ESTADO LIBRE ASOCIADO DE PUERTO RICO
OFICINA DEL COMISIONADO DE SEGUROS
SAN JUAN, PUERTO RICO

COLEGIO DE CIRUJANOS DENTISTAS DE PUERTO RICO (CCDPR) Querellante Vs. **MSO de Puerto Rico** **MMM Healthcare LLC** Querellados	**QUERELLA NÚM**.: **SOBRE:** Ley Para el Pago Puntual, Ley Núm. 104-2002, según enmendada, 26 LPRA sec. 3001 et seq.y Regla 73 de la OCS.

QUERELLA

AL HONORABLE COMISIONADO DE SEGUROS:

COMPARECE el Colegio de Cirujanos Dentistas de Puerto Rico, en respresentación de sus miembros colegiados quienes muy respetuosamente expone, alega y solicita:

I. LAS PARTES

A. Querellante:

1. La parte querellante es el Colegio de Cirujanos Dentistas de Puerto Rico, (CCDPR), una entidad jurídica o corporación cuasi pública que agrupa a los profesionales con derecho a ejercer la cirugía dental en Puerto Rico al amparo de la Ley Núm. 162-1941 quien comparece en representación de sus colegiados y cuya dirección es: Urb. Baldrich, 200 Avenida Domenech San Juan, Puerto Rico 00918.

B. Querelladas:

2. MMM Healthcare, LLC., es un plan HMO POS y un plan HMO C-SNP con un contrato Medicare. MMM Healthcare, LLC., es un plan HMO D-SNP con un contrato Medicare y un contrato con el programa Medicaid de Puerto Rico. con dirección física de 350 Chardón Ave. Torre Chardón, Suite 500, San Juan, Puerto Rico 00918-2101, número de teléfono 1-866-333-5470 y portal cibernético https://www.mmm-pr.com/sobre-mmm/quienes-somos.

3. El MSO de Puerto Rico, tiene como objetivo principal la gestión y administración de redes de proveedores, incluyendo la de empresas afiliadas como MMM Healthcare, LLC. Su dirección postal es PO BOX 71500, San Juan, P.R. 00936, con teléfono 1-866-676-6060 y dirección de portal cibernético www.mso-pr.com.

II. HECHOS

4. El 23 de noviembre de 2022, las partes querelladas le notificaron a todos los dentistas participantes de MSO para Mediacare Advantage cambios en el tarifario. Estas enmiendas al contrato entre las partes que conllevan reducciones en las tarifas fueron realizadas de manera unilateral por la parte querellada. En la misma comunicación y tambien de forma unilateral se notificó la elminación del Código D2710 (Crown-resin base composite). Se incluye como anejos 1 y 2 la carta y el tarifario enviado por las querelladas para el año 2023.

5. El 30 de noviembre de 2022, las partes querelladas le notificaron a todos los dentistas participantes cambios sustanciales en los procedimientos dentales que a partir de enero de 2023 requerirán preautorización. Esta enmienda al contrato entre las partes que aumenta considerablemente las preautorizaciones fue realizado de manera unilateral por las querelladas. Se incluye como anejos 3 y 4 la carta y el listado de los procedimientos que requieren preautorización.

6. Las tarifas reflejan una reducción de un diez por cento (10%) en cada procedimiento al que se le añade el requisito de la preautorización. Ambos cambios contractuales llevados a cabo de manera unilateral por las querelladas.

7. El contrato entre las querelladas y los dentistas participantes es un contrato de adhesión. Ya que fue diseñado y redactado por una sola de las partes o sea las querelladas. Sus cláusulas tienen que interpretarse en sentido desfavorable a las querelladas y a favor de los dentistas participantes. Artículo 1248 del Código Civil de Puerto Rico de 2020.

8. La reducción de tarifas y el aumento en los procedimientos que requieren preautorización constituyen una violación al Artículo 1249 del Código Civil de 2020[1].

9. Las mencionadas enmiendas unilaterales constituyen una violación al Código de Seguros de Puerto Rico que contiene la Ley 104 del 19 de julio de 2002, según enmendada, mejor conocida como la "Ley de Pago Puntual" de Reclamaciones de Proveedores de Servicios de Salud. Dicho estatuto establece que *"[e]l Comisionado tendrá la jurisdicción original respecto a las controversias que surjan entre proveedores participantes y aseguradores u organizaciones de servicios de salud, al amparo de esta Ley. …*" Ver 26 L.P.R.A. § 3007(c).

10. La Oficina del Comisionado de Seguros también es la encargada de reglamentar y fiscalizar el sector de los seguros de salud y se le confirieron amplios poderes para investigar, adjudicar las controversias y velar por el cumplimiento estricto de las disposiciones del Código de Seguros de Puerto Rico. Arts. 2.010 y 2.020 del Código de Seguros, 26 LPRA §§ 201 y 202.

11. El propio contrato vigente del MSO, reconoce que la jurisprudencia, legislación y reglamentación del Comisionado de Seguros son aplicables a situaciones similares. Ver inciso 1.3 del contrato denominado *Provider Services Agreement & GHP Addendum MSO-LEG-GHP-102018 2018©, MSO of Puerto Rico, LLC*. (anejo 5), el cual se cita a continuación:

> "*1.3 Applicable Law means such federal, state, and Commonwealth of Puerto Rico laws, rules and administrative regulations and guidance, including manuals, guidelines, operational policy letters, court decisions and written directions to Health Plans, that are adopted and/or published or sent to Health Plans by CMS, the Puerto Rico Office of the Insurance*

[1] Artículo 1249. — Cláusulas abusivas en los contratos celebrados por adhesión. (31 L.P.R.A. § 9803) Son especialmente anulables en los contratos celebrados por adhesión las siguientes cláusulas:
(a) la que no se redacta de manera clara, completa y fácilmente legible, en idioma español o inglés;
(b) la que autoriza a la parte que la redactó a modificar, unilateralmente, los elementos del contrato;
(c) la que le prohíbe o limita al adherente la interposición de acciones, y restringe las defensas o los medios de prueba a disposición del adherente, o invierte la carga de la prueba;
(d) la que excluye o limita la responsabilidad de la parte que la redactó;
(e) la que cambia el domicilio contractual del adherente sin que medien razones para ello;
(f) la que, ante el silencio del adherente, prorroga o renueva un contrato de duración determinada; y
(g) la que excluye la jurisdicción de una agencia reglamentadora.

Commissioner, or any other governmental body with authority over Health Plans. Applicable Law includes Medicare Program Requirements and all applicable requirements of the Puerto Rico Health Insurance Administration (Administración de Seguros de Salud de Puerto Rico or "ASES")." Énfasis suplido.

12. Conforme a los poderes delegados, la Oficina tiene la facultad de ordenarle a una parte que desista de violar la ley o el reglamento e imponer multas administrativas por infracciones al Código o los reglamentos promulgados o cualquier otra sanción autorizada estatutariamente. 26 LPRA §§ 203, 214-227, 320, 321, 946 y 948. Si la Oficina determina que la aseguradora ha violado alguna de las disposiciones del Código, este funcionario cuenta con la facultad de así declararlo dentro del adecuado trámite administrativo.

SÚPLICA

POR TODO LO ANTES EXPUESTO, se le solicita a la Oficina del Comisionado de Seguros que ordene a las querelladas a dejar sin efecto la reduccion de tarifas notificadas y la notificación añadiendo procedimeientos que requieren preautorización, así como cualquier otra enmienda unilateral al contrato que no sea requerida de manera obligatoria por legislación y reglamentación gubernamental.

Además, se solicita que la OCS dicte una orden para proteger a los dentistas partiipantes de cualquier acto de represalia por las querelladas por éstos radicar la querella que se presenta ante la OCS.

En San Juan, Puerto Rico, a 7 de diciembre de 2022

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Arminda Rivera Mora, DMD, MPH
Presidente
Colegio de Cirujanos Dentistas de Puerto Rico

MSO
OF PUERTO RICO

23 de noviembre de 2022 MSO-CTD-LET-065-111722-S

A TODOS LOS DENTISTAS PARTICIPANTES DE MSO OF PUERTO RICO PARA MEDICARE ADVANTAGE

Ref. Tarifario 2023

Estimado proveedor:

A continuación, le presentamos los cambios al tarifario para la línea de negocio de Medicare Advantage, que MSO of Puerto Rico está realizando conforme a lo establecido en el *MSO Provider Service Agreement*. Estos cambios serán efectivos el 1 de enero de 2023.

Además, le notificamos que el código D2710 (Crown - resin-based composite) fue eliminado del tarifario. Para más información, acceda a nuestro portal de proveedores en www.Innovamd.com., en el cual podrá obtener la lista actualizada del *MSO Fee Schedule*.

Agradecemos la calidad del servicio que ofrece a los afiliados de MMM. De tener cualquier pregunta, comuníquese con el Departamento de Relaciones con el Proveedor, de lunes a viernes, de 7:00 a.m. a 7:00 p.m., al 787-993-2317 (Área Metro), o al 1-866-676-6060 (libre de cargos).

Cordialmente,

Nelson A. Pérez Surillo, JD
Vicepresidente de Contrataciones a Proveedores

2023 Dental Fee Schedule for General Dentists

Classification	Procedure Code	Procedure Description	Fee Schedule	Please Include
Diagnostic and Preventive				
	D0120	Periodic Oral Evaluation	$14.28	
	D0140	Emergency Oral Evaluation	$20.70	
	D0145	Oral Evaluation for a patient under 3 years of ages and counseling with primary caregiver.	$16.56	
	D0150	Comp. Oral Evaluation	$22.58	
	D0210	X ray Complete Series	$47.00	
	D0220	X ray First P.A.	$8.28	
	D0230	X ray Additional P.A.	$7.60	
	D0270	Bitewing/Single	$8.28	
	D0272	Bitewing/2 films	$15.53	
	D0330	Panoramic Film	$45.00	
	D0367	Cone Beam CT capture and interpretation with field of view of both jaws Upper/Lower	$125.00	
	D0383	Cone Beam CT capture with field of view of both jaws Upper/Lower	$125.00	
	D0460	Pulp vitality tests (includes multiple teeth and contra lateral comparison)	$10.00	
	D1110	Prophylaxis Adult	$40.00	
	D1120	Prophylaxis Children	$25.00	
	D1208	Topical Fluoride (Children under 19)	$17.60	
	D1351	Sealant Per Tooth	$18.00	
Comprehensive Treatment				
	D2140	Amalgam 1 Surface	$34.67	
	D2150	Amalgam 2 Surface	$42.68	
	D2160	Amalgam 3 Surface	$50.92	
	D2161	Amalgam 4 or more Surfaces	$60.10	
	D2330	Resin- 1 Surface	$39.93	
	D2331	Resin- 2 Surfaces	$49.07	
	D2332	Resin- 3 Surfaces	$58.81	
	D2335	Resin- 4 Surf/Incisal	$70.38	
	D2391	Resin Posterior	$43.74	
	D2392	Resin- 2 Surfaces Posterior	$56.06	
	D2393	Resin- 3 Surfaces Posterior	$68.00	
	D2394	Resin- 4 or more Surfaces Posterior	$78.61	
	D2940	Sedative Filling	$31.25	
Crowns Treatment				
	D2712	Crown – ¾ resin-based composite (indirect)	$157.50	

	D2740	Crown – porcelain/ ceramic	$460.35	Preauthorization Pre and Post X-rays
	D2750	Crown – porcelain fused to high noble metal	$460.35	Preauthorization Pre and Post X-rays
	D2751	Crown – porcelain fused to predominantly base metal	$410.85	Preauthorization Pre and Post X-rays
	D2752	Crown – porcelain fused to noble metal	$410.85	Preauthorization Pre and Post X-rays
	D2799	Provisional crown	$63.00	
	D2910	Re- cement or re-bond inlay, onlay, veneer or partial coverage restoration	$30.00	
	D2915	Re- cement or re-bond indirectly fabricated or prefabricated post and core	$30.00	
	D2920	Re-cement or re-bond crown	$30.00	
	D2931	Prefabricated stainless-steel crown – permanent tooth	$90.00	
	D2932	Prefabricated resin crown	$54.00	
	D2950	Core buildup, including any pins when required	$75.00	
	D2951	Pin retention – per tooth, in addition to restoration	$20.00	
	D2952	Post and core in addition to crown, indirectly fabricated	$165.00	
	D2954	Prefabricated post and core in addition to crown	$99.00	
	D2962	Labial veneer (porcelain laminate) - indirect	$400.00	Preauthorization Pre and Post X-rays
Endodontics Treatment				
	D3120	Pulp Cap-Indirect	$20.00	
	D3220	Therapeutic pulpotomy (excluding final restoration)	$48.85	
	D3221	Pulpal debridement, primary and permanent teeth	$24.15	
	D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$173.25	
	D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$275.00	
	D3330	Endodontic therapy, molar tooth (excluding final restoration)	$375.00	Pre and Post X-rays
	D3333	Internal root repair of perforation defects	$40.00	By Report
	D3346	Retreatment of previous root canal therapy - anterior	$200.00	Preauthorization Pre and Post X-rays
	D3347	Retreatment of previous root canal therapy - premolar	$300.00	Preauthorization Pre and Post X-rays
	D3348	Retreatment root canal	$375.00	Preauthorization Pre and Post X-rays
Periodontics Treatment				
	D4210	Gingivectomy or Gingivoplasty-Four or More Contiguous Teeth, Per Quadrant	$160.00	Preauthorization X rays & Periocharting
	D4211	Gingivectomy or Gingivoplasty-One or Three Teeth, Per Quadrant	$80.00	Preauthorization X rays & Periocharting

	D4341	Periodontal Scaling and root planning (4 or more teeth per quadrant)	$71.50	Preauthorization X rays & Periocharting
	D4342	Periodontal Scaling and root planning (1 to 3 teeth per quadrant)	$38.50	Preauthorization X rays & Periocharting
	D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis on a subsequent visit	$40.00	
	D4910	Periodontal Maintenance	$44.00	
Complete and Partials Dentures (Partials Dentures no need Preauthorization)				
	D5110	Complete Denture- Maxillary	$500.00	
	D5120	Complete Denture - Mandibular	$500.00	
	D5130	Immediate Denture- Maxillary	$475.00	
	D5140	Immediate Denture- Mandibular	$475.00	
	D5211	Maxillary partial Denture including any conventional clasp	$450.00	
	D5212	Mandibular partial Denture including any conventional clasp	$450.00	
	D5213	Maxillary partial Denture –metal base	$550.00	
	D5214	Mandibular partial Denture – metal base	$550.00	
	D5225	Maxillary partial denture- flexible base (including retentive/ clasping materials, rest and teeth)	$650.00	
	D5226	Mandibular partial denture- flexible base (including retentive/ clasping materials, rest and teeth)	$650.00	
	D5282	Maxillary Partial Dent - Unilateral – one-piece cast metal (including retentive/ clasping materials, rest and teeth)	$220.00	
	D5283	Mandibular Partial Dent – Unilateral – one-piece cast metal (including retentive/ clasping materials, rest and teeth)	$220.00	
	D5284	Removable unilateral partial denture, one-piece flexible base per quadrant	$450.00	
	D5286	Removable unilateral partial denture, one-piece resin base per quadrant	$220.00	
Repairs and Adjustments for Dentures				
	D5410	Adjust Complete Maxillary Denture	$19.80	
	D5411	Adjust Complete Mandibular Denture	$19.80	
	D5421	Adjust Partial Denture - Maxillary	$19.80	
	D5422	Adjust Partial Denture – Mandibular	$19.80	
	D5511	Mandibular Partial Dent - Resin base (including retentive/clasping materials, rest and teeth)	$39.60	By Report
	D5512	Maxillary Partial Dent - Resin base (including retentive/clasping materials, rest and teeth)	$39.60	By Report
	D5520	Replace Tooth On Denture	$29.70	By Report
	D5611	Repair Resin Partial Dent. Mandibular	$44.55	By Report
	D5612	Repair Resin Partial Dent. Maxillary	$44.55	By Report
	D5630	Repair or replace broken retentive/clasping materials – per tooth	$69.30	By Report
	D5640	Replace BRKN Tooth	$39.60	By Report
	D5650	Add Tooth to existing Partial Denture	$49.50	By Report
	D5660	Add Clasp to existing Partial Denture	$74.25	By Report

	D5710	Rebase Complete Maxillary Denture	$74.25	
	D5711	Rebase Complete Mandibular Denture	$74.25	
	D5720	Rebase Maxillary Partial Denture	$74.25	
	D5721	Rebase Mandibular Partial Denture	$74.25	
	D5730	Reline Full Maxillary Denture/ direct	$89.10	
	D5731	Reline Full Mandibular Denture/direct	$89.10	
	D5740	Reline Partial/ Maxillary Denture/ direct	$49.50	
	D5741	Reline Partial/ Mandibular Denture/ direct	$54.45	
	D5750	Reline complete maxillary denture /indirect	$125.00	By Report
	D5751	Reline complete mandibular denture / indirect	$125.00	By Report
	D5850	Tissue Conditioning Maxillary	$34.65	
	D5851	Tissue Conditioning Mandibular	$34.65	
Implants Treatments: General Dentist must be certified to perform an implant (see important notes for details)				
	D6010	Surgical Placement of Implant body; endosteal implant	$800.00	Preauthorization Pre and Post X-rays
	D6011	Surgical access to an implant body (Second Stage of Implant Surgery)	$250.00	Preauthorization Pre and Post X-rays
	D6056	Prefabricated Abutment - includes placement	$300.00	Preauthorization Pre and Post X-rays
	D6057	Custom Abutment - includes placement	$450.00	Preauthorization Pre and Post X-rays
	D6058	Abutment supported porcelain/ceramic crown	$550.00	Preauthorization Pre and Post X-rays
	D6059	Abutment supported porcelain to metal (high noble)	$550.00	Preauthorization Pre and Post X-rays
	D6060	Abutment supported porcelain to metal (noble)	$550.00	Preauthorization Pre and Post X-rays
	D6061	Abutment supported porcelain fused to metal crown (nobel metal)	$550.00	Preauthorization Pre and Post X-rays
	D6062	Abutment supported cast metal crown (high nobel metal)	$550.00	Preauthorization Pre and Post X-rays
	D6063	Abutment supported cast metal crown (predominantly base metal)	$550.00	Preauthorization Pre and Post X-rays
	D6064	Abutment supported cast metal crown (Nobel metal)	$550.00	Preauthorization Pre and Post X-rays
	D6065	Implant supported porcelain/ceramic crown	$550.00	Preauthorization Pre and Post X-rays
	D6066	Implant supported porcelain crown (ceramic)	$550.00	Preauthorization Pre and Post X-rays

	D6067	Implant supported metal Crown (Titanium, Alloy, High Noble Metal)	$550.00	Preauthorization Pre and Post X-rays
	D6068	Abutment supported retainer for porcelain/ceramic FPD	$550.00	Preauthorization Pre and Post X-rays
	D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$550.00	Preauthorization Pre and Post X-rays
	D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$550.00	Preauthorization Pre and Post X-rays
	D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$550.00	Preauthorization Pre and Post X-rays
	D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$550.00	Preauthorization Pre and Post X-rays
	D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$550.00	Preauthorization Pre and Post X-rays
	D6074	Abutment supported retainer for cast metal FPD (noble metal)	$550.00	Preauthorization Pre and Post X-rays
	D6075	Implant supported retainer for ceramic FPD	$550.00	Preauthorization Pre and Post X-rays
	D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$550.00	Preauthorization Pre and Post X-rays
	D6077	Implant supported retainer for metal FPD – high noble alloys	$550.00	Preauthorization Pre and Post X-rays
	D6085	Provisional implant crown	$195.00	Preauthorization Pre and Post X-rays
	D6094	Abutment supported crown - titanium and titanium alloys	$550.00	Preauthorization Pre and Post X-rays

	D6110	Implant/Abutment supported removable denture for edentulous arch – maxillary.	$600.00	Preauthorization Pre and Post X-rays
	D6111	Implant/Abutment supported removable denture for edentulous arch – mandibular	$600.00	Preauthorization Pre and Post X-rays
	D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	$600.00	Preauthorization Pre and Post X-rays
	D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$600.00	Preauthorization Pre and Post X-rays
	D6191	Semi-precision abutment - placement	$405.00	Preauthorization Pre and Post X-rays
	D6192	Semi- precision attachment - placement	$90.00	Preauthorization Pre and Post X-rays
Prosthodontics Fixed				
	D6240	Pontic porcelain fused to high noble metal	$460.35	Preauthorization Pre and Post X-rays
	D6241	Pontic- porcelain fused to predominantly base metal	$410.85	Preauthorization Pre and Post X-rays
	D6242	Pontic – porcelain fused to noble metal only	$410.85	Preauthorization Pre and Post X-rays
	D6245	Pontic – porcelain/ ceramic	$460.35	Preauthorization Pre and Post X-rays
	D6750	Retainer crown porcelain fused to high noble metal	$460.35	Preauthorization Pre and Post X-rays
	D6751	Retainer crown - porcelain fused to predominanlty base metal	$410.85	Preauthorization Pre and Post X-rays
	D6752	Retainer Crown – porcelain fused to noble metal only	$410.85	Preauthorization Pre and Post X-rays
	D6740	Retainer crown - porcelain/ceramic	$460.35	Preauthorization Pre and Post X-rays

	D6930	Re-cement or re-bond fix partial denture	$39.00	
Oral Surgery				
	D7140	Extraction Erupted	$45.00	
	D7210	Extraction, erupted tooth	$80.00	
	D7220	Removal of impact tooth – soft tissue	$112.15	
	D7230	Removal of impact tooth – partially bony	$138.25	
	D7240	Removal of impact tooth – completely bony	$160.00	
	D7250	Surg Ext Residual Roots	$50.00	
	D7471	Removal of lateral exostosis (maxilla or mandible)	$200.00	By Report
	D7472	Removal of Torus Palatinum	$200.00	By Report
	D7473	Removal of Torus Mandibularis	$200.00	By Report
	D7510	Incision and drainage of abscess – intraoral soft tissue	$22.41	
	D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (*includes drainage of multiple fascial spaces)*	$50.00	
	D7961	Buccal / labial frenectomy (frenulectomy)	$125.00	By Report
	D7962	Lingual frenectomy (frenulectomy)	$125.00	By Report
Other Services				
	D9110	Palliative Treatment-Pain	$23.76	By Report
	D9410	House/ extended care facility call	$45.00	
	D9420	Hospital or ambulatory surgical center call	$220.00	By Report

Important Notes:

- Some coverage has a maximum annual benefit for all comprehensive services.
- **The maximum annual benefit exclude** Diagnostic and Preventive Services, **except for Platino Coverages**, that the maximum annual benefit also excludes the following codes: D2140 - D2150 - D2160 - D2161 - D2330 - D2331 - D2332 - D2335 - D2391 - D2930 - D2940 - D3120 - D3220 - D3221 - D3310 - D3320 - D7140 - D7210 - D7220 - D7230 - D7240 - D7250 - D7510 - D9110 and D9223.
- It is very important that before providing a service to a patient, verify the ***2023 Benefits Table*** and/or contact a Provider Representative in our Call Center for the availability of annual maximum and the service to be provided.
- Code **(D0145**) is covered 1 per year and limited for patient under three (3) years of ages and counseling with primary caregiver.
- Comprehensive Oral Evaluation (**D0150**). Up to 2 per year with different provider and different dental office. Covered every 36 months per provider.
- Radiographies (**D0220 and D0230**) will be covered per teeth up to 6 every 12 months, Bitewing (**D0272 and D0270**) covered every 12 months. This benefits only applies 12 months after a one full mouth (**D0210**) radiographic images or one (1) panoramic (**D0330**) radiographic image.
- The codes (**D0210 and D0330**) are limited to 1 every 36 months and one limits the other. Any other periapical or bite wing radiographs will be covered 12 months after the date of service of one full mouth (D0210) or one (1) panoramic (D0330 is done.
- **Cone Beam** CT capture and interpretation with field of view of both jaws Upper/Lower; with or without cranium, code **(D0367)** covered 1 every 6 months
- **Cone Beam** CT image capture with field of view of both jaws Upper/Lower; with or without cranium, code **(D0383)** covered 1 every 6 months
- Pulp vitality tests (**D0460)** will be covered per quadrant, every 6 months. One pulp vitality test per visit, regardless of the number of teeth evaluated.
- Code **(D1110)** is covered (1) one every 6 months and will be limited by (**D4910**) or vice versa.
- Codes **(D2712 – D2799 - D2931- D2932)** are authorized to be used as a temporary crown in cases where codes (**D2740, D2750, D2751 and D2752)** will be the final restoration.
- Temporary Crowns **(D2712, D2740, D2750, D2751, D2752, D2799, D2931 and D2932**) will be covered every 5 years per tooth and post and core (**D2952 and D2954**) will be covered 1 per tooth, for life.

- **Codes (D2712 -D2799 - D2931- D2932- D2950- D2951- D2952 - D2954)** do not need preauthorization, except if 8 or more will be made.
- **Codes (D2740- D2750- D2751- D2752) require preauthorization and must be sent with x-rays.**
- Once the crown (**D2740, D2750, D2751 and D2752)** work is completed and ready to send for payment, the claim should be sent with doctor signature and a post-operative radiography for final evaluation and payment approval.
- Re-cementation of crowns (**D2910 -D2915 - D2920 and D6930**) is limited for payment to 1 per tooth per life, after 6 months of the initial cementation.
- **(D2950)** Core buildup, including any pins when required. Covered every 24 months.
- **(D2951)** Pin retention – per tooth, in addition to restoration. Covered every 24 months.
- (D2962) Labial veneer (porcelain laminate) – indirect will be covered every 5 years per tooth **require preauthorization and must be sent with x-rays.**
- Pulpotomy and Pulpal debridement (**D3220 and D3221**) are covered on permanent teeth only, one per tooth per life.
- Root Canal therapy **(D3310 – D3320 and D3330)** is covered on permanent teeth only and limited one per tooth per life.
- Code (**D3330)** must be bill with **pre and post x-rays for payment.**
- An endodontic treatment will not be recognized for payment when it is performed for preventive purposes in asymptomatic tooth, and if documents received do not show clinical pathology radiographically.
- (D3333) Internal root repair of perforation defects in covered 1 per tooth per life. Required By Report.
- Retreatments (**D3346 – D3347 and D3348**) are covered in permanent teeth only and 1 treatment per tooth per life.
- Retreatments requires predetermination and must be accompanied by a detailed report of the clinical findings and possible causes to redo the root canal and the pre and post-operative radiographies.
- Retreatment will be approved if it is performed by a different dentist and/or different dental office and must be sent with a by report and x-rays for evaluation.
- A retreatment will be covered by the same dentist/ same dental office, only if the service was performed before 3 years of the original endodontic treatment. For evaluation and final determination, must be sent to pre-authorize with radiographs and a by report.
- Full mouth debridement (**D4355**) is covered 1 every 12 months.

- Code **(D4910)** is covered (1) one every 6 months, should have a previous periodontal treatment history and will be limited by (D1110) or vice versa.

- Codes **(D4210 – D4211- D4341-D4342)** **Required preauthorization.**
- Codes (**D4210 – D4211 - D4341- D4342**) are covered every 24 months.

- Codes **(D4210 and D4211)** are related to cases of gingival hyperplasia with no or minimal bone loss.

- Code (**D4210**) it is used when the quadrant contains 4 or more teeth requiring surgery; for cases where surgery is only required on 1 or 3 teeth in the same quadrant, the code to be used is (**D4211**).

- Any predetermination for a soft tissue surgery requires a report indicating the need for it. In addition, photos should be included as a diagnostic aid.

- Exclude any surgical procedure for cosmetic purposes.

- Codes **(D5110- D5120- D5130 - D5140 – D5211 – D5212 - D5213 – D5214 - D5225- D5226 – D5282 – D5283 D5284 and D5286) do not need preauthorization** and will be limited to one per arch every 5 years and limited by any other removable prosthesis and vice versa.

- Dentures in flexible base (Valplast), codes (**D5225 and D5226**) will not be covered on full dentures.

- Dentures in flexible base (Valplast), codes (**D5225 and D5226**) will be limited to one per arch every 5 years and will be limited by any other removable prosthesis and vice versa. Exceptions may apply by report.

- Unilateral Dentures (**D5282 – D5283 – D5284 and D5286**) must include tooth/teeth numbers.

- Unilateral dentures **(D5282 – D5283 - D5284 and D5286)** will be limited up to 2 unilateral per arch every 5 years.

- Study Models (D0470) are included in the fee for all prosthetic services (D5110- D5120- D5130 - D5140 – D5211 – D5212 - D5213 – D5214 - D5225- D5226 – D5282 – D5283 D5284 and D5286) including crowns, fix bridges and implants.

- **Adjustment, rebase, repairs, relines or replace clasps** for flexible partial denture (Valplast*) are not covered**.** Exceptions may apply by report.

- Codes (**D5511, D5512, D5611 and D5612**) are covered 2 repairs per denture every 12 months after 6 month of denture delivery.

- Codes (**D5511 to D5660**) must be sent with by report.

- **Relines Complete Dentures** (**D5750 and D5751)** require by report and are covered 1 per denture every 5 years and will be covered after 6 months from the date of insertion. Includes all necessary adjustments within 6 months of insertion date.

****Implants will be covered <u>when performed by a certified dentist.</u>**

- Some Alianza coverage does not have a maximum annual benefit <u>but does have up to 8 implants covered.</u> (*See **2023** **Benefits Table for details)***

- **Implant Services:**

    - All Implants codes require pre-authorization.

    - Surgical placement of the implant body, endosteal implant (**D6010)** and Second Stage of Implant Surgery **(D6011)** are covered 1 per tooth per life.

    - Implant body is also included in the fee of code (D6010)

    - Implant Abutments, codes (**D6056, D6057, D6191 and D6192**) are covered 1 per tooth per life. Before being requested, the implants must be inserted, otherwise, they will be denied.

    - Crowns on implants (**D6058 - D6059 - D6060 - D6061 – D6062 – D6063 – D6064 -D6065 – D6066 – D6067 – D6072 – D6073 – D6074 -D6076 – D6094**) covered 1 per tooth every 5 years. Before being requested, the implants must be inserted, otherwise, they will be denied.

    - Implant/Abutment supported removable denture codes (**D6110 – D6111 – D6112 – D6113**) covered 1 per tooth every 5 years and need preathorization

    - Once the implants work is completed and ready to send for payment, <u>the claim should be sent with doctor signature, a post-operative radiography and implants stamp for final evaluation and payment approval.</u>

    - The tooth number to be used to identify the place of insertion of the crown on an implant will be the area of the absent tooth replaced by the corresponding implant.

    - The implant where the crown will be inserted must radiographically show osseointegration and comply with the most recent standards established by the dental profession.

    - Replacement of crowns on implants will be considered after 5 years with appropriate justification.

    - Partials and implant dentures are mutually exclusive and cannot be replaced for 5 years.
    - Constructing a complete or partial removable denture on an implant includes all procedures, techniques and materials. It also includes all adjustments, repairs and overruns up to 6 months after the date of insertion.

<u>Important Notes for Implants services:</u>

- Mini Implants will not be accepted as part of Implants coverage

- ***Implant failure will be absolute responsibility of provider and will not be payable if the retreatment is performed by the same provider.

- Some Alianza coverage does not have a maximum annual benefit but does have up to 10 of Retainer Crowns covered. (*See **2023** **Benefits Table for details)***

- **Pontics and Retainers** (D**6240- D6242- D6245- D6740- D6750 and D6752**) will be covered 1 per tooth per life. For more details see benefits table.
- **Pontics and Retainers codes** (**D6240 - D6242- D6245- D6740 – D6750 -D6751 and D6752**) the claim should be sent with **pre and post x-rays and dentist signatures for final evaluation and payment approval.**

- Each retainer and pontic (**D6240, D6242, D6245 and D6740 D6750, D6751, D6752**) constitutes a unit in a fixed partial denture.

- **Re-cement or re-bond fix partial dentures** (**D6930**) covered every 5 years and will be covered after 6 months from the date of insertion.

- Removal of lateral exostosis **(maxilla or mandible) (D7471),** Removal of torus Palatinum **(D7472)** and Removal of torus Mandibularis **(D7473)** are covered 1 per arch every 5 years. Require by report.

- Codes **(D7961)** Buccal / labial frenectomy and **(D7962)** Lingual frenectomy are covered 1 per arch, per life. Require By Report indicating the need for the frenectomy. In addition, photos should be included as a diagnostic aid.

- Incision and drainage (**D7510 – D7521)** are covered 1 per quadrant per year.
- Local Anesthesia, sutures and surgical tray are included in the fee for all surgical services.

- House/ extended care facility call (**D9410**) includes visits to nursing homes, hospice sites, institution, etc., and is payable 1 per facility with by report.

- Hospital or ambulatory surgical center call – care (**D9420**) is covered when is provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center and is payable 1 per hospital with by report.

- It is very important that before performing any dental procedure contact our Call Center and verify that the services are available on the day that will be rendered or are covered by MSO of Puerto Rico.

- Almost all covers have a maximum quantity, so it is important to verify the available balance before performing any comprehensive service.

- Only some crowns, pontics, and implants services need to be sent with x-rays. For more information regarding the codes that need to be sent with specific documents, please refer to the list of dental codes mentioned above.

- The provider will have up to **180 days** to complete a preauthorized service, if you understand that it will take longer, you must request an extension before the expiration date of the existing preauthorization, which will have an additional 180 days to be completed.

- All payments are subject to the balance available at the moment the service was done.
- Being a participating provider of MSO of Puerto Rico, you should not charge our members for any service covered by the plan.
- MSO will deny payments in any claim with more than 90 days from the date of service.

For additional information, please visit www.innovamd.com or consult the Provider Manual or refer to the letters and / or notifications that are sent from MSO of Puerto Rico, LLC and / or contact a Provider Service Representative in our Call Center at (787) 522 -5699 (Metro Area), or 1-877-522-0670 (toll free), Fax (787) 625-3372.

Remember to send your correspondence to the following address:

PO BOX 71303
SAN JUAN PR 00936-8403

Échale leña al fuego!

"Además, reconocemos que la clave para ofrecer servicios de salud oral de alta calidad es trabajar en equipo con nuestros proveedores."...😂🤣😡🤬🤐

MSO
OF PUERTO RICO

Departamento Dental de MSO

30 de noviembre de 2022 MSO-DEN-LET-015-113022-S

A TODOS LOS PROVEEDORES PARTICIPANTES EN LA RED DENTAL

Estimado proveedor:

Deseamos comunicarle que, como todos los años, actualizamos la lista de los servicios que requerirán preautorización a partir del 1 de enero de 2023. Usted tendrá acceso a esta lista de códigos en formato electrónico a través de www.innovamd.com a partir de hoy.

Valoramos su colaboración para cumplir con los criterios de preautorización, según nos requieren las agencias reguladoras. Además, reconocemos que la clave para ofrecer servicios de salud oral de alta calidad es trabajar en equipo con nuestros proveedores. Para más información, comuníquese con Servicios al Proveedor al 787- 993-2317 (Área Metro) o 1-866-676-6060 (libre de cargos), lunes a viernes, de 7:00 a.m. a 7:00 p.m.

Cordialmente,

Dr. Waldemar Ríos Álvarez
Principal Oficial Médico
MSO of Puerto Rico, LLC

Dental Services with PA Requirements

Effective on January 1st, 2023, the codes listed below are subject to Prior Authorization. Please submit the applicable documentation along with the diagnoses and patient information through the MMM Dental Portal available from the Inmediata Group provider portal, SecureTrack® Health

Service Category	Dental Code	Dental Code Description	Documentation Required
Diagnostic Services Imaging – CT	D0367	Cone Beam CT capture and interpretation with field of view of both jaws U/L	Narrative of Medical Necessity
	D0383	Cone Beam CT capture with field of view of both jaws U/L	
Restorative Crowns	D2799	Provisional Crown (only coverage with fixed prosthodontics coverage)	Pre-treatment radiographic image; narrative of medical necessity
	D2950	Core Buildup, Including Any Pins	Pre-treatment radiographic image
	D2952	Cast Post and Core in Addition to Crown	
	D2954	Prefabricated Post and Core in Addition to Crown	
Endodontic Therapy Including Treatment Plan, Clinical Procedures and FU Care	D3310	Anterior Canal Therapy (excluding final restoration)	Pre-treatment radiographic image
	D3320	Bicuspid Canal Therapy (excluding final restoration)	
	D3330	Molar Canal Therapy (excluding final restoration)	
	D3333	Internal root repair of perforation defects	
Periodontics Surgical Services (Including usual post operative care)	D4260	Osseous Surgery NC Four or More Teeth	Pre-op x-rays, period charting, narrative of medical necessity
	D4261	Osseous Surgery – One to Three Teeth	
Removable Prosthodontics	D5110	Complete Denture – Maxillary	
	D5120	Complete Denture – Mandibular	
	D5130	Immediate Denture – Maxillary	
	D5140	Immediate Denture – Mandibular	

Dental Services with PA Requirements

Effective on January 1st, 2023, the codes listed below are subject to Prior Authorization. Please submit the applicable documentation along with the diagnoses and patient information through the MMM Dental Portal available from the Inmediata Group provider portal, SecureTrack® Health

Service Category	Dental Code	Dental Code Description	Documentation Required
	D5211	Maxillary Partial Denture – Resin Base (including retentive/ clasping materials, rest, and teeth)	
	D5212	Mandibular Partial Denture – (including retentive/ clasping materials, rest, and teeth)	
	D5213	Maxillary Partial Denture – Cast Metal Framework	
	D5214	Mandibular Partial Denture–Cast Metal Framework	
	D5225	Maxillary partial denture- flexible base (including retentive/ clasping materials, rest, and teeth)	
	D5226	Mandibular partial denture- flexible base (including retentive/ clasping materials, rest, and teeth)	
	D5282	Maxillary Partial Dent - Unilateral – one-piece cast metal (including retentive/ clasping materials, rest, and teeth)	
	D5283	Mandibular Partial Dent – Unilateral – one-piece cast metal (including retentive/ clasping materials, rest, and teeth)	
	D5284	Removable Unilateral Partial Denture – one-piece flexible base per quadrant	
	D5286	Removable Unilateral Partial Denture - one piece resin base per quadrant	
Adjunctive General Services Deep Sedation	D9222	Deep sedation /general anesthesia First 15 minutes increment	Narrative of medical necessity
	D9223	Deep sedation /general anesthesia each subsequent 15 minutes increment	

PROVIDER SERVICES AGREEMENT
BETWEEN
MSO of Puerto Rico, LLC.
AND

[redacted]

THIS PROVIDER SERVICES AGREEMENT (the "Agreement"), is made and entered into as of the day of _____ by and between **MSO of Puerto Rico, LLC. ("MSO"),** and [redacted] ("Provider") with National Provider Identification number (NPI) [redacted]

WHEREAS, MSO is a corporation organized under the laws of the Commonwealth of Puerto Rico that has as its primary objective the management and administration of provider networks whose participants agree to participate in and comply with the policies, procedures and reimbursement mechanisms established by MSO.

WHEREAS, MSO will offer to certain Health Plans the opportunity to enter into agreements for use of the providers participating in the MSO provider network.

WHEREAS, MSO and PROVIDER mutually desire to enter into an agreement whereby PROVIDER shall arrange for the provision of Services to Beneficiaries of a Health Plan, (as defined below), in compliance with MSO quality standards that preserves and enhances patients dignity.

NOW, THEREFORE, in consideration of the premises and mutual covenants herein contained and other good and valuable consideration, it is mutually covenanted and agreed by and between the parties hereto as follows:

ARTICLE I.
DEFINITIONS

For purposes of this Agreement and any attachment, addendum, exhibit or schedule attached hereto, the following terms shall have the meanings set forth below. In the event that any of the following defined terms are inconsistent with any federal and/or Commonwealth of Puerto Rico law or regulation which requires conformity of such terms, then the term as used herein shall automatically be deemed to be defined consistently with the applicable law and/or regulation

1.1 Accreditation Agency means any nationally recognized, non-governmental accreditation agency generally recognized in the managed care industry, including without limitation the National Committee for Quality Assurance ("NCQA") and the Utilization Review Accreditation Commission ("URAC"), which monitors, audits, accredits or performs other similar functions with respect to health maintenance organizations and other managed care organizations.

1.2 Advance Directive means a Beneficiary's written instructions, recognized under state law, relating to the provision of health care when the Beneficiary is not competent to make health care decisions as determined under state law. Examples of Advance Directives are a living will, a durable power of attorney for health care and health care surrogate designation.

1.3 Applicable Law means such federal, state, and Commonwealth of Puerto Rico laws, rules and administrative regulations and guidance, including manuals, guidelines, operational policy letters, court decisions and written directions to Health Plans, that are adopted and/or published or sent to Health Plans by CMS, the Puerto Rico Office of the Insurance Commissioner, or any other governmental body with authority over Health Plans. Applicable Law includes Medicare Program Requirements and all applicable requirements of the Puerto Rico Health Insurance Administration (Administracion de Seguros de Salud de Puerto Rico or "ASES")

1.4 ASES- means the Spanish acronym for the Puerto Rico Health Insurance Administration created by Law 72

[redacted]

of September 7, 1993, as amended, responsible for the administration of the benefits of Medicaid eligible and the Puerto Rico Government Health Insurance Plan ("GHIP" or "Mi Salud").

1.5 Beneficiary - means an eligible individual or Beneficiary covered by the Health Plan and/or enrolled under a Health Benefit Plan, and the eligible dependents of such individual who are enrolled under such Health Benefit Plan. In the event that a Health Plan has a government contract, the definition of Beneficiary shall include enrolled individuals from such government contracts.

1.6 CMS - is the Center for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare and Medicaid programs.

1.7 Coordination of Benefits - means the combining of Benefits under a Member Agreement with duplicate coverage under another health insurance policy such that total Benefits paid for Covered Services rendered to a Member do not exceed the amount the MSO would have paid under the terms of this Agreement had the Health Plan been the primary payer or in the case of a Medicare beneficiary the amount permitted to be paid pursuant to Title XVIII of the Act and its implementing regulations.

1.8 Covered Services - means those medical, dental and/or hospital services and benefits to which Beneficiaries are entitled under the terms of the applicable Health Benefit Plan as determined by a Health Plan, and has been contracted or otherwise delegated to the MSO the relevant portions of which may be made available upon request to PROVIDER by MSO or Health Plan.

1.9 Credentialing - means the process of collecting, verifying and evaluating information gathered in the Credentialing process, Medical Director interviews, site visits, references and peer review committees or organizations for the purpose of determining whether MSO shall designate or continue to consider Physician/Dentist as a Network Provider with respect to any or all of its products and provider networks. This process takes into account the past performance and volume of clinical activity of Physician/Dentist office with MSO. Credentialing will be repeated on a periodic basis ("Re-Credentialing") as per accrediting or certifying agencies requirements.

1.10 Dental Necessary – means those Covered Services provided by a dental professional which are:

- appropriate for the symptoms and diagnosis or treatment of a condition, illness, or injury;
- provider for the diagnosis, or the direct care and treatment of the condition, illness, or injury;
- in accordance with generally accepted standards of good dental practice;
- not primarily for the convenience of the member, or the member's dentist, or other provider; and
- the most appropriate Covered Services to be provided to the member.
- the fact that a Dentist prescribes, orders, recommends or approves a service does not, in and of itself, make the service or supply Dental necessary (or a Covered Services). The MSO Dental Director has final decision-making authority regarding decisions pertaining to dental necessary services under MMM/PMC coverage, subject to the Grievance and Appeals Systems.

1.11 Emergency/ Emergency Medical Condition - means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) serious jeopardy to the health of the individual or, in the case of the pregnant woman, the health of the woman or her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

1.12 Emergency Care and Services - means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a Covered Service by a physician necessary to relieve, stabilize or eliminate the Emergency Medical Condition, within the service capability of a hospital.

1.13 Health Benefit Plan- means the contract or certificate that sets forth the terms and conditions governing the relationship between a Health Plan and Beneficiary including the medical, dental and/or hospital benefits provided to, or arranged for, Beneficiary by a Health Plan.

1.14 Health Plan - means an entity licensed by the Office of the Insurance Commissioner as a health services organization or insurer under the laws of the Commonwealth of Puerto Rico that may have contracts with ASES, CMS, beneficiaries which have a direct contract with the plan, or employer groups to provide or arrange for covered benefits under a Health Benefit Plan. Health Plans who have entered into an agreement with MSO to arrange for and/or manage the provision of Covered Services to Beneficiaries are set forth on a schedule ("Health Plan Schedule") attached to the product specific Addendum. The Health Plan Schedule shall be deemed a part of this Agreement. Notwithstanding anything to the contrary in this Agreement, the Health Plan Schedule may be amended from time to time by MSO upon written notice to PROVIDER and may include health maintenance organizations, preferred provider organizations, indemnity plans, workers compensation plans, self-insured plans, employer groups, local, state, federal government bodies or agencies (including but not limited to CMS and ASES), prepaid health clinics, Beneficiaries of discount card organizations, and any and all other third party Health Plans who may offer, underwrite and/or administer health benefits.

1.15 HIPAA – means The Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191), which provides, among other things, for the continuity of healthcare, non-discrimination, payment integrity, and the privacy and security of health information.

1.16 Incident - is defined as any occurrence that is not routine in a health care facility. These situations may include, but are not limited to, the following: (a) any unusual occurrence; (b) a happening which could have or did result in an injury to a Beneficiary; (c) a condition, situation, procedure, etc., which could or did result in an injury to a Beneficiary, including any happening of an untoward (unusual) nature to a Beneficiary. Incidents shall not be limited to quality of care issues.

1.17 Laboratory Services – means covered clinical laboratory testing to provide information for the diagnosis, prevention or treatment of disease, or the assessment of a medical condition and includes, but is not limited to, microbiological, serological, chemical, hematological, cytological, immune-hematology, and pathological examinations performed on materials derived from the human body. Laboratory Service shall also include consulting services for all tests performed courier services, specimen collection, and specimen preparation at designated locations of Network Provider.

1.18 Medical Director - means a Physician/Dentist or his/her designee who has been designated by MSO to monitor and implement the provision of Covered Services to Beneficiaries.

1.19 MSO Dental Director – means a dentist appointed by MSO to assume overall responsibility for: (1) supervision of day-to-day dental administrative policies and procedures related to Network Provider activities; (2) coordination of peer review and Dental Quality Management activities; and (3) other Utilization Management activities.

1.20 Medically Necessary - means Covered Services which are defined by a Health Plan and described in the plan benefit package given to the Beneficiary and required by a Beneficiary of such Health Plan and which are all of the following: (a) Rendered for the treatment or diagnosis of an injury or disease; (b) Appropriate for and consistent with the symptoms, diagnosis, and treatment of a Beneficiary's condition, disease, ailment or injury and otherwise in accordance with standards of good medical practice within the community; (c) Not furnished primarily for the convenience of such Beneficiary, such Beneficiary's family, the attending Physician or other provider of service; and (d) Furnished at the most appropriate level that may be provided safely and effectively to the Beneficiary.

1.21 MSO Fee Schedule - means the fee schedule for Covered Services as established by the MSO, which may be modified from time to time in whole or in part at the sole discretion of the MSO.

1.22 MSO Provider Network means a network of Participating Providers contracted for the delivery of dental healthcare services to Health Plan Beneficiaries.

1.23 Participating Provider - means a health care provider including, but not limited to, physicians, dentist, hospitals and ancillary providers, that have entered into an agreement with the MSO, or on whose behalf a contract has been entered into with a the MSO, for the provision of Covered Services to Beneficiaries.

1.24 Physician - means a duly licensed doctor of medicine, osteopathic medicine, chiropractic, or podiatric medicine, each respectively having an unrestricted license to practice medicine in the Commonwealth of Puerto Rico, including, if applicable, an unrestricted license to prescribe controlled medications, substances and supplies. Every Physician must be credentialed pursuant to each Health Plan's (or MSO, if such function is delegated by Health Plan to MSO) credentialing criteria as required by the regulatory standards applicable to the Health Plan.

(a) Specialty Physician - means the Physician who has entered into a separate agreement with MSO or Health Plan, or on whose behalf an agreement has been entered into with MSO or a Health Plan (including any Physicians employed by, associated with or contracting with Specialty Physician), to provide certain services to Beneficiaries upon appropriate referral, as applicable.

(b) Covering Physician - means the Physician or other licensed health care provider, as may be appropriate, who has entered into an agreement, either oral or written, with a Provider to arrange Covered Services for his/her Beneficiaries when the Participating Provider is not available. Covering Physician may or may not be under an agreement with MSO or a Health Plan, however Covering Physicians shall meet each Health Plan's contracting criteria (or MSO's, if such function is delegated by Health Plan to MSO).

(c) Primary Care Physician - means a Participating Provider who has agreed to provide certain services to Beneficiaries who have selected or have been assigned to such Participating Provider and to assume primary responsibility for arranging and coordinating the overall health services of such Beneficiaries, as applicable.

1.25 Provider Manual - means the manual and materials furnished to Provider and/or Dentist/Physician by MSO for use of the former during the term of this Agreement, as amended and supplemented by MSO from time-to-time that provides specific guidelines and direction by which Provider may meet their contractual responsibilities. MSO retains the right to add to, delete from and otherwise modify the Provider Manual. The Provider Manual and other information and materials provided by MSO are proprietary and confidential and constitute trade secrets of MSO. The Provider Manual is available through the MSO InnovaMd web application.

1.26 Provider Services - means any and all professional services (and/or other services, equipment, supplies, etc. if PROVIDER is an ancillary or hospital provider) customarily provided in the community by a physician, dentist or other provider practicing or providing services in the specialty / field / business of PROVIDER which are Covered Services, rendered in a manner consistent with all provisions of this Agreement and MSO and the Health Plan's UM/QI protocols and the applicable Health Benefit Plan, and with respect to which PROVIDER has been credentialed in accordance with the terms of this Agreement, except as otherwise set forth in a subsequent Attachment or Plan Addendum.

1.27 Provider Services Agreement or Agreement – means this written Agreement between Provider and MSO designating Provider as eligible to provide Covered Services and incorporates by reference: Provider Manual, other written or web based communication, or any Addenda or Amendments.

1.28 Quality Management Program (QM) - means the policies, procedures, protocols, developed by MSO which can be amended from time to time, designed to monitor and ensure the quality of Covered Services by

Health Plan Members.

1.29 Surcharge - means a fee charged to a Health Plan Member for or with respect to a Covered Service, other than a Copayment, which fee is not authorized under the applicable Plan Agreement. Surcharges are prohibited.

1.30 Utilization Management Program (UM) - means the policies, procedures, protocols and functions developed by MSO which can be amended from time to time, designed to monitor and ensure the appropriate utilization of Covered Services by Health Plan Members.

1.31 Urgently Needed Services – means Covered Services provided when a Beneficiary is temporarily absent from the HEALTH PLAN Medicare Advantage Service Area (or, under unusual and extraordinary circumstances, provided when the Beneficiary is in the Service Area but HEALTH PLAN's provider network is temporarily unavailable or inaccessible) when such services are Medically Necessary and immediately required as a result of an unforeseen illness, injury, or condition; and it is not responsible given the circumstances to obtain the services through HEALTH PLAN's Network Providers.

ARTICLE II.
RELATIONSHIP OF THE PARTIES

2.1 Independent Contractor. MSO and PROVIDER are independent contractors. Neither PROVIDER nor other agents or representatives of PROVIDER shall be considered to be employees of MSO for any reason including, but not limited to, the Federal Unemployment Tax Act, any workers compensation act, and income tax withholding laws. PROVIDER shall have sole responsibility for the payment of all Federal and Commonwealth of Puerto Rico income taxes applicable to its services and the services of Provider and its other agents and representatives.

PROVIDER expressly acknowledges its understanding that this Agreement constitutes a legally binding agreement between PROVIDER and MSO. PROVIDER further acknowledges and agrees that it has not entered into the Agreement based upon representations by any person other than MSO and that no person, entity, or organization other than MSO shall be held accountable or liable to PROVIDER for any of MSO's obligations to PROVIDER created under this Agreement. This paragraph shall not create any additional obligations on the part of MSO other than those obligations created under this Agreement.

In the performance of this Agreement and in rendering Covered Services as required herein, PROVIDER shall at all time act as an independent contractor. Nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee or principal and agent, or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement. MSO shall not have nor exercise any control or direction over the methods by which PROVIDER shall perform their professional duties.

2.2 Patient Care. PROVIDER shall remain solely responsible for exercising independent judgment in decisions about patient care. PROVIDER hereby expressly acknowledges that MSO does not practice medicine/dental, and that PROVIDER shall be solely responsible for all clinical decisions regarding the admission, treatment and discharge of eligible persons under Providers care, notwithstanding the receipt by PROVIDER of any denial, authorization, or recommendation issued by MSO pursuant to the Utilization Management and Medical Quality Management Programs.

2.3 Professional Judgment. PROVIDER is not required to:
(a) Recommend any procedure or treatment which PROVIDER deems professionally unacceptable; or
(b) recommend that MSO deny benefits for any Medically Necessary procedure or course of treatment.

2.4 Medical/Dental Care Decisions.

(a) Network Providers covered by this contract shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy or medical practice of MSO or an entity representing or working for MSO.

(b) MSO or an entity representing or working for MSO shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of Network Providers covered by this contract.

(c) MSO shall not terminate this contract because Network Provider expresses disagreement with a decision by MSO or an entity representing MSO to deny or limit benefits to a Beneficiary or because the Network Provider assists the Beneficiary to seek reconsideration of MSO's decision, or because the Network Provider discusses with a current, former or prospective Beneficiary any aspect of the Beneficiary's medical condition, any proposed treatments or treatment alternatives, whether covered by MSO or not, policy provisions of Health Plan, or a Network Provider's recommendation regarding selection of a Health Plan based on the Network Provider's personal knowledge of the health needs of such Members.

2.5 Rights Reserved by MSO. MSO does not guarantee to PROVIDER any minimum number of Members. In addition, Provider acknowledges that MSO does not warrant or guarantee that Provider will be providing services to a particular Beneficiary or to any number of Members, or that PROVIDER's services will be identified or made available as those of a Network Provider for any number, subset or group of Members.

ARTICLE III
OBLIGATIONS OF MSO

3.1 Beneficiary Eligibility. Health Plan will provide to each Beneficiary an identification card that Beneficiary will be expected to present when seeking Covered Services from PROVIDER. MSO shall establish procedures to assist PROVIDER in verifying whether an individual presenting to a PROVIDER is a Beneficiary and PROVIDER shall comply with such verification procedures. MSO and Health Plan cannot guarantee the eligibility status of any individual. Health Plans make final eligibility determinations in their sole discretion. MSO shall be permitted to recover payments made to PROVIDER pursuant to this Agreement for such individuals retroactively terminated by Health Plan, and/ or Federal or State regulator, as applicable, to the date of ineligibility and shall have no liability to PROVIDER for any services rendered on or after the date of ineligibility. PROVIDER shall be permitted to seek payment from such individuals for whom services were provided on or after the date on which the individual became ineligible. In the event such Beneficiary is Medicaid (Mi Salud) and/or Medicare eligible, PROVIDER may seek payment directly from Medicaid and/or Medicare respectively.

3.2 Administrative Requirements and Procedures. MSO shall make available to PROVIDER administrative requirements and procedures in the areas of prior authorization of services, record keeping, reporting and other administrative duties of PROVIDER under this Agreement. PROVIDER agrees to abide by these administrative requirements and procedures.

3.3 Compensation. For all Provider Services for which PROVIDER is responsible hereunder, PROVIDER shall be compensated in accordance with ***Attachment A,*** unless superseded in accordance with a Health Plan Schedule. Compensation to PROVIDER shall be in accordance with and subject to MSO authorization and claims payment interpretative requirements which PROVIDER agrees to and accepts. An MSO authorization shall be in writing from MSO. A written authorization from any other person or entity, including a referral from a primary care physician/dentist or other provider or Health Plan, shall not constitute an MSO authorization. MSO may from time to time furnish PROVIDER with Provider bulletins/updates containing requirements for compensation under this Agreement. A prior payment from MSO to PROVIDER under circumstances where PROVIDER was not entitled to compensation under the terms and conditions of this

Agreement shall not be deemed a waiver of any subsequent right not to compensate PROVIDER. If a PROVIDER provides any Covered Service that is not a Provider Service or not specified in any Attachments or any non-Covered Service, PROVIDER shall not be entitled to any compensation for such services, except as provided in Section 3.1. PROVIDER shall accept such compensation and any applicable co-payments and/or deductibles or self-pay discounted payments (collectively "Co-payments") as payment in full for all services provided by PROVIDER except as otherwise provided by this Agreement. Unless specified otherwise, such Co-Payments shall be included as part of the compensation. In those cases where a Health Plan has contracted with MSO to manage the provision of Covered Services to Beneficiaries while maintaining active its direct agreement between such Health Plan and PROVIDER, or when a Health Plan has not delegated claims payment to the MSO, PROVIDER shall solely be compensated by Health Plan and not MSO for the provision of Covered Services, however PROVIDER shall nonetheless remain obligated to adhere to the terms and conditions of this Agreement to allow MSO to effectively manage the care of such Health Plan's Beneficiaries. Notwithstanding anything to the contrary herein, MSO shall not be obligated to compensate PROVIDER to the extent Health Plans have not compensated MSO with respect to such period of time or for such Covered Services.

3.4 Health Plan Liability. Health Plan shall have the full and final responsibility and liability for payment of all claims for Covered Services. MSO shall not be liable for the payment from its own funds of any claims under a plan unless funds for such certain services have been delivered by Health Plan to MSO. MSO is not the insurer, plan administrator, guarantor or underwriter of the liability of Health Plan to provide benefits to Beneficiaries. All final claims decisions will be the responsibility of Health Plan. Notwithstanding the foregoing, if for whatever reason PROVIDER is not entitled to compensation under the terms and conditions of this Agreement, Health Plan shall likewise not be responsible to PROVIDER. Notwithstanding anything to the contrary in this Agreement, in the event PROVIDER has any issue under this Agreement, payment or otherwise, it shall be a condition precedent for PROVIDER to seek recovery from MSO pursuant to this Agreement including appellate levels or otherwise, before proceeding in any manner against a Health Plan, unless otherwise specifically authorized in writing by MSO to PROVIDER.

3.5 MSO Provider Call Center. MSO has available to PROVIDER a Provider Call Center during normal business hours to respond to inquiries from PROVIDER.

ARTICLE IV.
OBLIGATIONS OF PROVIDER

4.1 Health Services, Authorizations and Referrals. PROVIDER agrees to provide or arrange for the provision of those Covered Services consistent with MSO's (or a Health Plan's, if applicable) utilization management and quality improvement program ("UM/QI Program") and the MSO Provider Manual as delivered to PROVIDER and modified from time to time. Provider Services are exclusively those Covered Services when performed by PROVIDER only to Beneficiaries in accordance with the applicable Beneficiary Agreement. PROVIDER also agrees to provide such records and other information as may be required or requested under such UM/QI Program. PROVIDER shall provide Covered Services, which except in the case of Emergencies, have been authorized according to MSO's UM/QI Program, including any referral and authorization procedures, as established by MSO or the Health Plan and modified from time to time, and to which compensation shall be subject. The issuance of a referral or authorization is not a guarantee of eligibility or payment. A Beneficiary's medical record must substantiate the provision of Covered Services and which record may be requested by MSO or Health Plan for such purpose. PROVIDER agrees, when applicable, (1) to refer Beneficiaries, when medically appropriate and except in Emergencies, only to other Participating Providers and only after receiving proper authorization as required by MSO; and (2) to comply with such other referral, authorization, pre-certification or pre-admission requirements as established by MSO and/ or Health Plan. In the event PROVIDER shall provide a Beneficiary non-Covered Services, PROVIDER shall, prior to the provision of such non-Covered Services, inform Beneficiary: (a) of the service(s) to be provided; (b) that MSO or the applicable Health Plan will not pay or be financially liable for said services; and (c) that

Beneficiary will be financially liable for such services. In the event the Beneficiary is not so informed, neither Beneficiary, nor such Health Plan shall be financially liable to PROVIDER for those services. PROVIDER shall not bill Beneficiaries for services that are determined by a Health Plan or MSO, in their sole discretion, not to be Medically Necessary unless PROVIDER has informed Beneficiary, in advance that the services are not Medically Necessary and has agreed in writing to be financially liable for those specific services. PROVIDER agrees to provide Covered Services in accordance with terms and conditions as specified in the Product-Specific ***Addendums*** incorporated herein by reference.

4.2 Provision of Services and Professional Requirements.

(a) PROVIDER shall make necessary and appropriate arrangements to ensure the availability of Provider Services to Beneficiaries on a twenty-four (24) hour per day, seven (7) day per week basis, including arrangements to ensure coverage of Beneficiaries after hours or when PROVIDER is otherwise absent. PROVIDER agrees that scheduling of appointments shall be done in a timely manner, as specifically defined in MSO Provider Manual or as otherwise required by applicable law. PROVIDER shall ascertain and ensure that such Covering Physician will cooperate with and accept the findings of MSO's peer review procedures as they relate to services provided to Beneficiaries and that such Covering Physician will seek authorization from the Medical Director prior to all hospitalizations, except for Emergencies or as otherwise provided in the UM/QI Program. For services rendered by Covering Physicians on behalf of PROVIDER, PROVIDER shall be responsible to make suitable arrangements with the Covering Physician regarding the amount and manner in which said Covering Physician will be reimbursed or otherwise compensated, provided, however, that PROVIDER shall ensure that the Covering Physician will not, under any circumstances, bill Beneficiaries (except Co-payments) or a Health Plan or MSO for Covered Services. PROVIDER shall be liable for paying Covering Physician provided that Provider has been compensated for such services, and PROVIDER hereby agrees to indemnify and hold harmless Beneficiaries, MSO, ASES, CMS and the applicable Health Plan against charges for Covered Services rendered by Covering Physician. It is understood that MSO reserves the right to make payment (directly or through the applicable Health Plan) to any Covering Physician for which a valid invoice, or portion thereof, is outstanding for more than thirty (30) days. MSO will provide notice of its intention to make payment of such claims but MSO need not wait the above thirty (30) day period where PROVIDER has engaged in a pattern of late payments to Covering Physician in the past, as reasonably determined by MSO. MSO or Health Plan may deduct any such payments plus a reasonable administrative fee from any amounts otherwise due PROVIDER pursuant to this Agreement.

(b) All services performed hereunder shall be consistent with the standards of medicine/dental and osteopathy in the community and such services shall, at a minimum, be performed in accordance with the customary rules of ethics and conduct promulgated by provider organizations, as applicable, and such other bodies, formal or informal, governmental or otherwise, from which health care providers seek advice and guidance or to which they are subject to licensing and control, as applicable. PROVIDER shall honor a Beneficiary's Advance Directive subject to the provisions of all applicable state and federal laws. At no time shall PROVIDER refuse or fail to provide medically necessary Covered Services to Beneficiaries.

(c) PROVIDER shall utilize such additional allied health and other qualified licensed personnel as are available and appropriate for effective and efficient delivery of health services, consistent with MSO policies. PROVIDER shall have an ongoing responsibility to ensure that PROVIDER'S employees, agents, and independent contractors meet, at all times during the term of this Agreement, all legal qualifications, including appropriate licensure and continuing education and that they are members in good standing of their profession.

(d) PROVIDER shall participate in any programs including continuing education as MSO or a Health Plan may require, as well as such programs that may be required by state regulatory authorities.

(e) PROVIDER shall notify MSO within one (1) business day of his/her/its becoming aware of: (i) loss or restriction of any of his/her/its hospital privileges; (ii) loss or limit of his/her/its DEA permit; (iii) loss or restriction of his/her/its license to provide health care services in any state as well as any actions taken by the state, any accrediting entity, or any other regulatory body that would materially impair the ability of PROVIDER to provide and/or arrange for health services to Beneficiaries; (iv) fine or other penalty, or loss or suspension of his/her/its participation in the Medicare and/or Medicaid Programs; (v) any adverse action by a governmental body, court or other forum having jurisdiction over PROVIDER; (vi) occurrence of an Incident at his/her/its facility involving a Beneficiary; (vii) conviction of a felony; or (viii) receipt of any state or federal government inquiry regarding PROVIDER which relates in any way to PROVIDER's authority or ability to perform its obligations pursuant to this Agreement.

(f) PROVIDER, in the event that PROVIDER is of a specialty that typically has admitting privileges, Internist or Family practioner only, shall have admitting privileges in at least one hospital with which MSO or each Health Plan has a written agreement or, in the alternative, PROVIDER must agree to use an admitting physician program panel as designated by MSO. In the event PROVIDER has admitting privileges at a hospital and loses such admitting privileges, PROVIDER shall advise MSO in writing within one (1) business day of such event and the reasons surrounding such event.

(g) PROVIDER and all health care providers employed by and/or associated with PROVIDER, including Covering Physicians, for the term of this Agreement, shall meet all credentialing and re-credentialing requirements as may be established by Federal and State regulators applicable to the MSO and/or a Health Plan from time to time. In the event PROVIDER is a primary care physician with assigned Beneficiaries and such PROVIDER'S credentialed status expires, such PROVIDER'S assigned Beneficiaries may be reassigned to another provider in lieu of termination of this Agreement.

(h) PROVIDER agrees and warrants that it is in compliance with all applicable local, state and federal laws and regulations relating to the operation, administration and maintenance of its facilities and the provision of medical/dental services.

(i) PROVIDER acknowledges MSO's and each Health Plan's obligation and right to report to and access the National Practitioner Data Bank as it relates to PROVIDER. PROVIDER agrees to assist MSO and Health Plans in accessing and reporting to the Data Bank, including making inquiries to the Data Bank on behalf of MSO and a Health Plan, if requested to do so by MSO or a Health Plan.

(j) PROVIDER agrees to implement applicable and reasonable procedures necessary for external accreditation of each Health Plan and/or MSO by the National Committee for Quality Assurance (NCQA) or any other similar organization selected by such Health Plan and/or MSO, and to perform in accordance with any and all applicable standards and requirements.

(k) PROVIDER shall comply with any and all applicable state, federal and other laws and regulations governing contracting providers of health care service plans and relating to the subject matter of this Agreement.

(l) In addition, the parties agree that the Medicare Advantage Addendum and any other product specific addendum, respectively, attached hereto and made a part hereof, shall apply to Covered Services rendered to Beneficiaries of a Health Plan's benefit plan pursuant to its Medicare Advantage contract with CMS.

4.3 Claims.

(a) PROVIDER shall, within ninety (90) days after (a) discharge for inpatient services or (b) the date of service for outpatient services, ("Claims Submission Period"), submit a bill to MSO in a billing form acceptable to MSO (i.e. CMS 1500 or ADA Dental Claims Form) along with any applicable authorization/referral documentation as instructed by MSO or other applicable documentary support, for

all services rendered in a manner consistent with the terms of the Agreement. MSO agrees that claims payments will be processed within thirty (30) days of receiving a clean claim or the time specified by current regulations as established in the product specific addendums. The MSO is not obligated to make any payment for claims received after the ninety (90) days mentioned in this section.

(b) Provider shall submit all claims and encounter data through electronic format. MSO reserves the right to charge PROVIDER a fee for the processing of claims and encounters submitted in paper form.

(c) Provider shall allow MSO to adjust CPT/HCPCS or CDT codes as appropriate if services have been unbundled or otherwise improperly coded.

(d) Provider agrees to submit claims for Covered Services including his/her National Provider Identifier (NPI) Number.

(e) Federal regulations require standards for electronic health care transactions change from Version 4010/4010A1 to Version 5010. These electronic health care transactions include functions like claims, eligibility inquiries, and remittance advices. If Provider does not conduct electronic health transactions using Version 5010 as required, delays and/ or denial of claim reimbursement may result. Provider shall prepare for HIPAA version 5010 and ICD-10 changes and is responsible to train, update software installations to assure compliance with the Version 5010 and ICD-10 upcoming changes.

(f) Provider acknowledges and agrees that ICD-10 codes must be used on all electronic HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge on and after October 1, 2015. Claims not submitted with the corresponding ICD-10 code will be rejected, and Provider will need to resubmit through the claims adjustment process, established in the Provider Manual, with the ICD-10 codes. Provider recognizes it is important to start as soon as possible to prepare for the changeover to ICD-10 codes.

(g) PROVIDER will also comply with MSO Dental Provider Manual as furnished to PROVIDER and modified from time to time. MSO may from time to time furnish PROVIDER with PROVIDER bulletins/updates containing requirements for claims submission and payment under this Agreement. If PROVIDER has not billed MSO for services rendered within the Claims Submission Period, PROVIDER's claim for compensation with respect to such services shall be deemed waived. MSO shall pay PROVIDER for Covered Services, less applicable Co-payments, in accordance with the terms of the relevant Attachment, Addendum or Health Plan schedule. PROVIDER agrees to accept the compensation paid by MSO as payment in full for all Covered Services, except for applicable Co-payments. In the event a claim for compensation is pended, contested or denied for any reason, PROVIDER shall resubmit such claim along with any applicable documentation to MSO consistent with the terms of the Agreement and the MSO Provider Manual within the longer of thirty (30) days or the time period provided by applicable law after receipt by PROVIDER of notice that such claim is pended, contested or denied for any reason. If Provider has not re-billed or re-submitted the applicable documentation to MSO for services rendered within such time period, PROVIDER's claim for compensation with respect to such services shall be deemed waived.

(h) Provider hereby agrees that in no event, including but not limited to non-payment by MSO, MSO's breach of this Agreement or MSO's insolvency, shall Provider, bill, charge, collect a deposit or Surcharge from, seek compensation, remuneration or reimbursement from, or have any recourse against a Beneficiary or persons acting on behalf of a Beneficiary for Covered Services or any charge made by MSO to Provider pursuant to this Agreement. This provision shall not prohibit collection of Beneficiary Cost Sharing in accordance with the terms of the applicable Beneficiary Agreement or collection of payment for non-covered services with appropriate signed financial responsibility forms.

(i) Provider further agrees that: (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Beneficiary; (b) this provision supersedes any oral or written agreement now existing or hereafter entered

into between the Provider and a Beneficiary, or persons acting on a Beneficiary's behalf; and (c) any amendments, modifications or changes to this Article shall be effective no earlier than thirty (30) days after the applicable Commonwealth of Puerto Rico and federal agencies have received written notice of such proposed changes, or such periods as the Commonwealth of Puerto Rico or federal regulatory entity may require.

(j) Provider will bill Beneficiaries for (1) non-covered services; and (2) applicable Beneficiary Cost Sharing amounts as provided in the Beneficiary Agreement. Except as provided in this paragraph, Provider agrees not to bill Beneficiaries for the difference between Physician's charges and MSO's reimbursement as set forth in Exhibit A. Payments made to Provider by MSO for all Covered Services are contingent upon the accuracy of diagnostic and other information provided by Physician to MSO.

(k) MSO shall be permitted to recover from Provider, and Provider shall refund to MSO, amounts paid by MSO because of: (1) payments made in error; (2) Utilization Management Program determinations; (3) services not rendered; (4) provider audits; (5) inaccurate payments, including, but not limited to, payments based upon erroneous or incomplete information provided by Provider; (6) payment for services later determined by MSO to be Non-Covered Services; and (7) payments made under a COB provision of a Beneficiary Agreement upon which payment has been or should have been made by a primary carrier including, but not limited to, auto medical-dental, or any other liability insurance, or for which benefits are available to a Beneficiary under the Worker's Compensation laws of any state, commonwealth or federal jurisdiction. MSO shall have the right to offset any such amounts due MSO from future payments due Provider. MSO shall make adjustments to PROVIDER for amounts due Provider because of payment errors made by MSO.

4.4 Hospital Admissions. In order to assure coverage, when a Beneficiary requires a non-Emergency hospital admission, PROVIDER, as provided in the applicable UM/QI Program shall utilize the MSO admitting physician program participating Specialty Physicians if such program has been implemented in the hospital or secure prior authorization from Health Plan or MSO for such admission. PROVIDER shall abide by the applicable UM/QI Program. A change in diagnosis or patient condition that may require a length of stay in excess of the UM/QA guidelines, must be reported to Health Plan or MSO, as applicable, in order to assure coverage.

4.5 No Discrimination Against Beneficiaries; Acceptance of Beneficiaries; Protection of Beneficiaries; Compliance with Civil Rights Laws.

(a) PROVIDER shall observe, protect and promote the rights of Beneficiaries as patients without regard to race, age, sex, national origin, religion, place of residence, economic status, health status or health care needs, benefit plan or source of payment of such Beneficiaries, including individuals who have or are currently receiving care from PROVIDER for whom payment is being made on a self-pay basis or through another third-party Health Plan program.

(b) PROVIDER may not impose any limitations on the acceptance of Beneficiaries from a product line of a Health Plan for care or treatment that it does not impose on other patients with respect to the same product line. PROVIDER may not request, demand, require or seek directly or indirectly the transfer, discharge or removal of any Beneficiary for reasons of Beneficiary's need for, or utilization of, Medically Necessary Covered Services, except in accordance with the procedures established for such action.

(c) PROVIDER agrees to abide by the non-discrimination and affirmative action requirements of Executive Order 11246, title VI of the Civil Rights Act of 1964, as amended, the Vietnam Era Veterans Readjustment Assistance Act of 1974, Sections 503 and 504 of the Re-habilitation Act of 1973, as amended by the Age Discrimination Act of 1975, as amended, the implementing rules and regulations of the Office of Federal Contract Compliance Programs, U.S. Department of Labor, as found in the Code of Federal Regulations, Title 41, Chapter 60, and any other anti-discrimination laws applicable to PROVIDER.

4.6 Charges to Beneficiaries. Each Health Plan shall require Beneficiaries to pay applicable Co-payments for certain Covered Services at the time services are rendered. In addition, Beneficiaries shall be financially liable to PROVIDER for Non-Covered Services or self-pay discounted services provided by PROVIDER pursuant to Section 4.1. PROVIDER shall indemnify and hold MSO, the applicable Health Plan and Beneficiaries harmless from any costs, including legal fees, relating to improper billing practices or efforts which breach the terms of this Agreement.

4.7 Records and Reports; Encounter Data.

(a) PROVIDER shall maintain such records and provide such medical-dental, financial and administrative information to MSO and/or Health Plans as may be necessary for compliance by MSO and Health Plans with state and federal law, as well as for program management purposes. Encounter data shall be in accordance with the MSO Provider Manual as furnished to PROVIDER, as modified from time to time. Encounter data is subject to review for Medical Necessity, proper referral and authorization, substantiation of services provided and appropriate treatment/billing practices. The Beneficiary's medical record must substantiate the services provided. If PROVIDER is capitated or has some other compensation arrangement for which claim submission is not required for payment (i.e. flat fee, case rate, or retainer), PROVIDER agrees to provide MSO through electronic format monthly encounter data on such forms as may be approved by MSO and MSO may withhold PROVIDER's monthly capitation payment if such encounter data is not received from PROVIDER within thirty (30) days from the date PROVIDER renders services. Records shall be maintained for a period of not less than ten (10) years from the termination of this Agreement and be retained further if records are under review or audit until such review or audit is complete. MSO, the applicable Health Plan, NCQA, state and federal officials or their assigned agents shall have access at reasonable times, upon demand, to the books and medical records of PROVIDER relating to the health care services provided to Beneficiaries and to Co-payments received by PROVIDER from Beneficiaries and MSO shall have the right to copy such books and medical records, either with the written consent of Beneficiaries which consent as contained in the applicable Health Plan's enrollment form is hereby deemed satisfactory by PROVIDER for such purposes, or as otherwise provided by applicable law. In the event appropriate state, federal or other governmental officials conduct an examination of the Covered Services rendered under this Agreement, PROVIDER shall submit any required books and records to facilitate such examination. MSO, each Health Plan, NCQA, state and federal officials shall also have the right to inspect, at reasonable times, PROVIDER's facilities pursuant to MSO's quality improvement and peer review procedures and state and federal mandated procedures. PROVIDER shall comply with any requirements or directives issued by Health Plans, NCQA or government authorities as a result of such evaluation inspection or audit of MSO or PROVIDER. The obligations under this Section 4.7 shall survive the termination of this Agreement without regard for the cause of such termination.

(b) PROVIDER shall maintain a separate medical record for each Beneficiary in accordance with the requirements established by MSO, consistent with applicable state and federal laws. Medical records of Beneficiaries will include but not be limited to reports from referral providers, discharge summaries, records of Emergency care received by such Beneficiary and such other information as MSO may reasonably request. Medical records of Beneficiaries shall be treated as confidential so as to comply with all applicable state and federal laws and regulations regarding the confidentiality of patient records, including without limitation, Title 45, Code of Federal Regulations, Section 250.50 and HIPAA. Where required by applicable law, PROVIDER will obtain specific written authorization from a Beneficiary prior to releasing such Beneficiary's medical records.

(c) In the event that MSO requests copies of medical records from PROVIDER for any reason whatsoever, including but not limited to a request from a Health Plan for any purpose related to conduct or administration of a health plan, such records shall be copied and delivered to MSO at PROVIDER's expense.

(d) PROVIDER shall establish and maintain procedures and safeguards so that no information pertaining to Beneficiaries contained in PROVIDER's records or obtained from OIC, CMS or ASES in carrying out the

terms of this Agreement shall be used by PROVIDER or PROVIDER's agents, officers or employees other than for purposes directly connected with the administration of the Beneficiary's Health Plan, or except as provided in Section 1106 of the Social Security Act, as amended, and the regulations promulgated there under.

(e) PROVIDER represents and warrants that PROVIDER will comply with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), as a covered entity under such laws, including but not limited to all confidentiality and disclosure requirements and compliance with the business associate provisions thereto.

4.8 Beneficiary Grievances. PROVIDER agrees to cooperate with MSO and the applicable Health Plan in resolving any Beneficiary grievances related to the provision of health services hereunder. In this regard, PROVIDER agrees to participate in grievance procedures, as MSO and such Health Plan from time to time may establish, and comply with all final determinations rendered.

4.9 Insurance.

(a) PROVIDER agrees to maintain in force such policies of general and professional liability insurance, as shall be necessary, to insure PROVIDER and their employees against any claim or claims for damages arising by reason of personal injuries or death occasioned, directly or indirectly, in connection with the performance of any service by PROVIDER or as otherwise required by applicable laws or regulations. The amounts, type and extent of such professional liability insurance coverage shall be subject to the approval of MSO. If PROVIDER is a licensed Physician, Physician Group or Dentist, amounts shall not be less than $100,000 per occurrence, $300,000 per policy period, Health Professionals shall have liability insurance coverage not less than $75,000 per occurrence or as otherwise required by applicable laws or regulations. PROVIDER shall also secure and maintain during the term of this Agreement worker's compensation insurance for all its employees performing services under this Agreement for whom such insurance is required. PROVIDER shall immediately notify MSO and Health Plan of any material changes in insurance coverage and shall provide certificates of insurance to MSO and Health Plan upon request. MSO and PROVIDER shall each obtain worker's compensation insurance to cover all of its respective employees as required by applicable state law. PROVIDER further agrees that MSO shall be given thirty (30) days prior written notice of any material changes, cancellation or termination of PROVIDER's insurance policies. In the event of such cancellation and/or termination, MSO may terminate this Agreement effective immediately upon PROVIDER's receipt of written notice from MSO. In the event PROVIDER procures a claims made policy as distinguished from an occurrence policy, PROVIDER shall procure prior to termination of such insurance, and thereafter maintain, (i) a replacement policy or policies, in the same coverage amounts specified above, with retroactive date(s) no later than the effective date of this Agreement; and/or (ii) purchase unlimited "tail" insurance coverage in the same coverage amounts specified herein, effective on the date of termination of such "claims made" policy, so that continuous general and professional liability insurance coverage in the above amounts is provided with no gaps in coverage, relative to the acts and omissions of PROVIDER in connection with this Agreement, regardless of whether a claim is asserted during the term of this Agreement or thereafter. PROVIDER shall provide a certificate of insurance for any coverage required hereunder to MSO or any Health Plan, upon request.

(b) PROVIDER agrees to notify MSO immediately whenever a Beneficiary files a claim or a notice of intent to commence legal action against PROVIDER. Upon request by MSO, PROVIDER agrees to provide full details of the nature, circumstances and disposition of such claims to MSO or its legal representative.

(c) The parties agree to adhere to and be bound by the common law and statutory principles of indemnification and contribution as they exist in the applicable jurisdiction.

4.10 Indemnification and Hold Harmless.

(a) PROVIDER agrees to indemnify and hold MSO and each Health Plan, and their respective officers,

directors and employees, ASES, CMS and any Beneficiary harmless from and against any and all debts of PROVIDER. PROVIDER agrees to indemnify and hold harmless MSO, Health Plan and their respective officers, directors and employees and ASES and CMS from any and all debts, claims, damages, costs, causes of action, expenses or liabilities, including reasonable attorneys' fees (at trial and all appellate levels) and court costs, to the extent proximately caused by or which may arise out of and/or be incurred in connection with, any negligent act or omission or other wrongful conduct by PROVIDER or any employee of PROVIDER arising from this Agreement and any act or matter arising from or related to any balance billing of Beneficiaries prohibited by this Agreement. This Section shall survive the termination of this Agreement for any reason, including insolvency.

(b) MSO agrees to indemnify and hold PROVIDER and each Health Plan, and their respective officers, directors and employees, ASES, CMS and any Beneficiary harmless from and against any and all debts of MSO. MSO agrees to indemnify and hold harmless PROVIDER, Health Plan and their respective officers, directors and employees and ASES and CMS from any and all debts, claims, damages, costs, causes of action, expenses or liabilities, including reasonable attorneys' fees (at trial and all appellate levels) and court costs, to the extent proximately caused by or which may arise out of and/or be incurred in connection with, any negligent act or omission or other wrongful conduct by MSO or any employee of MSO arising from this Agreement and any act or matter arising from or related to any balance billing of Beneficiaries prohibited by this Agreement. This Section shall survive the termination of this Agreement for any reason, including insolvency.

4.11 Administration.

(a) PROVIDER agrees to cooperate, participate in and comply with Health Plan's or MSO's UM/QI Program, including peer review and/or provider or Beneficiary grievance programs, if and when applicable, external audit systems and administrative programs as may be established by MSO. PROVIDER shall comply with all final determinations rendered pursuant to the UM/QI Program. The UM/QI Program may include, but not be limited to, pre-certifications, pre-authorization of elective admissions and procedures, referral processes, authorizations, treatment plans and reporting of encounter data. Each party agrees to immediately date stamp with the date received any written complaints and to notify the other party within one (1) business day whenever a Beneficiary files an informal or formal complaint as set forth in MSO's and the applicable Health Plan's grievance procedure, as provided to PROVIDER by MSO from time to time, and to refer Beneficiaries who have complaints to Health Plan's Beneficiary Services Department. Each party shall cooperate with the other party in the investigation of any such complaint.

(b) PROVIDER will allow the MSO and/or Health Plan to use practitioner performance data to support quality improvement activities (or any other way that performance data could be used, such as preferred provider status).

(c) PROVIDER agrees that MSO and/or Health Plans may use PROVIDER's name, address and telephone number, type of practice, hospital affiliations, as may be applicable, and an indication of PROVIDER's willingness to accept additional Beneficiaries in order to carry out the terms of this Agreement and in the usual course of advertising, marketing and promotion, including, but not limited to, Participating Provider rosters or directories. PROVIDER may use the name of MSO and/or Health Plans to indicate it is a contracting provider, subject to MSO's written approval, which shall not be unnecessarily withheld. PROVIDER shall provide immediate written notice to MSO of any changes in such information.

(c) PROVIDER will cooperate to the fullest extent possible to allow MSO to evaluate possible subrogation claims and to coordinate benefits. In the event PROVIDER provides Covered Services to a Beneficiary, PROVIDER, at his/her sole cost and expense, will cooperate to the fullest extent possible to:

(1) Determine whether the Beneficiary has medical services coverage in addition to the applicable Health Plan;

(2) Determine the Beneficiary's primary and secondary Health Plan; and

(3) Secure reimbursement from primary Health Plan.
(4) Report COB revenues received to MSO in a format determined by MSO.

If, under applicable industry standards for coordination of benefits, Health Plan is other than the primary carrier, and PROVIDER'S bill to primary carrier(s) was not computed on the basis specified in this Agreement, then any further reimbursement to PROVIDER from Health Plan or MSO will not exceed an amount which, when added to amounts charged to the primary carrier(s), equals the amount specified in this Agreement, less applicable co-payments and deductibles.

(d) PROVIDER agrees to assist and work with the Medical/Dental Director in implementing the UM/QI Program and resolving other issues related to the delivery of health services that may arise from time to time.

4.12 Cooperation and Relationship with Health Plan. PROVIDER understands that each Health Plan will place certain obligations upon MSO regarding the quality of care received by its Beneficiaries and that Health Plans in certain instances will have the right to oversee and review the quality of care administered to their Beneficiaries. PROVIDER agrees to cooperate with each Health Plan in the review of the quality of care administered to its Beneficiaries. Notwithstanding any provision or anything to the contrary in this Agreement, the Agreement makes reference to determinations by Health Plan, contracts with Health Plan, policies/programs/procedures of Health Plan or otherwise, however the applicability of any of these matters involving any Health Plan shall be as determined at the sole and absolute discretion of MSO and any such reference in this Agreement shall not relieve PROVIDER'S duties or obligations or impair MSO's rights under this Agreement.

4.13 Risk Management. PROVIDER shall participate in MSO's and/or a Health Plan's risk management program by allowing access to his/her respective facilities for scheduled reviews and audits. Additionally, PROVIDER shall notify MSO's and/or such Health Plan's risk management department of any and all Incidents including, without limitation the occurrence of Incidents which are: (i) required by applicable law or regulation to be reported to a Health Plan or any applicable governmental authority, or (ii) reasonably likely to result in a claim for damages or services in writing within two (2) calendar days of occurrence. Thereafter, MSO's and the Health Plan's risk management departments shall coordinate all investigative efforts and if necessary, PROVIDER shall assist in such efforts.

4.14 Representation of PROVIDER. MSO shall represent PROVIDER in matters with each Health Plan pertaining to the provision of Covered Services under this Agreement, and PROVIDER grants MSO the written consent to such representation. Such representation shall not constitute in any way an assumption of liability for PROVIDER'S acts or omissions.

4.15 Equipment and Facilities Used by PROVIDER. PROVIDER agrees that all facilities, equipment, goods and supplies used by PROVIDER to provide Covered Services to Beneficiaries will be available, properly serviced and maintained, otherwise appropriate for providing any Covered Services to Beneficiaries pursuant to this Agreement and comply with facility standards established by MSO, Health Plan, URAC, OIR, CMS or ASES. In addition, PROVIDER shall assure the availability of appropriate ambulatory care facilities required for the provision of PROVIDER's services to Beneficiaries, which shall include the availability of PROVIDER's current facility(ies), or any other facility used by PROVIDER to provide covered services to Beneficiaries pursuant to this Agreement.

4.16 Connectivity. PROVIDER shall comply, in a timely and accurate manner, with the requirements for electronic submission of claims, referrals, and preauthorizations as well as any other electronic submission initiative established by the Health Plan or MSO. PROVIDER shall participate in the MSO Health Information Exchange (HIE) program.

ARTICLE V.

TERM AND TERMINATION

5.1 Term. When executed by both parties, this Agreement shall become effective as of the date set forth in the signature page hereof and shall continue in effect for a period of one (1) year from that date. Thereafter, the Agreement shall be automatically renewed for periods of one (1) year unless terminated as provided below.

5.2 Termination.

(a) This Agreement may be terminated without cause by either party at any time by written notice given at least sixty (60) days in advance of such termination. This Agreement may also be terminated by MSO effective immediately upon written notice if PROVIDER violates Sections 4.2(a), (b), (e), (g), (h), (k), 4.6, 4.7, 4.8, 4.9(a), 4.11 or 4.12 hereof or if, in MSO's reasonable opinion, continuation of this Agreement will negatively affect Beneficiaries' care. MSO may also terminate this Agreement immediately in the event of an occurrence under Sections 4.2(e) (ii) through (v) and (vii) and (viii), regardless of whether notice is provided or not. Either party may terminate this Agreement with at least thirty (30) days prior written notice to the other party upon the failure of the other Party, as specifically set forth in such notice, to perform, keep or fulfill any covenants, undertakings, obligations or conditions set forth in this Agreement. Such termination will not become effective if the default is cured within the thirty (30) day notice period. In addition, MSO may terminate PROVIDER from participation with a certain Health Plan under this Agreement with the balance of the Agreement remaining in full force and effect. MSO shall immediately terminate any provider in part or in whole from participating under this Agreement in the event such provider fails to adhere to the terms and conditions of this Agreement or as otherwise requested by a Health Plan, however the termination of such provider from participation shall not impact the full force and effect of this Agreement.

(b) PROVIDER agrees that, pursuant to the underlying agreement between MSO and each Health Plan, a Health Plan may, with or without cause, terminate or obligate MSO to terminate PROVIDER's participation on a Health Plan or Plan-specific basis. In such event of termination, PROVIDER expressly agrees to hold MSO and such Health Plan harmless from any liability or damage arising from, relating to or resulting from MSO's compliance with its obligations under the underlying agreement with such Health Plan to terminate PROVIDER's provision of services to such Health Plan's Beneficiaries in connection with such underlying agreement. This provision shall survive the termination of this Agreement. Such termination shall have no effect on Provider's participation under the Provider Services Agreement.

(c) Upon termination and for a reasonable period of time thereafter, PROVIDER shall cooperate with MSO in making other arrangements for the health care of Beneficiaries affected by such termination. In the event PROVIDER is a Specialty Physician and without diminishing any other duties and obligations on PROVIDER as otherwise set forth herein, once PROVIDER or any physician associated with PROVIDER becomes unavailable to treat an Affected Beneficiary, whether by termination or otherwise, PROVIDER agrees to notify the Affected Beneficiary prior to the unavailability or termination. An Affected Beneficiary shall be a Beneficiary who has been under the ongoing care of the PROVIDER.

ARTICLE VI.
RESOLUTION OF ISSUES

6.1 Good Faith Meeting. In the event any dispute shall arise with respect to performance or interpretation of this Agreement each party hereto agrees that it shall continue to be obligated to perform all of its obligations hereunder and all provisions of the contract shall remain in full force and effect. MSO and PROVIDER agree to meet and confer within fifteen (15) days of the dispute arising, in good faith to resolve any problems or disputes that may arise under this Agreement.

If PROVIDER is not satisfied with resolution of any matter in controversy submitted to MSO, the matter in controversy shall be submitted to the Executive Management of MSO, at which time the disputed matter will be considered and PROVIDER will be afforded an opportunity to present supporting statements and documentation. The MSO Executive Management shall make a recommendation within fifteen (15) days after the meeting and the submission of evidence submitted by the parties.

6.2 Dispute Resolution Provision

A. *Tolling.* All applicable statutes of limitation and defenses based on the passage of time shall be tolled and otherwise waived during the conduct of the dispute resolution processes described in this Agreement.

B. *Performance.* Notwithstanding any conditions impliedly or expressly set forth in this Agreement, the parties shall continue to perform their obligations under this Agreement pending the conclusion of the dispute resolution procedures described in this Agreement.

C. *Time Limitations.* All claims and disputes regarding over or underpayment of a claim must be brought within one year of the date of payment or denial as expressed in the remittance advice. All other matters must be brought within one year of the act or omission forming the basis of the complaint.

D. *Subject Matter Jurisdiction.* These dispute resolution provisions shall govern all disputes arising out of, relating to, or in any way connected to this Agreement or the relationship between the Provider and MSO.

E. *Frequency Limitation.* Disputes regarding claims payments or denials and/or overpayments or underpayments shall be submitted to arbitration no more frequently than once a calendar quarter.

F. *Exclusive Remedy.* Binding arbitration is the exclusive remedy of Provider and MSO for all disputes arising out of, relating to, or in any way connected to this Agreement or the relationship between Provider and MSO. Such exclusive remedy shall not provide either party any right to conduct class arbitration.

G. *Waiver.* MSO and Provider hereby waive all rights to a trial by jury or judge including, but not limited to, antitrust, class action, qui tam, and RICO actions arising out of, relating to, or in any way connected to this Agreement or the relationship between Provider and MSO. Provider and MSO expressly agree that nothing herein is intended to create, and they each hereby waive, any right for either party to a initiate or conduct a class arbitration. Provider and MSO also waive the right to claim or receive punitive, consequential, indirect, or noneconomic damages and agree to seek and accept only actual damages directly resulting from the claims asserted.

H. *Exhaustion.* Provider and MSO must exhaust the applicable procedures set forth in Section J before being able to file a complaint for arbitration under Section K.

I. *Survival.* These provisions regarding arbitration shall survive the termination or expiration of this Agreement with respect to liabilities, obligations, and services arising, accruing, or rendered prior to termination or expiration of this Agreement. If after or upon the expiration or termination of this Agreement (for any reason), there are disputes which arose during the term of this Agreement, such disputes shall be governed by these dispute resolution provisions.

J. *Administrative Procedures.*

1. *Default Rules.* Except as modified by this Agreement, the parties agree that the arbitration shall

be administered by JAMS is accordance with its Comprehensive Arbitration Rules and Procedures as they exist on the, date of the initial commencement of the arbitration under Section K.

2. *Over/Under Payment Disputes.* Any disputes between the parties where Provider is alleging underpayment or nonpayment of one or more specific health claims or where MSO is alleging overpayment or wrongful or erroneous payment of one or more specific health claims shall be resolved though the following process. Coverage disputes and medical necessity disputes are not intended by the parties to be included with over/under payment disputes. Any demands by either Provider or MSO must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. All demands shall be organized into categories that identify the reason the claims are being submitted for review. Each demand submitted must be accompanied by a copy of the claim form and a copy of the Explanation of Payment/ Benefit or Statement of Remittance.

   a. Provider shall initially attempt to resolve the issue by following the appeals process reflected in any communication of denial or payment. If such process does not resolve the matter to Provider's satisfaction within sixty (60) days of Provider's notice to such person identified in the communication of denial or payment, Provider may proceed to Section J.2.b.

   b. If the process described in Section J.2.a. does not resolve the matter to Provider's satisfaction within sixty (60) days of Provider's notice of appeal, Provider may submit the matter, in writing, to MSO's Chief Operational Officer. If MSO's Chief Operational Officer does not resolve the matter to Provider's satisfaction with thirty (30) days of the Provider's notice to the Chief operational Officer, Provider may proceed to Section K.

3. *All Other Disputes.* All disputes other than disputes described in Section J.2 shall be resolved though the following process:

   a. Business Representative. Either party shall first give written notice of the issue to the other party and the usual business representative of each party shall work in good faith to resolve the issue.

   b. Senior Executive. If the usual business representatives are not able resolve the matter to the parties' mutual satisfaction within sixty (60) days, either party may submit the matter to the parties' senior executives. Within twenty (20) days of such submission, senior executives with authority to resolve the matter shall meet and attempt to resolve the dispute.

K. *Arbitration.* Any dispute, claim or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation or validity thereof, including the determination of the scope or applicability of this agreement to arbitrate shall, if incapable of being settled pursuant to the processes described in Section J, be determined by arbitration administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures. The arbitration shall be commenced by either party submitting a notice to the other and JAMS of the intent to commence arbitration. If there are disputes involving multiple claims from the Provider, such dispute shall to the extent possible be consolidated in a single arbitration.

1. *Selection of Arbitrator(s).* The arbitration shall be conducted before three (3) neutral arbitrators, and at least one (1) of the three (3) arbitrators shall be a retired judge. The arbitrators shall be selected by agreement of Provider and MSO. If Provider and MSO cannot agree on such arbitrator(s) within ninety (90) days of the notice of the arbitration, JAMS shall select three (3) neutral arbitrators, at least one of them being a retired judge.

2. *Authority of Arbitrators.* The arbitrators shall have subpoena power. The arbitrators shall have the

authority to decide all claims among Provider and MSO. The judgment and award must be in writing. The parties shall be bound by the decision of the arbitrators. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction over the parties. Any award by the arbitrators shall be final and may be enforced in any court having jurisdiction in accordance with applicable law. Any decision and award must be made based upon a preponderance of the evidence. Without the explicit written consent of the parties to the arbitration, there shall be neither "high-low" nor "Final Offer (Baseball)" arbitration. The arbitrators may not award punitive, consequential, indirect, or noneconomic damages.

3. *Place of Arbitration.* The dispute shall be submitted to arbitration in San Juan, Puerto Rico.

4. *Record.* There shall be no hearing record.

5. *Choice of Law.*

   a. *Substantive Law.* The arbitrators must apply the Laws of the Commonwealth of Puerto Rico.

   b. Procedural Law. Provider and MSO may agree in writing to forego an evidentiary hearing and present the case on briefs alone or on briefs and oral argument. Except as (i) otherwise set forth in this Agreement, (ii) may be mutually agreed upon in writing by MSO and Provider, or (iii) directed by the arbitrators the arbitration shall be governed by the rules of procedure of the Federal Arbitration Act. Within thirty (30) days of the empanelment of the arbitrators the party initiating the arbitration shall submit a reasonably detailed statement of its position, both as to claims for affirmative relief, and in defense of the opposing party's claims. Within thirty (30) days of receipt of the complaining party's statement, the responding patty shall submit a reasonably detailed statement of its position, both in defense of the complaining party's claims and as to counter claims for relief. Within thirty (30) days of receipt of any counterclaim by the respondent, the complaining party may answer the counterclaim (but may not offer rebuttal to the respondent's answers to the complaining party's claims). Within twenty (20) days following receipt of the last of such statements, the parties shall confer and agree to a schedule for exchange of relevant documents/data. Within thirty (30) days thereafter (or as soon thereafter as a panel is fully constituted) the arbitrator(s) shall convene a preliminary conference for purposes of resolving any procedural disputes, narrowing the issues in dispute, confirming or determining the schedule for completion of document/data exchange, scheduling any further pre-hearing proceedings, setting a date or dates for final hearing, and taking any other action they may deem appropriate for reasonably expediting the proceedings.

6. *Discovery.* Notwithstanding the discovery rules of JAMS or applicable law set forth in Section K.5., discovery shall be limited as follows. In any disputes between the parties where Provider is alleging underpayment or nonpayment of one or more specific health claims or where MSO is alleging overpayment or wrongful or erroneous payment, depositions cannot be taken except where a witness will not be available for direct and cross examination. For all disputes other than disputes relating to the over or under payment of specific claims, MSO and Provider shall each be allowed to take no more than three (3) depositions of the opposing party of: representatives and individuals associated with the other party to the arbitration; expert witnesses of the other party to the arbitration; and third party witnesses. MSO and Provider shall each be entitled to serve upon the other one set of interrogatories (seeking no more than twenty (20) responses, including subparts); one set of a request for production of documents and tangible things (limited to twenty (20) requests, including subparts) and one set of request for admissions (limited to twenty (20) requests, including subparts) each of which shall be answered and delivered to the requesting party by the recipient on or before forty-five (45) days after its receipt. Service of such discovery requests shall be made by certified mail or electronic delivery (with proof of receipt) to counsel representing the opposing party and shall be

considered received on the date of receipt. Any objections to discovery, motions to compel and motions for protective order may be presented to the arbitrator(s) for consideration and shall be ruled upon and finally determined by the arbitrators. Any such rulings on discovery matters shall be final and unappealable except as set forth below.

7. Costs of Arbitration. Each party shall be responsible and financially liable for its own attorneys' fees, and such other expenses incurred by that party related to arbitration including, without limitation, the cost of document/data production and witness fees. The parties shall each pay one-half the common costs of the arbitration including the fees and expenses of the arbitrators and JAMS.

8. Confidentiality. The parties agree that this dispute resolution process in confidential and represents a compromise or settlement procedure. All offers, promises, conduct, statements made by any party and their representatives and by any arbitrator (including the award by the arbitrators are confidential, are privileged, inadmissible, and not discoverable for any purpose under state or federal law including impeachment and as direct evidence with the exception of appeals under Section 8 and as necessary to enforce the award.

ARTICLE VII
MISCELLANEOUS

7.1 Modification of this Agreement. Subject to the provisions hereafter, this Agreement may be amended or modified in writing as mutually agreed upon by the parties. In addition, MSO may modify this Agreement, including the MSO fee schedule, upon thirty (30) days prior written notice to PROVIDER. This Agreement shall automatically be amended to comply with the requirements of state, federal or other applicable law. MSO may also amend any product specific Addendum of this Agreement or a Health Plan Schedule by giving thirty (30) days written notice to PROVIDER. Any Addendum to this Agreement may modify the Provider Services and / or reimbursement for such Provider Services for a specific product, such as Medicare Advantage plans, as well as any particular Health Plan Schedule.

7.2 Interpretation. The validity, enforceability and interpretation of any of the clauses of this Agreement shall be determined and governed by applicable law as well as applicable federal laws. In the event of any conflict between this Agreement and a contract entered into between MSO and a Health Plan or between a Health Plan and (a) a state for prepaid Medicaid Beneficiaries, (b) CMS for prepaid Medicare Beneficiaries, and/or (c) any governmental entity with respect to a government health care or benefit program (the "Government Contracts") for which PROVIDER is providing services, the Government Contracts shall govern. PROVIDER agrees to be subject to all requirements that may be imposed on MSO and PROVIDER by a Health Plan under the underlying agreement between such Health Plan and MSO. In the event of any conflict between this Agreement and the underlying agreement between a Health Plan and MSO for which PROVIDER is providing services, the underlying agreement shall govern. The parties agree that jurisdiction for any legal action regarding this Agreement shall be in the state or federal courts in the Commonwealth of Puerto Rico. Beneficiaries shall not be third-party beneficiaries to this Agreement. All the terms and conditions in this Agreement have been bargained for and agreed to between the parties, each party has had the opportunity for independent legal counsel and representation, and this Agreement shall not be construed or interpreted against one party or the other notwithstanding the original drafter of this Agreement.

7.3 Severability. The illegality, unenforceability or ineffectiveness of any provision of this Agreement shall not affect the legality, enforceability or effectiveness or any other provision of this Agreement.

7.4 Waiver. The waiver of any breach of any term, covenant or condition of this Agreement, shall not be deemed a waiver of any subsequent breach of the same or any other term, covenant or condition.

7.5 Assignment. This Agreement, being intended to secure the services of PROVIDER shall not be assigned, sublet,

delegated or transferred by PROVIDER without the prior written consent of MSO. In addition, PROVIDER agrees that PROVIDER shall render services in accordance with the terms and conditions of this Agreement to any Beneficiaries connected with any MSO affiliated entity, client, subsidiary or other entity under common control or ownership with MSO or otherwise contracted with MSO.

7.6 Notice. Any notice required to be given pursuant to the terms and provisions hereof shall be sent by certified mail, return receipt requested, postage prepaid, or by overnight mail service such as Federal Express, to MSO at: MSO of Puerto Rico, LLC., 350 Chardón Avenue, Suite, 500, San Juan, PR 00918, Attn.: President; and to PROVIDER at his/her/its place of business. Either party may change the address for notice by notifying the other party with thirty (30) days prior written notice of the new address. Notwithstanding the above, the Health Plan Schedule, an amendment or Health Plan Schedule notices pursuant to Section 6.1 of the Agreement and any notices related thereto may be sent via regular mail, facsimile or electronic transmission.

7.7 Relationship of Parties.

(a) None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. None of the above nor any of their respective employees shall be construed to be the agent, employer or representative of the other nor will any of the above have an expressed or implied right of authority to assume or create any obligation or responsibility on behalf of or in the name of the other party.

(b) Nothing contained in this Agreement shall be construed to require PROVIDER to: (i) recommend any procedure or course of treatment which a PROVIDER deems professionally unacceptable; or (ii) recommend that MSO or a Health Plan deny benefits for any procedure or course of treatment.

(c) MSO agrees that it shall not intervene in any way or manner with the rendition of medical/dental services by PROVIDER, it being understood and agreed that the traditional relationship between Physician and patients will be maintained. Thus, PROVIDER agrees that denial of authorization by MSO or a Health Plan for a particular course of medical treatment shall not relieve PROVIDER from providing or recommending such care to Beneficiaries as they deem to be appropriate nor shall such benefit determination be considered to be a medical determination by MSO or Health Plan. PROVIDER agrees to inform Beneficiaries of their right to appeal an adverse utilization review or coverage determination pursuant to MSO's and the applicable Health Plan's grievance procedures.

(d) Nothing in this Agreement shall be construed to require MSO or any Health Plan to assign any minimum or maximum number of Beneficiaries to PROVIDER or to prohibit MSO or such Health Plan from adding or transferring Beneficiaries.

(e) Nothing herein shall be construed as authorizing or permitting PROVIDER to abandon any Beneficiary.

7.8 Headings. The headings in this Agreement are inserted merely for the purpose of convenience and do not limit, define or extend the specific terms so designated.

7.9 Agreements with Employees and Independent Contractors. Notwithstanding any interpretation of this Agreement to the contrary, PROVIDER agrees that all of the provisions of this Agreement, unless clearly inapplicable, shall apply with equal force to PROVIDER's employees or independent contractors and PROVIDER agrees to assure such compliance. PROVIDER agrees, and shall require its employees and independent contractors who are providing Provider Services to Beneficiaries to agree that in the event of any inconsistency, omission or misinterpretation in the contract entered into by PROVIDER and the employee or independent contractor, the terms of this Agreement shall control, notwithstanding any review and/or approval of those agreements by MSO. At MSO's request, PROVIDER shall provide MSO with copies of all forms of agreements entered into to render services to each Health Plan's Beneficiaries pursuant to this Agreement.

7.10 PROVIDER Subcontracts and Professional Corporations or Partnerships. Notwithstanding any interpretation of this Agreement to the contrary, PROVIDER shall require that all of the provisions of this Agreement, unless clearly inapplicable, shall be incorporated in its subcontracts and agrees to require such compliance.

PROVIDER agrees, and shall require its providers to agree, that in the event of any inconsistency, between the terms and conditions of a subcontract and the terms and conditions of this Agreement, the terms and conditions of this Agreement shall control, notwithstanding any review and/or approval of those contracts by MSO. In the event that MSO has hereby entered into or if PROVIDER enters into a subcontract with a provider that is a professional corporation, professional association or partnership rather than an individual physician or provider, PROVIDER shall require by written provision in such subcontracts that all of the terms set forth herein applicable to PROVIDER, including all credentialing and accreditation requirements shall also apply with equal force to both the professional corporation, professional association or partnership and the individual physicians/dentist or providers associated with such entity. Any provider by performing services under this Agreement agrees to be bound to all the provisions of this Agreement.

7.11 Confidential and Proprietary Information. PROVIDER recognizes that this Agreement and all material provided to PROVIDER by MSO or a Health Plan, including Beneficiary lists, is confidential and not the property of PROVIDER. PROVIDER shall not use such information for any purpose other than to accomplish the purposes of this Agreement. PROVIDER shall not disclose or release this Agreement or such material to any third-party without the prior written consent of MSO or the applicable Health Plan. This specifically includes, but is not limited to, use of any of the above-referenced materials, directly or indirectly, to further the business purposes of any other organization or business including, but not limited to, PROVIDER, Health Plan's or other alternative health care delivery systems or other entities in the business of MSO or such Health Plan. Upon notice of the termination of this Agreement, PROVIDER agrees to return all such materials, including all copies, whether authorized or not, to MSO. For purposes of this Section, information shall not be considered proprietary if (i) such information is required to be disclosed pursuant to law, provided, however, that MSO and the applicable Health Plan are provided reasonable advance notice of such disclosure, or (ii) such information is generally available to the public other than through a violation of this Section by PROVIDER. This provision shall survive the termination or expiration of any term or provision of this Agreement. In addition, PROVIDER shall not solicit Beneficiaries, directly or indirectly, to enroll in any other insurance or health coverage or alternative health care delivery system other than the one such Beneficiaries are currently enrolled in. "Solicitation" or "soliciting", as used herein, shall mean conduct by an officer, director, agent, or employee of PROVIDER during the term of this Agreement and for a period of one (1) year after the effective date of termination of this Agreement, which may be reasonably interpreted as designed to persuade Beneficiaries, employer groups, employees or providers to discontinue their relationship with MSO and/or such Health Plan or to continue to receive health care services from PROVIDER, other than as a Beneficiary of such Health Plan, or to encourage Beneficiaries, employer groups, employees or providers to participate in any other prepaid health service plan. This provision shall survive the termination or expiration of any term or provision of this Agreement with respect to such Health Plan for a period of one (1) year from the effective date of termination except where such termination occurred following an event permitting MSO to terminate such Health Plan under the agreement between MSO and such Health Plan. The parties agree that any violation of this Section by PROVIDER will result in irreparable injury to MSO and Health Plan. Therefore, in addition to any remedies otherwise available to MSO and such Health Plan, MSO and such Health Plan are hereby entitled to an injunction enjoining and restraining PROVIDER and any related individuals or parties from violating this Section. If it is determined that the scope of the provisions of this Section are too extensive to be enforceable by court, then they shall be modified to be whatever is determined by a court to be reasonable in order to obtain enforcement and the parties hereto agree to accept such determination subject to any appeals.

7.13 Entire Agreement. This Agreement (including all Attachments or Addendum annexed hereto) contains all the terms and conditions agreed upon by the parties and supersedes all other agreements of the parties, oral or otherwise, regarding the subject matter hereof.

{Signature following page}

IN WITNESS WHEREOF, the undersigned have executed this Agreement and shall become effective the latest date set forth below.

	PROVIDER		**MSO of Puerto Rico, LLC.**
By:	[redacted] Signature	By:	Signature
Printed Name:	[redacted]	Printed Name:	Raúl F. Montalvo-Orsini, MD
Title:	[redacted]	Title:	President
Billing NPI:	[redacted]		
Date:	[redacted]	Date:	

ATTACHMENT A
COMPENSATION FOR, AND
SCOPE OF, PROVIDER SERVICES

COMPENSATION FOR HMO PROGRAM MEMBERS

With respect to Provider Services rendered to Beneficiaries of a Health Plan that is a health maintenance organization, PROVIDER shall render services in a manner consistent with the terms of this Agreement and according to the rate set forth below.

For Medicare Advantage Beneficiaries, payment shall be the lesser of the MSO Fee Schedule established for Medicare Advantage services in effect at the time of service for the locality where services are rendered or the amount billed by the Provider, and subject to MSO authorization and claims payment interpretative guidelines.

For Commercial Beneficiaries, payment shall be the lesser of the MSO Fee Schedule established for commercial services in effect at the time of service for the locality where services are rendered or the amount billed by the Provider, and subject to MSO authorization and claims payment interpretative guidelines.

COMPENSATION FOR PPO, INDEMNITY PLAN AND SELF INSURED PLAN/EMPLOYER

With respect to Provider Services rendered to Beneficiaries of a Health Plan which is a PPO, indemnity plan, self insured plan/employer or any other Health Plan, PROVIDER shall render services in a manner consistent with the terms of this Agreement and according to the rate set forth below.

For Medicare Beneficiaries, payment shall be the lesser of the MSO Fee Schedule established for Medicare Advantage services in effect at the time of service for the locality where services are rendered or the amount billed by the Provider, and subject to MSO authorization and claims payment interpretative guidelines.

For Commercial Beneficiaries, the lesser of the MSO Fee Schedule established for commercial services in effect at the time of service for the locality where services are rendered or the amount billed by the Provider, and subject to MSO authorization and claims payment interpretative guidelines.

APPLICABLE TO ALL THE ABOVE

1. Reimbursement for services which do not have a corresponding CPT, HCPC, or Revenue Code, or for situations not addressed above, including without limitation unbundling and upcoding, shall be determined in accordance with guidelines established by the American Medical Association (AMA), CMS, Medical Data Research (MDR), MSO guidelines and/or other accepted payment guidelines, at MSO or Health Plan's sole discretion.

APPLICABLE TO COMMERCIAL BENEFICARIES

Submission of Claims. Provider shall submit all claims for payment of Covered Services pursuant to the terms and provisions of Act No. 104 of July 19, 2000, as amended, and the regulations promulgated thereon by the Puerto Rico Commissioner of Insurance. Under Act 104, commonly known as, "Ley de Pronto Pago" any provider must submit a claim for payment of services rendered within ninety (90) days from the date the services were rendered and the claim, if clean and complete, shall be paid within thirty (30) days from the date of receipt of said claim. The MSO is not obligated to pay any claim received after the ninety (90) day time period specified in this section.