ARIZONA STATE PHYSICIAN ASSOCIATION

Provider Agreement

Effective Date: _____

3030 North Central, Suite 1106, Phoenix, Arizona 85012
(602) 265-2524 FAX (602) 265-3289

ARIZONA STATE PHYSICIAN ASSOCIATION
Provider Agreement

This Agreement is made and entered into as of the _____day of _____, 20____by and between **Arizona State Physicians Association,** an individual practice association incorporated under the laws of the state of Arizona (Association) and _____ a Provider licensed to practice medicine in the State of Arizona (Provider).

I. GENERAL

1.1 Provider intends to participate in Association for purposes of providing Health Care Services to members of contracted health maintenance organizations, preferred provider organizations, and other payor groups and programs. Provider may also participate in various Association-sponsored programs that are developed from time to time to create a benefit of membership or opportunity to satisfy a need for Provider and Association.

1.2 Provider's membership in Association does not guarantee or require that Provider participate in any or all Association-sponsored programs.

1.3 Nothing in this Agreement is intended to create, nor shall it be construed to create, any right of Association to intervene in any manner with the method by which Provider renders Health Care Services to his or her patients, whether or not they may be Members of any Association contracted entities.

1.4 Nothing herein is intended to interfere with the Provider's own interpretation of Provider's professional ethics.

1.5 Association and Provider agree that Patients to whom Health Care Services are provided by Provider and for which Provider is compensated hereunder shall not be third party beneficiaries of the rights and obligations assumed by either party hereto.

II. DEFINITIONS

2.1 Credentialing Program: A continuous process whereby Association seeks and maintains professional information on all Providers and other Association members in order to document the professional quality and integrity of the Association's health care service providers.

2.2 Health Care Service: The service to be provided through Association by Participating Providers and Providers and for which the Provider is duly licensed by state to provide.

2.3 Health Care Service Organization (HCSO): An organization, such as a health maintenance organization (HMO), licensed to conduct business in the State of Arizona.

2.4 Member: Any person and /or family dependent covered under a group or individual benefit agreement with any payor or any beneficiary of an agreement under Section 3.4.

2.5 Non-Participating Provider: A Provider or other health care service provider not under contract with Association or contracted payor.

2.6 Patient: A Member covered under a contracted health plan or Payor requiring Health Care Services.

2.7 "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a. in accordance with the generally accepted standards of medical practice;

b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, jury or disease; and

c. not primarily for the convenience of the patient or Provider, or other Provider; or other providers of care, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

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

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

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

2.8 Participating Provider: Any Provider or other health care service provider of Health Care Services who has entered into a contract with Association for the provision of Health Care Services to Patients under a payor benefit agreement or an agreement under Section 3.4.

2.9 Payor: An entity such as an insurance company, HMO, PPO or other party, responsible for paying for Health Care Services and defined by a benefit program.

2.10 Third Party Administrator (TPA): An entity licensed by the State of Arizona to pay claims, collect premiums, and perform other functions involved in an administrative process for health insurance companies or self-funded employer groups.

2.11 Active ASPA Member: A member of ASPA, (Provider, provider, or facility) who has completed all requirements of credentialing, and is current with payment of ASPA annual dues.

III. ASSOCIATION PERFORMANCE PROVISIONS

3.1 Association shall cause Provider's name, address, phone number and areas of practice to be disseminated to Members and to other Providers, hospitals, and others associated with HCSOs, TPAs or other Payors in Section 3.4.

3.2 Association shall maintain and be responsible for administrative, accounting, enrollment and similar functions inherent in and appropriate for the provision of Health Care Services to Members in accordance with Association's agreements with contracted HCSOs, TPAs, or other Payors, under Section 3.4.

3.3 Association shall institute and maintain utilization management programs, peer review programs, and any other programs deemed necessary to promote quality, efficient health care and to monitor the cost and utilization of medical services rendered to Members whenever feasible.

3.4 It is agreed that Association, in an effort to promote a cost-effective practice of medicine, may establish (itself or through a duly designated independent agent) exclusive and preferred provider and other alternate delivery system relationships between its Affiliated Provider and contracted Payors under which Affiliated Provider may be rendering professional Health Care Services to individuals. Provider hereby grants Association (or a duly designated independent agent) the authority to act as Affiliate Physician's agent seeking out and entering into such contracts with HCSOs, TPAs or other contracted Payors on Affiliate Physician's behalf. Association agrees that it will use (and will require any duly designated independent agent to use) its best efforts to seek out and secure such contracts for its Provider for the provision of professional Health Care Services with duly qualified Payors on terms and conditions advantageous to Provider and Association, Provider may select on a case-by-case basis with which Payors he or she wishes to becomes Participating Provider.

3.5 Association shall maintain professional information on Provider through Association's Credentialing Program. This information may be made available to contracting payors or state or federal agencies required by law to access such information.

3.6 Neither the Association nor any of its officers, directors, shareholders, employees, agents, affiliates or other representatives shall be in any way liable or responsible to any party or person for any act or omission of Provider in connection with their rendering Health Care Services to Patients.

IV. PROVIDER PERFORMANCE PROVISIONS

4.1 Provider shall render Health Care Services to Patients in a reasonable, efficient, and professional manner, which shall be in accordance with the standards of the community, and within the same time availability as offered to Patients who are not Members.

4.2 Provider may not differentiate or discriminate in the treatment of Patients or in the quality of services delivered to Patients on the basis of race, color, national origin, sex, age, religion, ancestry, marital status, and sexual orientation, place of residence, health status, or source of payment.

4.3 Provider may not refuse to provide Health Care Services to any Patient on the basis of the extent of such Member's requirements for Health Care Services, consistent with Provider's capabilities and resources.

4.4 Provider shall cooperate with Association to assure twenty-four (24) hour accessibility for Patients.

4.5 If Provider is unable to provide services to a Member, Provider agrees to refer such Member to another Participating Provider consistent with the terms and conditions of the agreement and Patient medical needs for which Provider is providing Health Care Services through Association. A copy of such referral terms and conditions shall be furnished to Affiliate Provider for each agreement under which Provider furnishes Health Care Services. Any emergency referral to a Non-Participating or unapproved Provider shall be subject to peer and utilization review by Association or contracted Payor.

4.6 Provider agrees, to the extent legally and reasonably possible and consistent with good patient care, to cooperate with Association programs designed to share medical records among Participating Providers who have contracted with Association.

4.7 Provider agrees to look solely to the entity designated by the Association for compensation for Health Care Services rendered to Members, and will not, under any circumstances (including nonpayment by an HCSO or other payor), assert any claim for compensation, other than for collection from Members of co-payments, payments for non-covered services, and if provided for in the applicable agreements any deductibles and coinsurance. This promise not to seek payment from the Member (except for applicable co-payments, payments for non-covered services, co-insurance and applicable deductibles) shall survive any termination of this Agreement with respect to services provided during the term of this Agreement pursuant to its terms and shall govern any agreement that Provider may have now or in the future with a Member during the term of this Agreement.

4.8 In presenting its claim for collection to Payors, Provider shall submit claims for payment within Ninety (90) days of the date of service or, if Patient is hospitalized, from the date of discharge. Claims submitted after Ninety (90) days may not be eligible for payment, unless otherwise specified in a specific Association/Payor contract.

4.9 Provider warrants that if Health Care Services are provided by a Non-Participating Provider who is providing practice coverage for Provider the Non-Participating Provider agrees to accept all payment and utilization management provisions set forth for Provider in this Agreement and shall hold Members harmless from any payment made in contravention of this Agreement.

4.10 Provider shall keep accurate and current medical files/records concerning Members seen pursuant to this Agreement. Medical records will be kept for the minimum time required by state and federal laws. Provider shall cooperate fully with any utilization review, peer review, and other programs that may be established by Association or contracted Payors to promote quality medical care and to monitor the cost and utilization of medical services. Provider agrees to allow Association or its designee to review all phases of Provider's patient-care activities, including, but not limited to, review and copying of medical records and inspection of Provider's facilities and practice management. Nothing in this section shall require Provider to reveal any confidential information of a Member without such Member's consent or be inconsistent with HIPAA regulations.

4.11 Provider shall establish and maintain procedures and controls so that no medical or enrollee information contained in Provider's records be used by or disclosed by Provider, Contractor Representatives, or Contractor's agents, officers, or employees except as provided in Section 1106 of the Social Security Act, as amended, and regulations prescribed there under.

4.12 Provider shall procure and shall maintain policies of general liability, professional liability with minimum coverage in the amount of $1,000,000 per incident and $3,000,000 aggregate, and any other insurance that is required by Association during the term of this Agreement and shall provide proof of such coverage upon request.

4.13 Provider shall comply with all policies and procedures and protocols as established and modified from time to time by Association or contracted Payors relating to the provision of Health Care Services to Patients, including, but not limited to, policies and procedures of the Board and the various advisory committees of Association and protocols related to precertification of hospital admissions, lengths of stays, referrals to Providers and other health care providers, purchase or rental of prosthesis and durable medical equipment, and use of non-emergency ambulance service as long as such agrees with community standards for the provision of medical care.

4.14 Provider hereby represents and warrants that Provider is currently and for the duration of this Agreement shall remain licensed to practice Provider's health care profession in the State of Arizona, and shall comply with all State and Federal laws and regulations pertinent to such practice. Provider shall immediately notify Association in the event of loss of license.

4.15 In the event that Provider changes the location in which Health Care Services are provided, Provider shall notify Association not less than thirty (30) days prior to such relocation.

4.16 Provider shall notify the Association within ten (10) calendar days of any of the following:

(a) any action taken to restrict, suspend or revoke Provider's license to practice his or her health care profession in this state; or (b) any action taken to restrict, suspend or revoke Provider's medical staff privileges; or (c) any suit brought against Provider for malpractice and the final disposition of such action; or (d) any other situation which might materially effect Provider's ability to carry out his/her duties under this Agreement.

4.17 Provider warrants that the statements set forth in his/her application for membership are true and may be relied upon by Association and will continue to be true throughout the term of this Agreement and any renewal thereof unless Provider notifies Association in writing that any such statements are no longer true.

4.18 Provider shall comply with all of the terms contained within Exhibit A to the Provider Agreement, "Required Contract Language in Support of Medicare Advantage Agreements" attached hereto and incorporated here by this reference.

4.19 Provider agrees to abide by and confirm annually the ASPA Code of Conduct; ASPA Compliance Policies; and Fraud, Waste and Abuse policy. This includes annual review and training as required by Medicare /AHCCCS and ASPA

V. PAYMENTS

51 Provider agrees that the fees payable to Provider, under the fee schedules for Health Care Services covered under the various Benefit Agreements between the Members and contracted Payors, are such fees as shall be specified by Association (or its duly designated agent) to Affiliated Provider from time to time for the various agreements for the provision of Health Care Services.

5.2 Provider shall be entitled to bill and collect from Patients those amounts for co-payment, non-covered services, and applicable deductibles or co-insurance identified to Provider by Association or contracted Payor under various agreements.

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

VI. TERMS OF AGREEMENT

6.1 This Agreement shall be in full force and effect for a period of one year commencing on the date first written above, and shall continue in effect under identical terms and conditions for additional one year periods thereafter unless either party terminates this Agreement in accordance with the provisions of this Article VI.

6.2 Either party shall have the option of terminating this Agreement, without cause, upon providing at least ninety (90) days' prior written notice to the other party. Provider may also terminate as a Participating Provider with a Payor upon providing Association with ninety (90) days' prior written notice.

6.3 Except as provided otherwise in this Agreement, Provider shall have the right to terminate this Agreement upon providing thirty (30) days prior written notice to Association of a material breach of this Agreement. Remedy of such breach by Association within twenty (20) days of the receipt of such notice shall revive the Agreement in effect for the remainder of its term, subject to any other properly exercised rights of termination contained in this section, in any other provision of this Agreement, or in the rules and procedures, Articles of Incorporation or Bylaws of Association as in force at time of termination.

6.4 In addition to the right to terminate without cause in Section 6.2, Association shall have the right to terminate or not to renew this Agreement on the terms and conditions of the policies and procedures, Articles of Incorporation, and Bylaws of Association as then in force. This includes the non payment of ASPA Membership Dues.

6.5 Each party acknowledges the right and obligation of the other to inform Patients that this Agreement has been terminated. If a Patient is under active treatment by Provider on the date this Agreement terminates, Provider shall abide by all the laws and ethical principles against the abandonment of patients and will accept Association's reimbursement schedule for this patient during the course of treatment. Following any notice of termination, Provider shall fully cooperate in all matters relating to the orderly transfer of Patient care to other Participating Providers.

6.6 This Agreement shall automatically terminate upon the revocation or suspension of Provider's license.

VII. ARBITRATION

7.1 Before instituting arbitration under the terms of this Agreement, Provider must exhaust any and all administrative relief that is available under the Articles of Incorporation, Bylaws, or policies and procedures of Association then in force. The parties agree to meet and confer in good faith to

resolve any problems or disputes that may arise under this Agreement.

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

7.3 Nothing contained herein is intended to create nor shall it be construed to create any right of any Patient to initiate independently the arbitration procedure specified in Section 8.2 above. This limitation shall also apply to Association and to Provider to prevent either or both parties from initiating such procedure in any representative capacity on behalf of a Patient.

7.4 Each party agrees to provide timely notice to each other if either party becomes aware of facts of circumstances which indicate a reasonable possibility of litigation with any third person or entity and which are relevant to any rights, obligations, or other responsibilities or duties provided for under this Agreement with respect to any party hereto. Each party further agrees not to counsel or encourage any third party or entity to pursue litigious action against the other party.

VIII. INDEPENDENT CONTRACTOR

8.1 Provider enters into this Agreement as an independent contractor and not otherwise and this Agreement does not make Provider or Association employees, agents, partners, or joint venturers of the other. Provider shall not publicize any relationship with Association without prior written permission. This Agreement in no way prevents Provider from participating in or contracting with any payor organization, other health care service organization or health care systems.

8.2 Provider agrees that, in the case of dual contracts with any Payor, the contract between Payor and Association will become the primary contract for Provider's services unless Provider notifies Association in writing of desire to act otherwise.

8.3 Nothing in this Agreement shall be construed or deemed to create, between the parties of this

Agreement or Payors, a relationship of employer and employee or principal and agent, or any relationship other than that of independent parties contracting solely for the purpose of carrying out the provisions of this Agreement. Neither party shall be liable to third parties for acts or omissions of agents, representatives or employees of the other party.

IX. NOTICES

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

9.2 Notices shall be deemed received upon receipt by the addressee.

X. MODIFICATIONS

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

XI. INVALIDITY OR UNENFORCEABILITY

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

XII. ATTORNEY'S FEES

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

XIII. MISCELLANEOUS

13.1 No waiver of any right hereunder shall be effective for any purpose unless it is in writing and signed by the party waiving such rights and shall not constitute waiver of any other right.

13.2 No right created under the provisions of this Agreement may be assigned and no duty hereunder may be delegated without the prior written consent of the other party.

13.3 Each party hereto agrees to perform all such acts as reasonably may be necessary to fulfill the purposes and intent of this Agreement. The toleration by either party of defective performance of any provision of this Agreement shall not be construed as a waiver of either the right to performance or the terms and conditions expressed in this Agreement.

13.4 The terms and provisions of this Agreement shall be construed in accordance with the laws of the

State of Arizona, as they may exist from time to time.

EXECUTED on the day and year written above.

Physician

_____
Signature

_____
Printed Name:

_____
Title

_____
Date:

_____
Address

_____
City, State Zip Code

_____
Telephone Number

Arizona State Physicians Association Inc.

_____
Director of Operations

_____
Date:

3030 N Central Avenue, Suite 1106
Phoenix, AZ 85012
602-265-2524

PROVIDER AGREEMENT

REQUIRED CONTRACT LANGUAGE
IN SUPPORT of ALL
MEDICARE ADVANTAGE AGREEMENTS

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

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

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

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

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

SECTION 1 DEFINITIONS

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

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

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

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

SECTION 2 EFFECTIVE DATE; SCOPE

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

SECTION 3 FINANCIAL AGREEMENTS.

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

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

SECTION 4 MEDICARE ADVANTAGE REQUIREMENTS

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

1. **Inspection and Audit of Records and Facilities.** Provider shall provide access at reasonable times upon demand by Provider and Government Agencies to periodically audit or inspect the facilities, offices, equipment, books, documents and records of Provider relating to the performance of the Addendum and the Medicare Covered Services provided to Medicare Members, including without limitation, all phases of professional and ancillary medical care provided or arranged for Medicare Members by Provider, Medicare Member medical records and financial records pertaining to the cost of operations and income received by Provider for Medicare Covered Services rendered to Medicare Members. Such access shall be limited to that necessary to perform the audit. Provider shall comply with any requirements or directives issued by Provider and Government Agencies as a result of such evaluation, inspection or audit of Provider. Provider shall retain the books and records described in this Section for at least ten (10) years and acknowledge that Government Agencies may have the right to inspect and audit Provider's books and records for ten (10) years beyond termination of the Addendum or until the conclusion of any governmental audit that may be initiated that pertains to such records, whichever is latest unless: (i) the CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies Contractor or Provider at least thirty (30) days before the normal disposition date; (ii) there has been a termination, dispute, or fraud or similar fault by Provider, in which case the retention may be extended to ten (10) years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or (iii) the CMS determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate, and audit Provider at any time. Without limiting the foregoing, following the commencement of any audit by a Government Agency, Provider shall retain its relevant books and records until completion of said audit. The provisions of this Section shall survive termination of the Addendum for the period of time required by State and Federal Law. [42 CRF 422.504 (e) (4) and 422.504(i)(2)(i) and (ii)]

2. **Compliance.** Provider agrees to comply with Contractor's policies and procedures and all applicable Federal, State and local laws, rules and regulations, now or hereafter in effect, including but not limited to 42 CFR §422.118 and 422.504 (a)(13) regarding the performance of Provider's obligations hereunder, including without limitation, laws or regulations governing the record timeliness, adequacy and accuracy, Medicare Member and Beneficiary privacy and confidentiality along with the appeal and dispute resolution procedures related to Covered Services provided to a Medicare Member, to the extent that they directly or indirectly affect Provider, Provider's facilities or Contractor and bear upon the subject matter of this Addendum.

3. **Applicable Federal Laws.** The compensation payable to Provider pursuant to the Addendum consists of Federal funds; accordingly, Provider acknowledges that Provider shall be required to comply with certain laws applicable to entities and individuals receiving Federal funds.

4. **Nondiscrimination.** Provider understands that CMS requires compliance with the provision of this Section as a condition for participation in Medicare plans. Provider and Contractor Representatives shall comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. Section 200d et. seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C.

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

5. **CMS Agreement Compliance and Delegation Requirements.** PROVIDER shall comply with all requirements in the CMS Agreement, which are applicable to Provider as a result of the Addendum. Without limiting the foregoing, Provider shall ensure that all provisions of the CMS Agreement, which are applicable to Provider and Providers representatives, are included in any of Contractor's subcontracts. A copy of the CMS Agreement shall be made available to Provider upon Provider's request. Provider shall comply with Title XVIII of the Social Security Act and the regulations adopted there under by CMS for the Medicare program. [42CFRs 422.504(i)(3)(iii) and 422.504(i)(4)]

6. **Medicare Participation Standards.** Provider and Contractor Representatives shall meet the standards for participation and all applicable requirements for providers of health care services under the Medicare program. In addition, Provider shall require that all facilities and offices utilized by Provider to provide Medicare Covered Services to Medicare Members shall comply with facility standards established by CMS.

7. **Certification of Truth and Accuracy.** Provider is required to submit claims or other data to the contractor that includes a certification from the Provider, that such data is accurate, complete and true.
8. **Submission of Claims.** Provider agrees to submit appropriate encounter to Contractor regardless of payment methodology.

9. **No Billing of Medicare Members (Medicare Member Hold Harmless Provision).** Provider hereby agrees that in no event, including, without limitation, non-payment by Contractor, Contractor's insolvency or breach of the Agreement, shall Provider or any Participating Provider covering for Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Medicare Member or person, other than Contractor, acting on his or her behalf, for Medicare Covered Services provided pursuant to the Addendum. This provision shall not prohibit collection of deductibles, co-payments, co-insurance and/or non-Medicare Covered Services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Medicare Members in accordance with terms of the Medicare Member's Subscriber Agreement and Coverage Description.

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

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

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

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

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

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

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

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

    a. Contractor's policies pertaining to the collection of co-payments, which prohibit the Collection of co-payments for routine injections, routine immunizations, flu immunizations, and the administration of pneumococcal/pneumonia vaccine.

    b. Contractor's policies pertaining to pre-certification which provide that Medicare Members may directly access a contracted provider for mammography and influenza vaccinations and women's health specialists for routine and preventative health care.

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

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

15. **Term of Addendum, Renewal and Termination.**

a. **Termination without Cause.** This Addendum may be terminated at any time by either party without cause upon thirty (30) days prior written notice to the other party.

b. **Termination of CMS Agreement.** In the event that CMS Agreement is not executed, or is terminated or not renewed, the provisions of this Addendum relating to the Medicare Members shall automatically terminate, unless otherwise specified by ASPA.

c. **Medicare Advantage Termination** The termination provisions contained in this Addendum shall permit Contractor to terminate the Provider with respect to Medicare Members in accordance with the terms contained in the applicable provision. In the event Provider or Contractor terminates this Addendum with respect to Medicare Members, the Agreement shall not terminate with respect to non-Medicare Members.

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

SECTION 5 NOTICE

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

Arizona State Physician Association
3030 North Central Avenue, Suite 1106
Phoenix, AZ 85012
Attn: Director of Operations

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

SECTION 6 GENERAL PROVISIONS

1. **Confidentiality.** The parties acknowledge that as a result of this Agreement, each may have access to certain trade secrets and other confidential and proprietary information of the other. Each party shall hold such trade secrets and other confidential and proprietary information, including the terms and conditions of this Agreement, in confidence and shall not disclose such information, either by publication or otherwise, to any person without the prior written consent of the other party except as may be required by law and except as may be required to fulfill the rights and obligations set forth in this Agreement.

2. **Assignment and Delegation of Duties.** Neither party may assign duties, rights nor interests under this Agreement unless the other party shall so approve by written consent.

3. **Interpretation.** The validity, ability to enforce, and interpretation of this Agreement shall be governed by any applicable federal law and by the applicable laws of the state of Arizona.

4. Amendment.

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

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

END OF ADDENDUM

Code of Conduct

The Code of Conduct states ASPA's over-arching principles and standards by which ASPA operates and defines the underlying framework for the compliance policies and procedures. Staff and Business Partners, from the top to the bottom of ASPA's organization, have the responsibility to perform their duties in an ethical manner in compliance with laws, regulations and ASPA's policies. The Code of Conduct provides the standards by which Staff, ASPA Members, and Business Partners will conduct themselves, in order to protect and promote organization-wide integrity, ensure adherence to ASPA values and enhance ASPA's ability to achieve the organization's mission. These standards are intended to provide guidance to ASPA Staff, ASPA Members, and Business Partners. These standards are neither exclusive nor complete. Staff. ASPA Members, and Business Partners are required to comply with all applicable laws, whether or not specifically addressed. All ASPA Staff, ASPA Members, and Business Partners must read the Code of Conduct annually and sign an acknowledgement that they agree to abide by the Code of Conduct. A copy is provided to all new Staff hires within 90 days of hire and is always available to review on the ASPA intranet by Staff and on www.AZSPA.COM . Each ASPA manager, director and officer is responsible for reinforcing the Code of Conduct.

ASPA requires that all FDRs supporting the Medicare Advantage and Part D Prescription Drug Program adopt and abide by the ASPA Code of Conduct or implement a Code of Conduct that incorporates standards of conduct and requirements consistent with ASPA's Code of Conduct.

This Compliance Program sets forth a Code of Conduct which includes components specific to the Medicare Advantage Prescription Drug Plan program. The Code of Conduct standards and expectations are listed below and are followed by detailed explanations.

A. Exercise Due Care
B. Adhere to Legal and Regulatory Requirements
C. Ensure Accurate Records and Financial Information
D. Maintain Confidentiality
E. Avoid Conflicts of Interest
F. Cooperate with All Investigations
G. Retention of Records
H. Accessing Electronic Information
I. Prohibited Insider Trading
J. Commitment to Employment Relationships
K. Seeking Guidance and Reporting Violations
L. Enforcement of Corrective Action and/or Discipline

A. Exercise Due Care

Staff, ASPA Members, and Business Partners must conduct themselves in an ethical manner, act in good faith, responsibly, with due care, competence and diligence by conducting all business activities with the highest level of integrity. To accomplish this Staff, ASPA Members, and Business Partners must observe professional standards with regard to licensure and scope of service, continually evaluate existing procedures to identify potential noncompliance and FWA, process improvements and to ensure that appropriate standards are met, be knowledgeable of and exercise diligence with applicable laws, regulations, corporate and departmental policies, and address deficiencies by reporting them to ASPA management, the Compliance Officer via phone call, email, in-person report, mail or fax. Any issues reported, will be documented by the Compliance Department. All reported issues will be promptly and fully investigated. If noncompliance is identified, a corrective action will be implemented. Implementation of the Corrective Action Plan (CAP) will be overseen by the Compliance Department to ensure the issue is addressed and corrected in a timely, thorough and compliant manner. Upon completion of a CAP, the Compliance Department will review the results and ensure the CAP is compliantly implemented and the issue is fully resolved.

B. Adhere to Legal and Regulatory Requirements

ASPA is committed to complying with all applicable laws and regulations including:

- Title XVIII of the Social Security Act
- Medicare Regulations Governing Parts C and D found at 42 CFR § § 422 and 423 respectively
- Patient Protection and Affordable Care Act (Pub. L. No 111-148, 124 Stat. 119)
- Health Insurance Portability and Accountability Act (HIPAA) (public Law 104-191)
- False Claims Acts (31 USC § § 3729-3733)
- Federal Criminal False Claims Statutes (18 USC § § 287.1001)
- Anti-Kickback Statute (42 USC § 1320a-7b(b))
- The Beneficiary Inducement Statute (42 USC § 1320a-7a(a)(5))
- Civil Monetary Penalties of the Social Security Act (42 USC § 1395w-27(g))
- Physician Self-Referral (Stark) Statute (42 USC § 1395nn)
- Fraud and Abuse, Privacy and Security Provisions of the Health Insurance Portability and Accountability Act, as modified by HITECH Act
- Prohibitions against employing or contracting with persons or entities that have been excluded from doing business with the Federal Government (42 USC § 1395w-27(g)(1))(G)
- Fraud Enforcement and Recovery Act of 2009
- All sub-regulatory guidance produced by CMS and HHS such as manuals, training materials, HPMS memos and guides

If these laws and regulations are ignored; it could lead to allegations of fraud, waste and abuse as defined by Federal statute'. "Fraud, waste and abuse" is an umbrella term that applies to a series of statutes and regulations designed to prevent government health programs from paying excessive and/or inappropriate claims.

Examples of fraud include, but are not limited to:

- Billing for services that were not rendered;
- Misrepresenting as medically necessary non-covered or screening services, by reporting covered procedure or revenue codes;
- Signing blank records or certification forms, or falsifying information on records or certification forms for the sole purpose of obtaining payment;
- Consistently using procedure/revenue codes that describe more extensive services than those actually performed;
- Up coding, unbundling, double billing or using an incorrect or invalid provider number in order to be paid or to be paid at a higher rate of reimbursement;
- Selling or sharing Medicare health insurance identification numbers so false claims can be filed;
- Falsifying information on applications, medical records, billing statements, cost reports or on any documents filed with the government.
- Misrepresenting or concealing facts that would cause ASPA to provide coverage to persons who are otherwise not eligible.

Examples of waste and abuse include, but are not limited to:

- Billing for services or items in excess of those needed by the patient;
- Adding inappropriate or incorrect information to cost reports;
- Collecting in excess of the deductible or co-insurance amounts;
- Requiring a deposit or other payment from patients as a condition for admission, continued care or other provision of service;
- Unbundling charges when there is one specific code that describes and includes payment for all components.

ASPA is committed to working with AHCCCS, CMS, state and federal regulators to report potential fraud, waste and abuse. Staff, ASPA Members, and Business Partners are responsible for reporting any suspected or observed health care fraud, waste or abuse to their supervisor,

manager, director, the Compliance Officer immediately and be prepared to provide a complete description of the suspected or observed activity. ASPA will make every effort to protect your identity and will not tolerate any form of retaliation against any person making such a report.

The three types of conduct that are generally prohibited by health care fraud laws are false claims, kickbacks and self-referrals. The consequences for violating these laws can include, in addition to imprisonment and fines, civil monetary penalties, loss of licensure, loss of staff privileges and exclusion from participation in federal health care programs.

False Claims Ace

A false claim is the knowing submission of a false or fraudulent claim for payment or approval or the use of a false record that is material to a false or fraudulent claim. False claims involve a pattern or practice of presenting claims in which the submitter knew, or should have known, would lead to greater payments than are appropriate or if they engage in a pattern or practice of submitting claims that they knew, or should have known, were for services that were not medically necessary. Additional behaviors likely to raise concern include reporting improper diagnosis or procedure codes to maximize reimbursement, double billing, claiming costs for non-covered services, providing questionable documentation for the medical necessity of professional services and misrepresenting information to obtain payments. Reckless disregard of the truth or falsity of the information on the claim filed or an attempt to remain ignorant of billing requirements are considered violations of the False Claims Act. Concerns regarding a potential violation of the False Claims Act must be reported to management. Staff, ASPA Members, and Business Partners may utilize other mechanisms of reporting to state or federal agencies through Whistleblower Provisions. Any person with actual knowledge of allegedly false claims may file a *qui tam* lawsuit on behalf of the government and can receive an award if, and after, the Government recovers money from the defendant as a result of the lawsuit. ASPA's policies prohibit retaliation against those who, in good faith, report inappropriate activities.

Stark Self-Referral Law[3] and Anti-Kickback Statute"'

The Stark Self-Referral Law, also known as the physician self-referral law, prohibits a physician from making referrals for certain designated health services (DHS) payable by government health care programs to an entity with which the physician (or an immediate family member) has a financial relationship (ownership, investment or compensation), unless an exception applies. It also prohibits the entity from presenting or causing to be presented claims to government health care programs (or another individual, entity or third-party payer) for those referred services. The following are DHS:

- Clinical laboratory services.
- Physical therapy services.
- Occupational therapy services.
- Outpatient speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment and supplies.
- Prosthetics, orthotics and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

The Anti-Kickback Statute makes it illegal to solicit, pay, offer or receive any remuneration, in cash or in kind (money, goods, services), in return for the referral or to induce the referral of a patient, or for ordering, providing, recommending or arranging for the provision of any service reimbursable under government health care programs. In general, the statute prohibits anyone from offering anything of value that is likely to influence the person's decision to select or receive care from a particular health care provider. The purchase or sale of goods and services

must not lead to Staff or Business Partners or their immediate families receiving kickbacks. Kickbacks or rebates may take many forms and are not limited to direct cash payments or credits. If a Staff, Business Partner or member/beneficiary stands to gain personally through a transaction, it is prohibited.

Gifts or Gratuities: Maintaining appropriate relationships with ASPA's vendors is imperative to ensuring the selection of quality products at fair prices. ASPA Staff may not accept or encourage gifts of money under any circumstances, nor may they solicit non-monetary gifts, gratuities or any other personal benefit or favor of any kind from suppliers or customers. ASPA Staff, ASPA Members, and Business Partners and their immediate families may accept unsolicited, non-monetary gifts of modest value from a business firm or individual doing or seeking to do business with ASPA only if the gift is primarily of an advertising or promotional nature. ASPA Staff, ASPA Members, and Business Partners should contact their supervisors or the Compliance Officer if they are unsure if accepting a gift or gratuity is permitted.

Federal law makes it a crime to give, offer or promise anything of value to any public official for or because of any official act performed or to be performed by such official. It is also a Federal crime to make any payments to public employees, made on account of or as compensation for public duties.

ASPA Staff will not give/nor receive gifts or gratuities exceeding the value of $10 per gift or $50 per calendar year in the aggregate. ASPA Staff will contact their supervisors or the Compliance Officer if they are unsure if giving a gift or gratuity is acceptable. ASPA Staff are prohibited from giving any government employee or representative any gifts or gratuities.

Entertainment: From time to time, ASPA Staff may offer or accept entertainment, as long as it is not excessive, provided it occurs infrequently and it does not involve lavish expenditures. Offering or accepting entertainment that is not a reasonable addition to a business relationship but is primarily intended to gain favor or influence must be avoided.

Payments to Agents and Consultants: Agreements with Business Partners (including agents or FDRs) must be in writing. Such agreements must clearly and accurately set forth the services to be performed, the basis for earning the commission or fee involved and the applicable rate or fee. Any such payment must be reasonable in amount, not excessive in terms of industry practices, not exceed any applicable statutory or regulatory maximums and be commensurate with the value of the services rendered.

Federal Procurement Integrity Act

The ASPA Medicare line of business is subject to the Federal Procurement Integrity Act when bidding on Federal contracts. This law prohibits certain business conduct for companies seeking to obtain work from the federal government. During the bidding process ASPA Staff may not:

- Offer or discuss employment or business opportunities at ASPA with agency procurement officials.
- Offer or give gratuities or anything of value to any agency procurement official.
- Seek or obtain any confidential information about the selection criteria before the contract is awarded.

In addition, other Federal provisions prohibit Federal officials from accepting anything of value, subject to reasonable exceptions such as modest items of food and refreshments. Because of these restrictions, no Staff shall either offer or make a gift to a federal employee.

In addition to health care fraud laws, ASPA Staff are expected to comply with laws and regulations regarding antitrust, tax and non-discrimination laws as well as lobbying/political activities and regulatory requirements.

Antitrust Laws

All ASPA Staff must comply with applicable antitrust and similar laws that regulate competition. Examples of conduct prohibited by these laws include (1) agreements to fix prices, bid rigging,

collusion (including price sharing) with competitors; (2) boycotts, certain exclusive dealing and price discrimination agreements; and (3) unfair trade practices including bribery, misappropriation of trade secrets, deception, intimidation and similar unfair practices. ASPA Staff are expected to seek advice from the ASPA General Counsel when confronted with business decisions involving a risk of violation of the antitrust laws.
In addition, it may analyze and take public positions on issues that have a relationship to the operations of ASPA, when ASPA's experience contributes to the understanding of such issues. ASPA has many contacts and dealings with governmental bodies and officials. All such contacts and transactions shall be conducted in an honest and ethical manner. Any attempt to influence the decision-making process of governmental bodies or officially by an improper offer of any benefit is absolutely prohibited. Any requests or demands by any governmental representative for any improper benefit should be immediately reported to the ASPA General Counsel.

Non-Discrimination
ASPA believes that the fair and equitable treatment of employees, patients and other persons is critical to fulfilling its vision and goals. It is the policy of ASPA to treat patients without regarding to the race, color, religion, sex, ethnic origin, age or disability of such person, or any other classification prohibited by law. It is the policy of ASPA to recruit, hire, train, promote, assign, transfer, layoff, recall and terminate employees based on their individual abilities, achievement, experience and conduct, without regard to race, color, religion, sex, ethnic origin, age or disability or any other classification prohibited by law. No form of harassment or discrimination on the basis of sex, race, color, disability, age, religion, ethnic origin, disability, or any other classification prohibited by law will be permitted. Each allegation of harassment or discrimination will be promptly investigated in accordance with applicable human resource policies.

Regulatory Requirements
ASPA staff must comply with applicable licensure, certification, permit and registration requirements as required by the business division they work in. This includes but is not limited to adherence to OSHA standards, compliance with Arizona state licensure and other applicable regulations, rules and laws.

C. Ensure Accurate Records and Financial Information

ASPA endeavors to ensure that all documentation, including but not limited to medical records, claims, time sheets, production standards, quality control, expense reports, formal certifications and financial statements accurately reflect the true nature of a fact or event. Loss of data or incomplete or inaccurate records could lead to a challenge of the integrity of the Compliance Program and diminish ASPA's reputation. Uniformity in retaining records is essential; therefore record retention policies must be followed to ensure proper retention and destruction of records.

All documentation must be complete, accurate and recorded timely. It is against ASPA's policy and a potential violation of law to cause documentation or financial records to be inaccurate or misleading in any way, for any reason or to make false or misleading oral or written statements.

When completing expense reports or financial statements, it is important to allocate the appropriate costs and to give consideration to the allowable, allocation and reasonableness of incurred costs. Management must be notified of significant transactions, trends and other financial or non-financial information that may be material to ASPA. It is against ASPA's policy to take any action to fraudulently influence, coerce, manipulate or mislead any independent public or certified accountant engaged in an audit of ASPA's financial statements.

D. Maintain Confidentiality

Patient and/or ASPA's Member Health Information
Staff, ASPA Members, and Business Partners will comply with Health Insurance Portability and Accountability Act (HIPAA) legal requirements, as well as the HITECH and GINA Acts, regarding the disclosure of Protected Health Information (PHI). ASPA's policies regarding health care

information that is protected by this law will be adhered to by all Staff and Business Partners. These policies conform to federal and state laws and have been designed to safeguard member privacy.
Confidential information is to be maintained and retained in accordance with written policies and applicable laws.

The Compliance Officer is responsible for the development and implementation of appropriate policies and procedures regarding patient privacy information in accordance with federal and state laws Questions regarding the release or disclosure of patient and ASPA's member information or violations of the federal or state privacy laws must be directed to the Compliance Officer.

ASPA's Business Information
Information obtained, developed or produced on behalf of ASPA by Staff, ASPA Members, and Business Partners is confidential and shall not be disclosed to anyone outside ASPA without proper authorization. Confidential information includes, but is not limited to patient or member lists, personnel data, fee schedules, clinical information, research data, financial data, legal advice/opinions and marketing strategies. Confidential information should be maintained in a secure location. Information expressly identified as "confidential" will be treated confidentially and access will be limited to those persons with a need to know. Staff who leave ASPA, as well as any other Business Partners who cease affiliation with ASPA may not take the originals or copies of any confidential and proprietary information and may not use this information for their own gain or that of another person or organization.

ASPA's Staff Information
ASPA Staff information, including social security numbers and personal identity data must be maintained in a confidential manner to protect the Staff from identity theft and to maintain the confidentiality of healthcare and benefits information.

E. Avoid Conflicts of Interest

A conflict of interest occurs when an individual's personal interest interferes or appears to interfere with the interest of ASPA. Such conflicts can limit an individual's ability to exercise due care, skill and judgment on behalf of ASPA. Because conflicts of interest may not always be clear cut, the Compliance Officer is available to answer questions that may arise. Staff and most Business Partners are screened for conflicts of interest at the time of hire and annually thereafter. Staff, ASPA Members, and Business Partners must review ASPA's conflict of interest policy, read and sign ASPA's conflict of interest attestation.

Board Member and Key Staff Responsibilities
All Board members and key Staff will recuse themselves from any discussion or decision affecting their business or personal interests. If an actual or potential conflict of interest should arise for a Board member, the Board member shall promptly inform the Chairman of the Board.

F. Cooperate With All Investigations

ASPA expects truthful and honest responses when participating in internal investigations or external agency reviews, audits or investigations. ASPA is prepared to demonstrate its program upon request by AHCCCS, CMS, the state or federal government, or its designee.

Internal Investigations
It may be necessary to conduct internal investigations to determine whether or not non-compliant activities have occurred. Cooperation and timely responses, without fear of retaliation, are required to ensure the prompt investigation and resolution of ethical and compliance issues. Concerns about retaliation should be reported to the Compliance Officer. Retaliation is prohibited against those who, in good faith, report inappropriate activities. Anyone who intentionally makes a false report or who has knowledge of or suspects a possible violation of laws or regulations and does not report it will be subject to disciplinary action up to and including termination.

Reviews by External Agencies
ASPA cooperates with all reviews by authorized external agencies in a direct, open and honest manner. No action may ever be taken that would mislead the reviewer or the survey team.

Government Investigations
ASPA agrees to permit and will fully cooperate with any authorized federal or state officials who conduct an onsite review as well as all legal demands made in any government investigation of ASPA. AHCCCS or CMS officials may also audit ASPA records and inspect ASPA facilities. ASPA will allow reasonable access to ASPA Staff and Business Partners, members and records.

Individuals approached by someone stating that they are a government agent, should confirm the representative's authority by requesting identification and obtaining the person's name, office, address, telephone number and identification number. Individuals must immediately notify their managers who will immediately notify the Compliance Officer who will determine the legitimacy and scope and establish the proper procedures for cooperating with the investigation.

Individuals may agree or refuse to talk with a government investigator and recognize that they have the right to seek legal counsel before responding to any questions. In all cases, it is imperative to tell the truth.

It is against ASPA's policy and a violation of the law to prevent, obstruct, mislead, delay or attempt to prevent, obstruct, mislead or delay the communication of information or records to a government investigator'. Staff, ASPA Members, and Business Partners that knowingly and willingly falsify, conceal, or cover up by a trick, scheme or device a material fact or make any false statements or fraudulent representations to a Federal agency may be subject to fines, imprisonment or both[6].

During a government investigation, all policies enabling the destruction of documents shall be suspended until the investigation has been completed and the Compliance Officer has reinstated the policies. If a subpoena or other legal document (such as a Civil Investigative Demand) from any government agency is received, the manager shall contact the Compliance Officer.

G. Retention of Records

Disposal or destruction of ASPA's records is not discretionary. The retention and disposal or destruction of records will be in accordance with legal and regulatory requirements and ASPA policy. Records pertaining to litigation or a government investigation or audit will not be destroyed. Records that are subject to audit or current/threatened litigation may not be destroyed unless there is written notification of expiration of the litigation and record destruction is approved by Senior Management and the Compliance Officer.

Records will be maintained in appropriate format (paper, microfilm, microfiche, electronic, and imaged) and available within the timeframes required by Federal and State regulations. The Compliance Officer or designee will oversee destruction of any records, which will comply with written policies and procedures.

H. Accessing Electronic Information

Staff, ASPA Members, and Business Partners are responsible for properly using information stored and produced by all information systems. Staff, ASPA Members, and Business Partners will comply with HIPAA and HITECH policies that reflect the legal requirements for protecting electronically submitted Protected Health Information (PHI).

System users are responsible for preventing unauthorized access to the systems. Passwords and other security codes may not be shared. Accessing ASPA system records for any reason or adjusting ASPA policy file or claims or those of other Staff and/or Business Partners without proper authority is a violation of the Compliance Program and an offense that may subject an offending Staff and/or Business Partner to disciplinary action up to and including termination.

Microcomputers, personal computers, internet access, e-mail or other communication systems are intended for business-related purposes only and not for use that may be considered disruptive, offensive, harassing or harmful to others. Each software package, unless specifically licensed for Local Area Network (LAN) use or site-licensed, may only be used on a single personal computer or microcomputer. Unless expressly permitted by the software license agreement, software cannot be copied for use on more than one ASPA or personal computer or microcomputer.

I. Prohibited Insider Trading

If any ASPA Staff becomes aware of non-public information about the Medicare line of business or another related company as a result of their affiliation, law prohibits disclosing this information to anyone. As an ASPA Staff member, you are prohibited from buying or selling securities based on this information. This also includes using insider trading to make investment decisions relative to ASPA's competitors. If you have any questions regarding adhering to trading laws, or are aware of others who may be in violation, notify the Compliance Officer immediately.

J. Commitment to Employment Relationship

ASPA believes that Staff should be able to work in a professional atmosphere without fear of retribution. Retaliation is prohibited against those who, in good faith, report inappropriate activities. Good faith is defined as a full, fair, accurate and timely disclosure.

In addition, ASPA is committed to providing a work environment that is free of harassment and discrimination in all aspects of the employment relationship, including recruitment and employment, work assignment, promotion, transfer, salary administration, selection for training, corrective action and termination.

All ASPA Staff are required to observe our commitment and extend to each other appropriate behavior in the workplace. All ASPA Staff should be familiar with ASPA's policies and procedures. Any questions on these policies should be directed to your supervisor or the Compliance Officer.

K. Seeking Guidance and Reporting Violations

Staff, ASPA Members, and Business Partners must report any actual or suspected violation of this Compliance Program by completing an incident form; speaking to their supervisors; ASPA management; reporting the matter to the Compliance Officer via phone call, email, in-person report, mail or fax All inquiries are confidential subject to the limitations imposed by law. Retaliation is prohibited against those who, in good faith, report inappropriate activities. Good faith is defined as a full, fair, accurate and timely disclosure. Anyone who intentionally makes a false report or who has knowledge of a possible violation of a law or regulation and does not appropriately report it will be subject to disciplinary action up to and including termination.

L. Enforcement of Corrective Action and/or Discipline

Individuals who violate any of the Compliance Program requirements or violate related ASPA policies and procedures and anyone who knowingly fails to report violations or any supervisor, officer, or agent who fails to oversee compliance by those he or she supervises is subject to corrective action and/or disciplinary action up to and including termination. Violations may also result in criminal referral and reports to law enforcement and government agencies. Any individual who harasses or threatens an ASPA Staff and/or Business Partner for reporting violations will be terminated.

This policy is reviewed and updated annually. Copies are given to the employees, ASPA Board and Committee Members in January each year to review and sign a Code of Confidentiality and Conduct.