enrollee needing such services, supplies or goods to the specified vendor.

5.2.2 Non-Complying Referrals. If a Physician refers an Enrollee to another Provider in a manner contrary to the referral policy of IPA or the applicable Health Plan, the additional cost of services rendered by such Outside Provider may be the financial responsibility of Physician, and IPA or the applicable Health Plan may fund such liability from the amounts otherwise due Physician pursuant to this Agreement of Health Plan contract or establish a withhold or offset fund with moneys otherwise due Physician.

5.3 Accreditation and Review Activities. Physician shall take all actions, including the auditing of Enrollees medical records, reasonably necessary to assist IPA and contracted Health Plans to obtain external accreditation by the National Committee for Quality Assurance or any other similar organization selected by Health Plan. Physician shall cooperate fully with any governmental review of Health Plan or a Health Benefit Program. Physician acknowledges IPA and Health Plans' right to cooperate with, and shall assist IPA and Health Plan in responding to requests from the Arizona Board of Medical Examiners, the Arizona Board of Osteopathic Examiners in Medicine and Surgery and the Healthplan Employer Data Information Set (HEDIS). Physician also acknowledges IPA and Health Plan's right to report to and access the National Practitioner Data Bank ("Data Bank") as it relates to Physician. Upon request, Physician shall assist IPA and Health Plan in accessing and reporting to the Data Bank, including submitting inquiries to the Data Bank.

5.4 Audits.

5.4.1 Physician Audit. Upon required notice by IPA or Health Plan, Physician shall participate in Participating Provider audits conducted by IPA and/or contracted Health Plan to ensure that Physician is complying with Health Plan standards, and Physician shall provide certain administrative policy and procedure data and documentation to IPA and/or Health Plan.

5.4.2 Medical Records Audit. Within sixty (60) days of the commencement of this or any contracted Health Plan agreement and periodically as required by the applicable health plan contract thereafter, Physician shall participate in medical records audits conducted by IPA and/or Health Plan to ensure that Physician is keeping proper and sufficient records of Enrollee visits, medical histories, diagnoses, treatments, therapies and similar information sufficient to character the content and purposes of each encounter and certifying the completeness and truthfulness of encounter data.

5.4.3 Facilities Audit. Within sixty (60) days of the commencement of this of this or any contracted Health Plan Agreement and bi-annually thereafter, Physician shall participate in facilities audits conducted by Health Plan to ensure that Physician is providing adequate, orderly and efficient services. The audits may include inspection and evaluation of the accessibility of Physician's facilities to the disabled, control procedures for narcotics and other medications, sterilization procedures and quality of equipment.

5.4.4 Inspections/Deficiencies. Audits shall, at IPA's or Health Plan's request, include on-site inspections of Physician's facilities. Physician shall correct any deficiencies revealed by the audits.

5.5 Credentialing. Physician agrees to be subject to and comply with credentialing standards outlined and identified in IPA Rules & Regulations, as well as all standards established by Health Plan contracts entered into by IPA. Physician shall provide IPA with the information necessary to ensure compliance with this paragraph. Unless expressly waived in writing, Physician shall maintain staff privileges with at least one (1) Participating hospital. Physician shall notify IPA within two (2) business days of any voluntary relinquishment or any revision, revocation, suspension or limitation placed on Physician's license to practice in Arizona or hospital staff privileges. Physician shall not allow any personnel employed by, associated with or under contract with Physician to provide any services to Enrollees when such personnel's licensure or hospital staff privileges are restricted by revision, revocation, suspension or limitation. Physician acknowledges that Health Plan may retain the right to terminate any Physician member of IPA who does not meet or maintain the Health Plan's credentialing or recredentialing standards.

5.6 Assignments of Benefits and Consents to Release of Medical Information. Physician shall obtain from all Enrollees to whom Physician Services are provided (i) signed assignments of benefits authorizing payment for Physician Services to be made directly to Physician or Physician's designee, and (ii)

consents to the release of medical information to IPA, Health Plan, payors, plan sponsors and their respective agents and representatives.

5.7 Notices to IPA. Physician shall notify IPA of: (i) any suit or other action brought against Physician by or relating to any Enrollee, Payor, Plan Sponsor or Health Benefit Program; (ii) any governmental action or investigation involving Physician or any entity in which Physician holds more than a five percent (5%) interest, or if a petition in bankruptcy has been filed by or against Physician or any such entity; (iii) any new investment in or change to Physician's ownership interest in any insurer, health maintenance organization, health management or health care delivery business in which Physician holds more than a five percent (5%) interest, or if a petition in bankruptcy has been filed by or against any such entity; (iv) any sale of all or any part of Physician's practice, or, if Physician is a corporation or other legal entity, any sale of stock (or its equivalent) of such entity (to other than a participating Physician as a new member of Physician practice); or (v) any adverse action regarding the licensure or medical staff privileges of Physician. All notices required by this section shall be provided to IPA within five (5) business days of the date that Physician acquired knowledge of the occurrence of the event requiring notice. At IPA's request, Physician shall provide all known details of the nature, circumstances, status and disposition of any suits, claims, actions or investigations.

5.8 Grievance Procedure. Physician agrees to cooperate and participate with IPA in its grievance procedures to resolve disputes which may arise between Physician and IPA and/or Health Plan and its Enrollees. Physician will comply with all final determinations made through the grievance procedures.

5.9 Share Information. Physician further agrees that IPA may share information, including but not limited to credentialing, recredentialing, quality management, and utilization management information as related to the treatment of Enrollees. However, its is expressly understood that the information shall not be shared with anyone other than IPA and applicable Enrollee's Health Plan, unless required by law or pursuant to prior written consent of Physician(s) involved.

5.10 Insurance and Malpractice Coverage. Physician at his/her sole expense shall maintain at all times, such policies of comprehensive and general liability, professional liability, and worker's compensation coverage, with such carriers and in such amounts as IPA deems necessary and appropriate for insuring IPA and its members, employees, agents representatives and subcontractors (as applicable) against any claim or claims for damages arising as a result of injury to property or persons, including death, occasioned directly or indirectly in connection with the performance of medical services contemplated by this Agreement and/or the use of any property or facilities provided by Physician, and activities performed by Physician in connection with this Agreement. Upon request, Physician shall provide IPA and or contracted Health Plan with evidence of said coverage, of which the minimum professional liability coverage shall be $1,000,000 per occurrence and $3,000,000 in aggregate, or such amount as required by a Health Plan or State law, whichever is greater. Physician shall require the carrier(s) to provide IPA thirty (30) days advance written notice of any suspensions, cancellations or modifications of insurance.

5.11 Notice of Claim. Physician shall notify IPA in writing, within five business days or such lesser period of time as required by the applicable Health Plan or the applicable statute of this State, of any Enrollee claim or demand alleging medical malpractice.

5.12 Indemnification. Physician shall defend, indemnify and hold harmless IPA from and against any and all loss, damages, costs, and claims that may arise out of any breach of Physician's obligations to IPA under this Agreement or out of any breach by a third-party of its contract duties or obligations to Physician.

6 OBLIGATIONS OF IPA

6.1 It is agreed that IPA shall promote the cost-effective practice of medicine by establishing (itself or through duly designated independent agent(s)) relationships between its Participating Physician Providers, Health Plans and other third-party payors under which Physician may provide professional medical services to individuals. Where possible, such contracts shall include terms providing for risk-sharing and incentive payments based on responsible utilization management supplied by IPA and its Participating Physician Providers. A portion of such incentive payments may be payable to IPA for inclusion in a shared risk pool reserve fund, as deemed prudent in relation to the risk assumed by IPA

and its Participating Physician Providers. IPA may also specify an amount of the payments for professional medical services to be retained by IPA to cover its administrative costs not covered in other manners by IPA or its Participating providers; and to protect and expand the business of IPA, as deemed prudent by IPA's board of directors in the best interest of IPA. Physician hereby grants IPA (or its duly designated independent agent(s)) the authority to act as Physician's agent in seeking out and entering into such contracts with Health Plans and other third-party payors on Physician's behalf. IPA agrees that it will use (and will require any duly designated independent agent to use) reasonable efforts to seek out and secure such contracts for its Participating Physician Providers for the provision of professional medical services with duly qualified payors on terms and conditions advantageous to Physician and IPA, and that, where possible, such contracts shall provide risk-sharing and other incentive arrangements for IPA and Physician. Nothing herein requires IPA to make any such contract available to all Participating Physician Providers or to guarantee Physician's continued participation at any specific level or volume in any such contract. Any Participating Physician Provider may be excluded from participating in any such contract if the Board determines that Physician no longer qualifies for participation therein or that limited participation by IPA's Physician Providers in any such contract is in the best interest of IPA.

6.2 Notification of Assigned Enrollees. IPA agrees to provide or cause to be provided to Physician, eligibility information concerning the covered Enrollees who have elected Physician as their primary care provider.

6.3 Quality Assurance and Utilization Management. IPA shall work with physician members of IPA to provide appropriate pre-authorization, utilization management and peer review programs and activities in accordance with the procedures as identified in IPA's Rules & Regulations and Health Plan requirements which are incorporated herein by reference. These measures are necessary to achieve and maintain cost effective delivery of quality health care by IPA Physicians and hospitals.

6.4 Documentation to Members. IPA agrees to provide training and information to Physicians and their staff regarding IPA's Rules & Regulations, Policies and Procedures, and IPA and Health Plan treatment protocols, pre-authorization and utilization management procedures and claims/billing submission.

6.5 Intermediary. IPA shall act as an intermediary between Physician and Health Plan by assisting Physician in complying with Health Plan policies regarding the provision of Covered Services, mediating disputes between Physician and Health Plan, and otherwise facilitating the various relationships contemplated by this Agreement.

7 PAYMENT FOR PROVISION OF COVERED SERVICES

7.1 No Liability to Enrollees for Charges. Physician agrees to submit claims to the Health Plan, third party administrator, IPA, or other third party payor as required by the respective Health Plan) and to seek payment only from IPA or other payor (as applicable) and will not under any circumstances seek payment from any Enrollee, except for the collection of applicable deductible and copayment amounts, and the amounts of Non-Covered Services as specified by IPA or Health Plan. Physician agrees that in no event, including but not limited to nonpayment by Health Plan or IPA, or insolvency or breach of this agreement, will they discontinue necessary medical treatment to Enrollees until Enrollee's medical treatment is assumed by another physician, or 60 days, whichever is longer. When an enrollee in a Medicare plan is hospitalized on the dated the plan terminates or does not renew the contract. or, becomes insolvent, Physician shall cooperate with the plan in protecting the enrollee from loss of benefits through the date of discharge or the date through which the CMS premium was paid. Physician further agrees that this provision shall survive the termination of this Agreement regardless of the cause for such termination and shall be construed to be for the benefit of the Enrollee, and this provision shall supersede any oral or written Agreement to the contrary now existing or hereafter entered into between IPA and Enrollee, or Physician and Enrollee, or any persons acting on behalf of IPA, Physician, or Enrollee.

7.2 Payment for Medical Services. Physician agrees to accept the payment from IPA, referenced in Attachment C hereto, as payment in full for those health services determined by IPA to be Covered Services, Physician understands the prohibition against billing Enrollee for services covered by this Agreement, other than for co-payments, third party collections or other charges or payments permitted to be billed or collected pursuant to Arizona insurance law. It is specifically understood and agreed that compensation arrangements with individual Health Plans may vary, as provided for in this Agreement,

and may include capitation, special withhold and other provisions specific to each IPA/Health Plan agreement. The terms of such different compensation arrangements under IPA Agreement shall be set forth in Schedules to this Attachment C. When a new or amended IPA/Health Plan agreement becomes binding on Physician, such Schedules shall be identified with the name of the Health Plan and/or Health Benefit Program, as applicable and forwarded to Physician for attachment to this Agreement.

7.3 Claims and Encounter Submission. Physician agrees to submit to IPA or the applicable Health Plan itemized statements for Covered Services rendered to Enrollee, including a full itemization of treatments given. Such billings shall be on the CMS 1500 Form or other such form as approved by IPA or the applicable Health Plan and must include all necessary provider and Enrollee identification, including Enrollee name and number; provider name; date of service, diagnostic code; procedure code; and copies of any required referral authorization forms. Physician shall be compensated those amounts set forth in the applicable Health Plan Schedules or Attachment C of this Agreement, which is attached hereto and incorporated by this reference, for Enrollees who have chosen to receive their medical care from a Primary Care Physician who is a member of IPA. All billings must be accompanied by proper authorization. Claims must be submitted within ninety (90) days of the date of service for payment to be made. Physician may not bill Enrollee for any Covered Service by reason of denial of payment by IPA or Health Plan for submission of statement later than ninety (90) days from date of service.

7.4 Copayments and Coordination of Benefits ("COB"). Physician shall be responsible for collection of copayments in accordance with the applicable Health Plan Benefit Agreement and shall cooperate with IPA and Health Plan in the collection of COB payments from or on behalf of Enrollee according to the Rules & Regulations of IPA.

7.5 Payment to Outside Providers. If any Outside Provider renders Covered Services to an Enrollee with respect to whom Physician is entitled to receive a capitation payment under this Agreement, IPA or Health Plan may make payments to such Outside Providers on behalf of Physician, in accordance with IPA's Rules & Regulations or Health Plan provisions. In these instances, IPA or Health Plan shall submit an itemized list to Physician and Physician's capitation payment may be reduced by an amount equal to such payments made to outside providers for such services that should have been provided by Physician.

8 GENERAL PROVISIONS

8.1 Term. This Agreement shall commence on the date set forth above and shall continue in effect for one (1) year. This Agreement shall automatically renew for subsequent one year terms unless either party provides written notice of termination to the other party at least ninety (90) days before the end of the initial term or any subsequent one year term.

8.2 Termination Without Cause. This Agreement may be terminated without cause by either party hereto, by giving 90 days prior written notice to the other party.

8.3. Termination For Cause. If either party defaults in performance of any duties or obligations stated in this Agreement, including failure of Physician to provide contracted services in accordance with IPA's Rules & Regulations, Quality Assurance and Utilization Guidelines, or failure of IPA to provide payment of amounts owed to Physician, and the default or breach has not been cured within thirty (30) days after receipt of written notice of such default or breach from the other party, the non-defaulting party may terminate this Agreement by delivering written notice of failure to cure to the defaulting party within five (5) days after the expiration of said thirty (30) day period. Termination under this section is effective ten (10) days from receipt of written notice of failure to cure to defaulting party. If the denial, suspension or termination if with respect to a Medicare plan, the plan shall notify Physician in writing of the reason(s) therefor.

8.4 Obligations Upon Termination. The rights of each party hereunder shall terminate upon termination; provided, however, that such termination shall not release IPA or Physician from obligations imposed by any existing Benefits Agreement covering an Enrollee, or the obligation of Physician to Enrollees then receiving treatment. Upon termination, Physician agrees to continue to provide Covered Services to Enrollees until IPA has made arrangements for the Enrollees medical care to be assumed by another Physician and Physician and Enrollee is notified of this change. IPA warrants that this process shall not exceed ninety (90) days from the termination date this Agreement. IPA agrees to compensate

Physician under IPA's Fee Schedule for all services rendered subsequent to the termination of this Agreement.

8.5 Assignment. This Agreement may not be assigned or transferred in any way by either party without the written prior consent of the other party.

8.6 Incorporation of Attachments. Attachments A and B and, IPA Rules and Regulations and Policies and Procedures are incorporated herein and made part of this agreement.

8.7 Binding Arbitration. If the parties cannot settle any dispute or controversy arising out of this Agreement, the parties shall submit such controversy or dispute to mandatory and binding arbitration in Phoenix, Arizona. For this purpose all parties hereby expressly consent to such arbitration in such place. At the request of any party, arbitration proceedings shall be conducted in the utmost secrecy. In such case, the arbitrator(s) shall receive, hear, and maintain all documents, testimony and records in secrecy, available for inspection only by the parties 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 parties and arbitrator(s) shall conduct the arbitration under the then-existing rules and regulations of the American Arbitration Association governing commercial transactions, and any award entered shall be subject to confirmation, opposition, modification, and enforcement in accordance with the Uniform Arbitration Act as then adopted in the State of Arizona. Each party to the arbitration proceeding shall pay its own attorneys fees and costs. The parties shall equally bear fees and related costs of the arbitrator(s). Notwithstanding anything herein to the contrary, nothing in this Paragraph shall preclude any party from seeking interim or provisional relief, including without limitation, a temporary restraining order or preliminary injunction, concerning the dispute or controversy, if necessary to protect the interests of such party. Bringing or defending an action for such relief shall not constitute waiver of the right or avoidance of the obligation to arbitrate contained in this Agreement

8.8 Patient Relationship. Physician shall take necessary and appropriate actions to maintain an effective physician-patient relationship with Enrollees. Physician is encouraged to discuss with Enrollees their medical conditions and their treatment options and to provide information required to obtain Members' informed consent to any proposed treatment or procedures, including the nature and purpose of the recommended procedures or treatment, associated risks and benefits and any alternatives. Nothing contained in this Agreement shall be construed to require Physician to recommend any procedure or course of treatment that Physician deems professionally unacceptable. The denial of payment for a particular course of professional or institutional treatment shall not relieve Physician from providing or recommending care to Enrollees as Physician deems appropriate. Nor shall such benefit determination be deemed a medical determination by IPA or Health Plan. Physician shall inform Members of their right to appeal adverse utilization decisions pursuant to their respective Health Benefit Programs and may participate in and serve as the Enrollees' advocate in any such appeal. Nothing contained in this Agreement shall be construed as preventing Physician from discussing IPA or Health Plan reimbursement methodology with Enrollees.

8.9 Independent Contractors. None of the provisions of this Agreement are intended to create, nor shall any be designed or construed to create, any relationship between Physician and IPA other than that of independent entities contracting with each other hereunder solely for effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective representatives, shall be construed to be the agent, employee, or representative of the other.

8.10 Controlling Law. This Agreement shall be governed in all respects by the Laws of the State of Arizona and by the laws of the Federal Government. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect the validity or enforceability of any other term or provision.

8.11 Use of Physician Names. IPA may list the names, addresses, phone numbers and specialty of practice of IPA Physicians participating with a Health Plan in a general list of Participating providers (Physicians Directory) which is distributed to Enrollees, potential Enrollees and other Participating Providers. IPA may also use physician directory information for advertising and other promotional activities upon approval of IPA Board of Directors.

8.12 Amendments or Modifications of Agreement. This Agreement constitutes the entire understanding of the parties hereto. Amendments or Modifications of this Agreement shall be mutually agreed to in

writing by IPA and Physician. If IPA is required to amend this Agreement in order to comply with changes required by the duly constituted regulatory authorities of the State of Arizona or the Federal Government, IPA shall furnish Physician written notice of any such Amendments and Physician shall be bound by such Amendments.

8.13 Exclusivity and Prior Agreement. By executing this Agreement and agreeing to be an IPA Physician, Physician agrees to be bound by all IPA/Health Plan agreements unless other arrangements are made by IPA. IPA shall act on behalf of Physician as his attorney-in-fact for the purpose of entering into such binding IPA/Health Plan agreements. "IPA/Health Plan agreements" shall be understood to mean agreements between IPA and a Health Plan to provide covered services, and no other agreements.

8.14 Notices. Any and all notices required to be given pursuant to the terms of this Agreement must be given in writing and delivered by United States mail, postage prepaid, return receipt requested at the addresses listed on the cover sheet.

8.15 Waivers of Default. Waiver, whether expressed or implied, of any breach of any provision of this Agreement shall not be deemed to be a waiver of any other provision or a waiver of any subsequent breach of the same provision. In addition, waiver of one of the remedies available to either party in the event of default, shall not at any time be deemed a waiver of the right to elect such remedy(ies) at any subsequent time if a condition of default continues or recurs. All waivers must be set forth specifically in writing and signed by the waiving party.

8.16 Entire Agreement. This agreement including cover sheet and Attachments hereto and documents incorporated herein, including Manual, rules and regulations, policies and procedures, constitute the entire agreement between Physician and IPA with respect to the subject matter hereof and its supersedes any other agreement, oral or written, between Physician and IPA.

8.17 Patient Self Determination Act. Physician and IPA acknowledge and agree to comply with applicable laws of Arizona respecting advance directives as defined in the Patient Self Determination Act (P.L. 101-508). An advance directive, such as a living will or a durable power of attorney in which an individual makes a decision concerning such medical care, including the right to accept or refuse medical or surgical treatment.

8.18 Confidentiality of Contract and Proprietary Information. Both parties agree that this contract and related Policies, Procedures, Rules and Regulations, Protocols, methods of operation, compensation methodologies and rates represent confidential trade secrets entitled to protection, and each party agrees not to reveal such information to any other person without the written consent of the other party, unless required by law. If disclosure is required pursuant to applicable law, the disclosing party shall provided reasonable advance notice of such disclosure to the other party, as applicable. This provision shall survive the termination of this agreement.

IN WITNESS WHEREOF the parties have executed this Agreement the day and year set forth, thereafter known as the effective date.

PHYSICIAN	**IPA**
_____	_____
Signature	Signature
_____	_____
Date	Date
_____	_____
Address	Address
_____	_____
City/State/Zip	City/State/Zip

ATTACHMENT A
DEFINITIONS

1. “Agreement” shall mean this Physician Service Agreement and any attachments hereto.

2. “Copayment” means the charge required under a Health Benefit Program that an Enrollee must pay when Covered Services are provided.

3 "Covered Services” means those health care services that an Enrollee is expressly entitled to under a Health Benefit Program and that are Medically Necessary.

4. “Enrollee”" shall mean any individual and the individual’s eligible dependents who is enrolled in any Health Plan program that has a service contract with IPA and who is eligible for provision of Covered Services.

5. “Emergency” is defined as a sudden and unexpected illness or injury which, if not immediately treated, could be life-threatening or result in permanent disability and which may preclude the Enrollee from obtaining prior authorization or care through a Participating Provider.

6. “Emergency Services” shall mean the medical care rendered to an Enrollee under the circumstances identified in Paragraph 5.

7. “Health Benefit Program” means a benefits program that: (i) specifies health care services to be reimbursed, paid for or provided to individuals lawfully participating in that benefits program; (ii) employs financial incentives for Enrollees to utilize Participating Providers; and (iii) is issued by a contracted Health Plan.

8. “Health Plan” shall mean any HMO, PPO, self insured company or other managed health care plan which is a duly constituted legal entity operating under the Federal HMO Act or other such applicable Federal and State laws and regulations with which IPA has contracted with the approval of its Board of Directors.

9. “Health Plan Provider Manual” means a Health Plan’s policies and procedures, including the Medical Management Programs, that set forth conditions with which Participating Providers must comply, as modified from time to time. The Participating Provider Manual is not the sole and exclusive source of Health Plan’s policies and procedures.

10. “Hospital” shall mean a hospital which has agreed contractually to serve as a Health Plan or IPA affiliated provider of hospital services to Enrollees under one of the specific Health Benefits Programs covered by this Agreement.

11. “Hospital Fund” is a pool of funds from which Health Plan or IPA pays all hospital costs and other provider costs.

12. “IPA” is an individual practice association which is an organization of physicians and other individuals who contract with Health Plans to provide, through IPA, certain covered physician services.

13. “IPA Provider Manual” means IPA’s policies and procedures, including the Medical Management Programs, that set forth conditions with which Physician Providers must comply, as modified from time to time. The Participating Provider Manual is not the sole and exclusive source of IPA’s policies and procedures.

14. “Medically Necessary” means (unless otherwise provided in the applicable Health Benefit Program), when applied to a health care service, that the service is: (i) required to treat an illness or injury; (ii) consistent with the diagnosis and treatment of the Enrollee’s condition; (iii) in accordance with the standards of good medical practice; (iv) performed at the most appropriate and cost-effective level of care for the Enrollee as determined by the Enrollee’s medical condition and not the distance the Enrollee lives from a health care facility or any other non-medical factor; and (v) not primarily for the convenience of the Enrollee, the Enrollee’s family, the Enrollee’s physician or any other Provider.

15. “Medical Management Programs” means the policies and procedures designated and adopted from time to time by IPA and/or Health Plan related to claims management, credentialing and

recredentialing of Participating Providers, utilization management and review, quality management, case management, Enrollee and Provider grievance procedures, and Provider appeals.

16. “Outside Provider” is any provider of Covered Services other than Physician, for example a non-IPA Physician, for which IPA is financially responsible under the terms of this Agreement.

17. “Participating Provider” shall mean all physicians, whether primary care or specialists, and ancillary providers and facilities who have contracted with IPA to provide medical services to Health Plan Enrollees under this Agreement.

18. “Participating” means: (i) credentialed by IPA and/or Health Plan or its designee consistent with IPA’s credentialing policies; (ii) designated as Participating by IPA and Health Plan; and (iii) under contract with Health Plan directly or indirectly, to provide Covered Services to Enrollees.

19. “Physician” or “IPA Physician” shall mean jointly and severally (i) a person who holds a license to practice medicine or osteopathy in the State of Arizona and is a party to this Agreement and (ii) the group practice entity identified on the Cover Sheet through which such person is a party to this Agreement.

20. “Physician Services” shall refer to those Covered Services which IPA agrees to arrange and pay for on behalf of Enrollees, that are within Physician’s licensure, certification, scope of competence, and usual and customary practice, and identified in the Health Benefits Program covered by this Agreement. “Physician Services” shall not include other professional and ancillary services incident to the delivery of physician services such as clinical or anatomical laboratory, radiology and other diagnostic or therapeutic services, unless specifically identified in Attachment C.

21. “Physician Referral Fund” is a pool of funds from which IPA pays all referral costs.

22. “Primary Care Physician” shall mean any Physician who has contracted with IPA to provide services and is practicing medicine in the area of internal medicine, family practice, general practice or pediatrics and who is deemed a Primary Care Physician by IPA and Health Plan.

23. “Rules & Regulations” shall mean an IPA document containing administrative Policies & Procedures pertaining to physician credentialing, recredentialing, utilization review, sanctions, appeals, quality assurance and other such regulatory protocol as required to manage IPA effectively. Such document is subject to change from time to time.

ATTACHMENT B

CMS Regulatory Requirements

This attachment applies to Participating Physician's participation in government programs through IPA group health plan contracts sponsored by U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services

Maintenance of Records.

Physician must give the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services ("CMS"), the U.S. Government Accounting Office and their designees the right to audit, evaluate, and inspect Provider's books, contracts, medical records, patient documentation and other relevant records. These rights will extend for six (6) years beyond termination of the Provider Agreement or until the conclusion of any governmental audit that may be initiated that pertain 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 contracted health plan and/or the Physician at least thirty (30) days before the normal disposition date; (ii) there has been a termination, dispute, or fraud or similar fault by the Physician, in which case the retention may be extended to six (6) 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 the Physician at any time. (42 C.F.R. Sections 422.502(e)(2); 422.502(e)(3); 422.502(e)(4); 422.502(i)(2)(ii);).)

Continuity of Care Obligations.

Physician has certain continuity of care obligations in the event that an IPA health plan agreement terminates or a health plan becomes insolvent. In addition to the additional requirements set forth in the Agreements, Enrollees shall continue to receive services through the period in which their CMS payments have been made to the contracted health plan. Additionally, if the Enrollee is hospitalized on the date the contract terminates or in the event of insolvency, services must be provided through the date of the Enrollee's discharge from the applicable facility. (42 C.F.R. Section 422.502(g).)

Accountability.

Managed Care Program Services, Health Plan Accountability and IPA Cooperation. Consistent with the requirements of State and Federal Law and the standards of Accreditation Organizations, Health Plan shall be accountable for the performance of the following services for all Managed Care Plans: (i) quality management and improvement, (ii) medical management, (iii) credentialing, (iv) Enrollee rights and responsibilities, (v) preventive health services, (vi) medical record review and (vii) payment and processing of claims (collectively, "Managed Care Program Services"). Without limiting the foregoing or Health Plan's delegation of any Managed Care Program Services to IPA, Health Plan shall remain accountable to CMS for complying with its obligations under the CMS Agreement. IPA and its Participating Providers shall cooperate with Health Plans in the performance of all Managed Care Program Services and conduct their activities in a manner consistent with the provisions of this Article including specifically, but without limitation, Health Plan's QI Program, MM Program, Credentialing Program, Member Services activities, and Claims Processing Guidelines.

Claims Payment Requirements.

The following is added the Claims Payment Requirements section:

In the event it is determined that a claim is not a Clean Claim, Health Plan shall, within 30 days of receipt, advise Participating Physician in writing of the basis in which a claim is not eligible for payment and specify any additional information required for Health Plan to make a final determination with respect to the applicable claim. Health Plan shall make a final determination on claims that are not deemed Clean Claims within sixty (60) days of receipt.

Compliance with Law.

Participating Physician shall comply with all applicable laws, including without limitation, laws, regulations, instructions issued by the CMS and Health Plan's Medicare contract obligations. (42 C.F.R. Section 422.502(i)(4)(v).)

Physician Obligations**.** Physician agrees, and shall require each Physican subcontractor to agree, to:

(a) For a period of ten (10) years from the final date of the Contract Period or the date of completion of any audit, whichever is later, allow HHS, CMS, the Comptroller General, or their designees the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation of Provider and any Provider subcontractor, involving transactions related to Health Net's contract with CMS. [*See 42 CFR §§ 422.504(i)(2)(i) and (ii); Ch. 11. §100.4, MMCM]

(b) Cooperate in, assist in, and provide information as requested for audits, evaluations and inspections performed under Section B.2(a) above. [*See Ch. 11. §100.4, MMCM]

(c) Safeguard each Medicare Member's privacy and confidentiality. [*See Ch. 11. §100.4, Medicare Managed Care Manual ("MMCM")]

(d) Specify a prompt payment requirement in its written agreement with a Provider subcontractor. [*See Ch. 11, §100.4, MMCM]

(e) Ensure the accuracy of each Medicare Member's health records. [*See Ch. 11. §100.4, MMCM]

(f) Hold each Medicare Member harmless for payment of any fees that are the legal obligation of Health Net in the event of, but not limited to, insolvency of, breach by or billing of Provider by Health Net. [*See 42 CFR §§ 422.504(g)(1)(i) and (h)(3)(i)]

(g) Comply with all applicable Medicare laws, regulations, and CMS instructions. [*See 42 CFR § 422.504(i)(4)(v)]

(h) Perform each service or other activity under this Agreement in a manner consistent and in compliance with Health Net's contractual obligations to CMS. [*See 42 CFR §§ 422.504(i)3)(iii)]

(i) Maintain all records relating to this contract for a minimum of ten (10) years from the final date of the Contract Period or the date of the completion date of any audit, whichever is later. [*See Ch. 11. §100.4, MMCM]

(j) Health Plan oversees and is ultimately responsible to CMS for any functions and responsibilities described in the Medicare Advantage regulations. Provider understands that this accountability provision also applies to this Addendum. [See CH. 11 §100.4, MMCM. See 42 CFR §§422.504 (i)(4)(iii)]

(k) Comply with Health Plan Policies. [*See Ch. 11. §100.4, MMCM]

(l) Effective January 1, 2010, not collect cost sharing from any Medicare Member that exceeds the amount of cost sharing that would be permitted with respect to the Medicare Member under Title XIX of the Social Security Act if the Medicare Member were not enrolled in the Health Plan Benefit Program. In no event shall Provider or a Provider subcontractor hold a Medicare Member responsible for any cost sharing for Covered Services when a State entity is responsible for paying such amount. Where the State is responsible for paying the cost share amount, Provider shall either accept Health Plan's contracted rate as payment in full or bill the appropriate State source for the cost share amount. [*See CMS 2010 Call Letter]

ATTACHMENT C
PAYMENT FOR SERVICES

PHYSICIAN

Physicians shall be paid either a per member per month amount or a fee for service payment for providing Covered Services. Compensation will be determined by the specific IPA/Health Plan agreement. If payment is administered by Health Plan, compensation for services will be made at Health Plan capitation or fee for service rate schedule and will be subject to all the terms and conditions of the Health Plan agreement (such as withholds, risk pools, and the like). If payment is administered by IPA, compensation for services will be made at IPA capitation or fee for service rate schedule.