# INLAND EMPIRE FOUNDATION FOR MEDICAL CARE

# ANCILLARY PROVIDER MEMBERSHIP AGREEMENT

This ANCILLARY PROVIDER MEMBERSHIP AGREEMENT ("AGREEMENT") is entered into as of this _____ day of _____, 20 by and between the **UFMC HEALTH SYSTEMS, INC. dba INLAND EMPIRE FOUNDATION FOR MEDICAL CARE ("IEFMC")**, a corporation organized under the laws of the State of California, and _____(**PROVIDER**). This Agreement is not effective until PROVIDER has completed the IEFMC application and submitted supporting documentation to IEFMC, and PROVIDER has received a letter from the IEFMC approving PROVIDER's application.

## ARTICLE I

1.1 Panel Creation. In consideration of PROVIDER's execution of this Agreement, IEFMC agrees that it shall contractually require each Payor to create incentives for Patients to utilize PROVIDERS which have contracted with IEFMC, to become preferred providers in IEFMC's Preferred Provider Organization (PPO). If elected by PROVIDER below the signature line at the end of this Agreement, this Agreement is applicable as well to IEFMC's exclusive provider organization (EPO) which is a part of the PPO, and all references to PPO shall, unless otherwise stated, apply to both the PPO and the EPO.

1.2 Panel Participant. PROVIDER hereby grants IEFMC the right, authority and direction to list PROVIDER as a participating provider in the provider panels and directories of IEFMC, the Inalnd Empire Foundation for Medical Care, and other individual Foundations for Medical Care with which the IEFMC is affiliated, subject to this Agreement, and to provide Payors with relevant information as may be necessary for this purpose.

## ARTICLE II

DEFINITIONS

2.1 "Benefit Agreement" means the governing document which establishes a Payor's obligation for payment of medical, surgical, hospital, ancillary and other healthcare benefits for its members, employees and dependents, beneficiaries, insured's or other persons entitled to benefits.

2.2 "Health Care Services" means all outpatients, emergency and inpatient services provided by PROVIDER and for which PROVIDER is compensated pursuant to this Agreement. Health Care Services shall not include those inpatient, outpatient or emergency services that are not maintained by PROVIDER due to religious or other reasons as of the effective date of this Agreement and throughout the term of this Agreement.

2.3 "IEFMC" means the Inland Empire Foundation for Medical Care and other individual Foundations for Medical Care, with which the IEFMC is affiliated, and which will be establishing, operating and/or arranging for the utilization management program under this Agreement (**if applicable**).

2.4 "Patient" means any person and/or family dependent who is covered under a Benefit Agreement.

2.5 "Payor" means a Payor of medical, hospital or other Health Care Services which has contracted with IEFMC to utilize IEFMC's PPO and/or EPO network of contracted healthcare providers, or who has contracted with the Inland Empire Foundation for Medical Care (IEFMC) and other individual Foundations for Medical Care with which IEFMC is affiliated, for access to their preferred provider networks. This definition includes, but is not limited to, health insurers, health maintenance organizations, Workers' compensation insurers, self-insured employers, trusts, associations, unions, bill review companies, national and statewide PPOs, EPOs and Workers' compensation networks who may wish to

affiliate with IEFMC for the purpose of serving large national clients, and employee welfare benefit plans. IEFMC and the other Foundations for Medical Care with which IEFMC is affiliated are not, and shall not be deemed to be, Payors for purposes of this Agreement.

2.6 "Provider" means any professional and/or institutional or ancillary provider who has contracted to participate in IEFMC's PPO and/or EPO.

## ARTICLE III

OBLIGATIONS OF IEFMC

3.1 Solicitation of Contracts and Use of Provider Identification. IEFMC shall solicit Payors from time to time for the purpose of enabling the Payors to access the professional services of PROVIDER at the rates in Exhibit A hereto to which PROVIDER has agreed in this Agreement. In connection therewith, PROVIDER authorizes and directs IEFMC to identify PROVIDER as a member in the PPO and/or EPO, as elected by PROVIDER, who will enter into alternate rate contracts with Payors and to release to Payors PROVIDER's name, address, business telephone number, tax I.D. number and other relevant information as may be necessary or prudent for this purpose.

3.2 Use of Provider Panels. IEFMC only leases, rents and makes its PPO and EPO Preferred Provider panels available by contract for the purpose of providing alternative rates to Payors. IEFMC's clients for this purpose include all organizations described in the definition of Payor in Article II. IEFMC does not sell, transfer or convey its preferred provider panels to any payors or other contracting agents as part of its business, and retains control over the lease or rental and use of its panels. IEFMC contracts only with those Payors that actively encourage their beneficiaries to use the list of contracted providers when obtaining medical care.

3.3. Payor Financial Incentives. The Payors with which IEFMC contracts use financial incentives to actively encourage their beneficiaries to use the list of contracted providers. Such incentives include reduced co-payments and coinsurance, reduced deductibles, and/or financial penalties attributable to the nonuse of a provider panel. The Payors also provide beneficiary ID card with appropriate network logo and toll free number with access to contracted providers via an On-line Provider website at www.IEFMCnet.org. iIEFMC shall not include from any list of contracted providers a provider who has declined to be included in a list of providers leased or sold to payors that do not actively encourage the payors' beneficiaries to use the list when obtaining medical care.

3.4 List of Payors. Within thirty (30) days of receiving from PROVIDER a written request for a summary list of the Payors who are eligible to receive the benefit of this Agreement, IEFMC will provide the list. The list of Payors is also accessible at www.IEFMCnet.org website.

3.5 IEFMC shall ensure the privacy and security of protected health information received from PROVIDER consistent with HIPAA, and with the provisions of Section 10.12 of this Agreement.

## ARTICLE IV

OBLIGATIONS OF PROVIDER

4.1 Payor Contracts and Alternative Rates. PROVIDER acknowledges and understands that IEFMC will solicit Payors for the purpose of entering into alternate rate contracts and that by executing this Agreement; PROVIDER agrees to be bound by all such contracts entered into between IEFMC and Payor. PROVIDER agrees during the existence of this Agreement to accept the fee schedule, Exhibit A, as payment in full for services rendered to Patients insured under IEFMC/EPO sponsored Benefit Agreements. The contracted fee schedule in Exhibit A hereto for providers participating in the PPO/EPO network may be changed if so determined by IEFMC, upon thirty (30) days written notice to PROVIDER.

Such change in the rates shall be effective thirty days after the date of the notice, unless PROVIDER provides written notice to IEFMC objecting to the new rates and declining to participate in the PPO/EPO panel. The rate change shall not affect any of the other provisions of this Agreement.

4.2 Membership Fees and Good Standing. PROVIDER agrees to pay the required initiation fee and/or dues which may be established from time to time by IEFMC and for the duration of this Agreement, and as condition of this Agreement remaining in effect, to maintain his or her membership in the IEFMC in good standing.

4.3 Medical Services. In accordance with generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment, PROVIDER agrees to render appropriate and medically necessary services and supplies to any Patient. This provision does not affect any right which PROVIDER may have to elect not to provide treatment to any Patient. PROVIDER shall also provide the required licensed nurses, technicians and other health care personnel as needed to perform the services required pursuant to this Agreement. PROVIDER shall be solely responsible for the medical care and treatment of Patients. PROVIDER agrees not to differentiate in the treatment of Patients by reason of their enrollment under a Payor's Benefit Agreement or the Patient's entitlement to the fee schedule in Exhibit A hereto.

4.3.1 For patients being seen under Workers' Compensation "Medically Necessary Services" are those that are determined to be appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition, and provided for the diagnosis or direct care and treatment of the medical condition, and within standards of good medical practice with the organized community, and not primarily for the convenience of the injured worker, the physician, or any other provider's convenience, and be the most appropriate level of service which can be safely provided.

4.3.2 For all patient's being seen under Workers' Compensation "Utilization Schedule" means the adoption by the Administrative Director of a utilization schedule presumptively correct on the issue of extent and scope of medical treatment. These guidelines are currently based on the American College of Occupational and Environmental Medicine's (ACOEM) Occupational Medicine Practice Guidelines as well as any other evidence based medical treatment guidelines generally recognized by the medical community.

4.4 Referrals To PPO and EPO Providers. Consistent with the exercise of PROVIDER's best professional judgment, PROVIDER agrees to make every effort to refer PPO Patients, when necessary, to Preferred Providers. Referrals of EPO Patients for elective care must be made only to other EPO Preferred Providers, and elective hospital admissions and outpatient services must be made only at EPO institutional providers. Referrals of EPO Patients to non-EPO providers must be pre-authorized in accordance with the EPO referral guidelines of the IEFMC. PROVIDER agrees that three (3) or more non-authorized referrals of EPO Patients to non-EPO physicians, hospitals or ancillary providers shall constitute cause for termination of this Agreement, at the option of the IEFMC. For out of area referrals, PROVIDER agrees, when necessary and consistent with PROVIDER's best professional judgment, to refer Patients to providers under contract with another Foundation for Medical Care.

4.5 Maintenance of Medical Records. PROVIDER shall maintain with respect to each Patient receiving health care services from PROVIDER a single standard medical record in such form, containing such information, and preserved for such time period(s) as is required by applicable law, including the rules and regulations of the California Department of Health Services, the Federal Medicare Program, the Joint Commission on Accreditation of Healthcare Organizations and the California Administrative Code.

4.6 Access to Medical Records. It is understood that the medical records shall be and remain the property of PROVIDER and shall not be removed or transferred from PROVIDER's premises except in accordance with applicable State and Federal law and regulations. To the extent permitted by law, in accordance with procedures required by law, and upon receipt of written notice from IEFMC, a Payor or a

Payor's administrator or authorized designee ("Requesting Party"), PROVIDER shall permit the Requesting Party, to inspect and make copies of said medical records, and shall provide copies of such records to the Requesting Party at no charge to Requesting Party. Prior to requesting a Patient's medical record, the requesting party shall have obtained a valid written release from the Patient (or his legal representative) giving authorization to obtain the medical records. When a Patient changes providers, PROVIDER shall upon request, furnish copies of the medical records, tests and diagnostic results within thirty (30) days or sooner if necessary, at no charge to the Patient.

4.7 Admitting Privileges. As a condition of participation in the PPO and the EPO panels under this Agreement, PROVIDER shall have and maintain admitting privileges, in good standing, at one or more of the participating PPO and/or EPO hospitals, as applicable. PROVIDER shall notify IEFMC in writing within five (5) days of any suspension, loss or restriction of medical staff privileges at these hospitals. If PROVIDER does not have admitting privileges at an EPO hospital, PROVIDER acknowledges that he or she may have to transfer the Patient to the care of another EPO physician with admitting privileges for the purpose of admission to an EPO hospital.

4.8 HIPAA. PROVIDER shall ensure the privacy and security of patients' protected health information contained in any form, including without limitation, electronic, paper and oral information, for each Patient, and specifically agrees to comply with the Health Insurance Portability and Accountability Act of 1996, all regulations promulgated pursuant thereto (hereinafter, "HIPAA"), and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act").

## ARTICLE V

UTILIZATION REVIEW AND DISPUTE RESOLUTION

5.1 Compliance with Utilization Management and Credentialing Programs. PROVIDER agrees that in the course of rendering Health Care Services to Patients he or she will be subject to utilization management by IEFMC, Payor or Utilization Representative in accordance with IEFMC's, Payor or Utilization Representative policies and procedures. PROVIDER agrees to comply with, and participate in, the utilization management, credentialing and peer review programs to be operated or arranged by IEFMC or Payor.

5.2 Prior Authorization in General. PROVIDER acknowledges that services provided following the initial evaluation, or for continuous treatment of chronic or acute conditions, may require prior verbal or written authorization by IEFMC, Payor or Utilization Representative under the terms of the applicable Benefit Agreement.

5.3 Medically Unnecessary Services. If it is prospectively determined by the utilization management program that a service to be rendered to a PPO/EPO Patient is not medically necessary or is inappropriate PROVIDER agrees to notify the Patient of that decision and that the PPO/EPO Payor shall have no responsibility for payment for the requested service. PROVIDER may bill the Patient for such services only if PROVIDER has so notified the Patient and has obtained a written agreement from the Patient to perform the services in which the Patient acknowledges that the service is not covered under the applicable Benefit Agreement.

5.4 Grievances and Appeals. PROVIDER agrees to comply with, and participate in, the mechanism for grievances and appeals to be developed or adopted by IEFMC which allows physicians the opportunity to resolve disputes regarding professional medical services, utilization review determinations and other grievances.

## ARTICLE VI

PAYMENT, BILLING AND CLAIMS

6.1 Claims Submission. PROVIDER agrees, throughout the term of this Agreement, to submit claims to Payor, or to Payor's third party administrator (hereinafter "TPA") for reimbursement of services. All claims shall be submitted no later than thirty (30) days from the date of service. In the event PROVIDER is unable to submit bills within the specified time, the time for submission shall be extended as reasonably necessary, as agreed by both parties. Time may not exceed one year or the time period allowed under an applicable Benefit Agreement or Workers' Comp Statutes, whichever is greater. Payor PROVIDER agrees to accept the fee schedule attached hereto as Exhibit A and hereby made a part hereof, as the applicable fee schedule for all services rendered by PROVIDER to Patients. PROVIDER agrees and acknowledges that the fee schedule contains a lower reimbursement for EPO Patients. PROVIDER further agrees that, the reimbursement paid by each Payor under the terms of the applicable Benefit Agreement, after applying the fee schedule in Exhibit A hereto, together with any coinsurance, co-payments and/or deductibles for which the Patient is responsible under the applicable Benefit Agreement, shall be payment in full for Health Care Services rendered by PROVIDER to Patients. Adjustments to bills submitted in a timely manner must be requested within 180 days after payment has been made or the matter will be considered closed and no further adjustments for either overpayment or underpayment of the bills will be considered.

6.2 IEFMC Not a Payor. The parties hereto acknowledge and understand that IEFMC is not, and shall not be considered to be, a Payor for the purposes of this Agreement.

6.3 No Billing of Patients. With the exception of co-payments, coinsurance and/or charges for non-covered services under the applicable Benefit Agreement, PROVIDER shall not bill, charge or collect payments from a Patient, unless PROVIDER has not received payment from Payor or Payor's TPA within ninety (90) days after rendering the service, in which case PROVIDER shall have the right to bill the Patient for services rendered at the rates set forth in Exhibit A hereto.

6.4 Assignment and Claim Forms. PROVIDER agrees to accept assignment of benefit payments for services provided to Patients, and to bill Payors or their designated administrators on CMSCMS 1500 forms, or equivalent, and to include on the form the diagnosis and procedure codes, and PROVIDER identification and address, including federal tax identification number or social security number.

6.5 Coordination of Benefits. PROVIDER understands that it is the Patient's responsibility to disclose multiple insurance coverage. If a Patient has multiple insurance coverage and a Payor under this Agreement is the primary payor, PROVIDER agrees to accept up to the contracted rate set forth in Exhibit A from such Payor and may recover an additional amount from the secondary payor. If the Payor under this Agreement is secondary, then PROVIDER agrees to look to such Payor only for the amounts, if any, for which the Patient is responsible under the primary benefit plan, up to the limits of the primary plan and subject to all limitations and exclusions of that plan, after giving effect to the coordination of benefits provisions under the respective benefit plans and applicable law. Any payments by a Payor who is secondary shall be made in accordance with the fee schedule in Exhibit A hereto.

## ARTICLE VII

MEDICAL MALPRACTICE INSURANCE

7.1 Liability Coverage. PROVIDER agrees to maintain adequate limits of liability for comprehensive general liability and professional liability and professional liability insurance issued by a company authorized to conduct the business of insurance in the State of California. For purpose of this Agreement, professional liability insurance in the minimum amounts of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate shall be deemed adequate. PROVIDER agrees to give IEFMC satisfactory evidence of such insurance or other coverage annually

and upon request. PROVIDER shall require the insurance carrier to notify IEFMC of any change in coverage, including termination of the policy, at least thirty days prior to any such change.

7.2 Responsibility For Own Acts. Each party shall be responsible for its own acts or omissions and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result from, or arise out of, any alleged malfeasance or neglect caused or alleged to have been caused by that party, its employees or representatives, in the performance or omission of any act or responsibility of that party under this Agreement.

## ARTICLE VIII

TERM AND TERMINATION

8.1 Termination Without Cause and Renewal. This Agreement shall commence as of the date hereof and shall remain in force for a period of one year. This Agreement shall thereafter be automatically and successfully renewed for one year periods from and after the expiration of the initial term, unless otherwise terminated as provided herein. Either party shall have the right to terminate this Agreement prior to expiration of the term, with or without cause by providing ninety (90) days advance written notice to the other party.

8.2 Termination With Cause. This Agreement may be terminated for breach upon thirty (30) days advance written notice of breach, which notice shall specify the nature of the breach. The party receiving the notice shall have thirty (30) days from receipt of the notice to cure the alleged breach. This Agreement may also be terminated immediately, at the option of IEFMC, upon written notice by IEFMC if PROVIDER loses his or her license to practice medicine, is found guilty by a court of law or governmental agency to have committed fraud or other unethical conduct, or if in IEFMC's reasonable determination, PROVIDER has, or will, endanger the health or safety of Patients.

8.3 Effect of Termination. In the event treatment of a Patient is commenced by PROVIDER prior to the expiration of the term of this Agreement, and continues beyond that date, PROVIDER agrees to accept the fee schedule in Exhibit A hereto as the applicable fee schedule for services rendered to said Patients for services covered under the applicable Benefit Agreement, until the conclusion of the course of treatment or transfer to a Preferred Provider.

## ARTICLE IX

PHYSICIAN/PATIENT RELATIONSHIP

PROVIDER is an independent contractor and shall not in any way be considered to be an agent or employee or joint venture with IEFMC. PROVIDER shall maintain a physician/patient relationship with all Patients for whom care or treatment is provided and shall be solely responsible to such Patients for care and treatment. IEFMC does not exercise any control or discretion over the manner and means of the care and treatment of the services which PROVIDER renders and shall at no time be, or be deemed to be, responsible to any extent for PROVIDER's practice of medicine or the quality of the services rendered by PROVIDER.

## ARTICLE X

MISCELLANEOUS PROVISIONS

10.1 Assignment. This Agreement is a personal Agreement solely between IEFMC and PROVIDER and shall not be transferred or assigned, delegated or sold by PROVIDER without first

obtaining written consent of IEFMC, which consent shall not be unreasonably withheld. IEFMC may assign, delegate, transfer, convey or sell its rights and/or obligations under this Agreement to a parent, subsidiary or affiliate, or to an entity into which IEFMC is merged or with which IEFMC is consolidated, or to a purchaser of all or substantially all of its assets, or as part of a corporate reorganization.

10.2 Sale of Business / Transfer of Assets. If PROVIDER desires to sell, transfer or convey its business or any substantial portion, or all of its business assets to another entity, PROVIDER shall so advise IEFMC at least ninety (90) days prior to the sale, transfer or conveyance. PROVIDER warrants and covenants that this Agreement shall be part of the transfer, conveyance or sale and will be assumed by the new entity.

10.3 Controversy and Arbitration. In the event of any controversy, claim or dispute between the parties hereto affecting or relating to the purposes or the subject matter of this Agreement, PROVIDER agrees to abide by and comply with the grievance and appeal mechanisms set forth by IEFMC, and payor or Utilization Representative which permit the filing of a complaint and dispute resolution regarding professional medical services, utilization determinations and other grievances. As to those controversies, claims or disputes not falling within this purview and/or not resolved thereby, PROVIDER and IEFMC agree to submit all such disputes to binding arbitration in accordance with the rules for commercial arbitration of the American Arbitration Association, before one neutral and disinterested arbitrator, with the prevailing party being entitled to recover all of its reasonable expenses including but not limited to attorney's fees, expert witness fees and legal costs.

10.4 Modification. This Agreement may be modified only in writing. Modification by IEFMC shall be effective thirty (30) days after giving PROVIDER written notice of the proposed modification unless PROVIDER shall within such thirty (30) day period notify FOUNDATION in writing of an objection to such modification.

10.5 Eligibility. The Payor shall be responsible for patient eligibility verification. This responsibility shall in no event obligate Payor for deductibles, co-insurance, exclusion or other limitations as may apply in accordance with the terms of an applicable Benefit Agreement.

10.6 Non-Exclusivity. PROVIDER may participate in other alternative health care delivery programs at PROVIDER's sole discretion, and IEFMC may contract with other medical providers in PROVIDER's specialty practice areas and in PROVIDER's geographic service areas.

10.7 Law. The invalidity or unenforceability of any of the terms or provisions hereof shall in no way affect the validity or enforceability of any of the remaining terms or provisions. This Agreement constitutes the entire Agreement and understanding of the parties hereto, and no changes, amendments or alterations shall be effective unless signed by both parties. If any provision of this Agreement shall be deemed to be invalid or unenforceable by a court of competent jurisdiction or in arbitration, the same shall be deemed savable from the remainder of this Agreement and shall not cause the invalidity or unenforceability of the remainder of this Agreement. This Agreement shall in all respects be governed by the laws of the State of California.

10.8 Notices. All notices, requests, demands and other communications hereunder shall be in writing, and shall be deemed to have been duly given if personally delivered or mailed, certified mail, first class, postage prepaid as follows:

To PROVIDER:
Attention: President

TO IEFMC-PPO: INLAND EMPIRE FOUNDATION FOR MEDICAL CARE PREFERRED PROVIDER ORGANIZATION
3993 Jurupa Ave
Riverside, California 92506
Attention: PPO Network

The above addresses may be changed by like notice

10.9 Silent PPO's. IEFMC will require, to the best of its ability, that all Payors and Clients leasing or renting the PPO/EPO Network provide evidence of compliance with SB559 prior to finalizing any or all agreements.

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

10.11 Benefit Plan Requirements. The parties recognize and agree that IEFMC will be contracting with many Payors and that each Payor's Benefit Plan may have different requirements. Therefore, the parties agree to comply with any such Plan's requirements and should this Agreement need to be modified to conform to such requirements, IEFMC shall so advise PROVIDER of the requirement and the necessary change in the Agreement at least five (5) days prior to amending the Agreement. If PROVIDER is not in agreement with the amendment, PROVIDER shall comply with the change, but shall advise IEFMC of the disagreement and the parties shall attempt to resolve PROVIDER's concerns. If this effort fails, PROVIDER shall have the right to terminate this Agreement on ten (10) days advance written notice to IEFMC.

10.12 Confidentiality. The terms of this Agreement, and in particular the provisions regarding payment for services, are confidential and shall not be disclosed except as necessary to the performance of this Agreement, or as required by law. PROVIDER agrees not to disseminate or publish information developed under this Agreement, or contained in reports to be furnished pursuant to this Agreement, without prior written approval of IEFMC.

10.13 Third Party Beneficiaries. Nothing in this Agreement, express or implied, is intended to, or shall be construed to, confer upon any person, firm or entity other than the parties hereto or parties specifically mentioned herein, and their respective successors and assigns, any right, remedy or claim under or by reason of this Agreement, as third party beneficiaries.

10.14 Language Assistance Program. IEFMC and PROVIDER must comply with applicable statutes and regulations regarding language assistance to Patients and cooperate by providing any information necessary to assist compliance with such requirements.

10.15 HIPAA Compliance. IEFMC and PROVIDER agree that if regulations promulgated under the Health Insurance Portability and Accountability Act ("HIPAA") apply to either or both of them and cause the performance of their obligations under this Agreement to constitute a function or activity of a "business associate" within the meaning of 45 CFR § 160.103, then IEFMC and PROVIDER agree to comply with the requirements of 45 CFR § 164.504(e) as such may apply to IEFMC and PROVIDER as a business associate, including the following: (i) to use and disclose protected health information ("PHI") only to perform their obligations hereunder and for their proper management and administration; (ii) not to use or further disclose PHI other than as permitted or required by this Agreement or as required by law; (iii) to use appropriate safeguards to prevent the use or disclosure of PHI other than as provided hereunder; (iv) to report to the other any use or disclosure of PHI other than as provided under this Agreement or which a party becomes aware; (v) to obtain reasonable assurances from any person or entity to whom IEFMC or PROVIDER discloses PHI as permitted hereunder, that it will hold the PHI in confidence according to the same conditions and restrictions that apply to IEFMC and PROVIDER hereunder; (vi) to make available PHI subject to the provisions of 45 CFR § 164.524; (vii) to permit amendment of PHI subject to the applicable provisions of 45 CFR § 164.526; (viii) to make available information required to provide an accounting of disclosures of PHI subject to the provisions of 45 CFR § 164.528; (ix) to make available its records relating to the uses and disclosures of PHI for inspection by the Secretary of the United States Department of Health and Human Services ("HHS") for the sole purpose of determining IEFMC's and PROVIDER's compliance with their obligations under the HHS privacy regulations; and (x) at termination of

this Agreement, to continue to maintain the confidentiality of PHI as required hereunder, for a period not less than six (6) years.

IN WITNESS WHEREOF, the undersigned have executed this Agreement effective as of the date and year first written below.

| **PROVIDER NAME** | **INLAND EMPIRE FOUNDATION FOR MEDICALCARE** |
|---|---|
| _____<br>(Signature)<br><br>_____<br>(Name)<br><br>_____<br>(Title)<br><br>_____<br>(Date)<br><br>Tax ID #_____ | _____<br>(Signature)<br><br>**Dolores L. Green**<br>(Name)<br><br>**Chief Executive Officer**<br>(Title)<br><br>_____<br>(Date) |

**Provider elects to participate in the following**
**Inland Empire Foundation for Medical Care Network(s)**

**(Please check all that apply):**

**_____PPO Network** **_____PPO/EPO Networks**

***Participation in the Workers' Compensation Specialty Panel (Exhibit D) is optional and requires the signed Workers' Compensation Addendum and MPN Acknowledgement to the IEFMC Agreement.***

## EXHIBIT A

## INLAND EMPIRE FOUNDATION FOR MEDICAL CARE

## FEE SCHEDULE

The following fees are not intended to establish fees to be charged by member or nonmembers health care professionals. PROVIDERS are to continue, by contract, to bill their usual and customary charges and the Payor shall reimburse according to the fee schedules listed below.

Payment shall be based on current CPT coding according to the Resource Based Relative Value Scale (RBRVS).

Payment shall be at the lesser of the rates set forth or billed charges.

PROVIDER agrees, according to the PROVIDER Agreement with CFMC, to accept the following fee schedule(s):

| **Services** | **Reimbursement, less any co-payments, co-insurance and/or deductibles** |
|---|---|
| CPT-4 Codes with a current RBRVS value | *PPO Reimbursement*:<br>One-Hundred Percent (100%) of current RBRVS<br><br>*EPO Reimbursement:*<br>One-Hundred Percent (100%) of current RBRVS |

**Notice: This Fee Schedule is confidential and proprietary. It is intended only for the personal and confidential use of the designated recipient. All parties shall refrain from releasing these reimbursement terms set forth herein to any person or entity without receiving the prior consent of IEFMC.**

**EXHIBIT B**

**INLAND EMPIRE FOUNDATION FOR MEDICAL CARE**
**APPEALS MECHANISM**

1. PROVIDER understands, acknowledges and agrees that this appeals process is (a) available only after PROVIDER has exhausted Payer's utilization management and review grievance and appeals process; (b) is strictly advisory and not binding on any party.

2. PROVIDER may file an appeal request in writing to FOUNDATION within thirty (30) calendar days from a final, non-appealable utilization review and management decision by Payer following PROVIDER 'S exhaustion of all of Payer's grievance, hearing and appeal rights that were available to and could have been pursued by PROVIDER .

3. FOUNDATION'S Review Coordinator will send a letter to PROVIDER confirming that PROVIDER'S appeal has been received. The case will be reviewed by FOUNDATION'S Medical Review Committee and Payer.

4. PROVIDER and Payer will be notified within sixty (60) days of the date of PROVIDER'S appeal regarding FOUNDATION's non-binding advisory opinion

(Remainder of Page Intentionally Left Blank)