HMO/MANAGED CARE CONTRACTS

The contracted HMO plans below are delegated to Santé Physicians for Claims, Utilization Management, and Customer Service. The policies contained in this manual pertain to these plans:

Aetna (Commercial & Medicare)
- Commercial HMO
- Medicare HMO
- D-SNP (Medi-Medi) *(Pre 2024 members only)*
- IVL

Alignment Health Plan (Medicare only)
- The One + Walgreens HMO (Plan 035)
- Health Heart & Diabetes CalPlus HMO CSNP (Plan 039)
- Health Heart & Diabetes HMO C-SNP(Plan 010)
- CalPlus + Veterans HMO (Plan 036)

Anthem Blue Cross (Commercial & Medicare)
- CaliforniaCare
- Anthem Blue Cross Plus POS
- Pathway-HMO-Individual
- Anthem Prime HMO (Medicare Only)
- Anthem Full Dual Advantage Aligned (HMO D-SNP) (Medi-Medi)

Blue Shield (Commercial only)
- Access + HMO
- CCPOA HMO
- CalPERS Access +
- FEHBP Access + HMO
- HMO Point of Service
- PSJH HMO + Network

Brand New Day (Acquired by Bright Health) (Medicare only)
- Classic Care I HMO 50-2
- Classic Care II HMO 51-1
- Embrace Choice HMO 40-2 (C-SNP)
- Embrace Care HMO 39-2 (C-SNP)
- Valor Care Plan HMO 48

Cigna (Commercial only)
- Cigna Healthcare (HMO/POS)

Health Net (Commercial)
- CHW
- Commercial IDV HMO
- Sapphire

Humana (Central Valley Health Plan) (Medicare only)
- Humana Gold Plus H5619-012 (HMO)
- Humana Gold Plus H5619-150
- Humana Honor H5619-121
- Humana Gold Plus H5619-148

UnitedHealthcare (Commercial & Medicare)
- SignatureValue HMO
- SignatureValue Alliance HMO
- SignatureValue CalPers Alliance HMO
- AARP Medicare Advantage from UHC CA-0005
- AARP Medicare Advantage from UHC CA-024P
- UHC Medicare Advantage CA-001A
- UHC Group Medicare Advantage HMO

***UHC has partial coverage in Madera County and is limited to the following zip codes:** 93601, 93604, 93614, 93636, 93643, 93644, 93645 and 93669. **UHC has full coverage in Fresno and Kings County.**

Wellcare By Health Net (Medicare)
- Wellcare No Premium Ruby
- Wellcare Cal Viva Dual Align (D-SNP) (Medi-Medi)

Medi-Medi D-SNP plans are considered Medicare Advantage plans.

Managed Medi-Cal Contracts

The Managed Medi-Cal plans below are contracted through Santé Physicians:

- **Anthem Blue Cross** Capitated
- **Health Net CalViva** Capitated
- **Health Net CalViva** Fee-for-Service (*Claims, Utilization Management and Customer Service are handled directly by Health Net.)* **Health Net FFS Rates:** PCP = 110% of Medi-Cal Fee Schedule / Specialist = 110% of Medi-Cal Fee Schedule) **HN Community Solutions:** (800) 675-6110

Contents

SPECIAL PACE PROGRAMS 3
Fresno PACE 3
WelbeHealth Sequoia PACE 3
HMO's NOT SERVICED THROUGH SANTÉ 5
Reciprocity "Out of Area" Contract Rates 5
AETNA HMO/POS 5
BLUE CROSS CaliforniaCare 5
BLUE SHIELD HMO/POS/Healthy Families 5
CIGNA HMO/POS 5
Health Net HMO/POS 6
UNITED HEALTHCARE 6
Santé NON-HMO CONTRACTS 7
Beech Street 8
Cigna 9
First Health 10
Fortified Provider Network 12
Galaxy Health Network 13
Health Net 14
HealthSmart 16
Humana ChoiceCare 17
Multiplan, Inc. 18
Networks by Design 19
Three Rivers Provider Network (TRPN) 20
TriStar Managed Care 21
UC Davis Health System 22
United Healthcare 23
USA Managed Care Options 25
FHCA PPO/EPO CONTRACTS 27

SPECIAL PACE PROGRAMS

Provider's office: If your provider is contracted with Santé HMO, then your provider is IN-NETWORK with both PACE programs. A description of each program follows.

PACE is the payor and pays FFS. Please send claims directly to PACE.

Fresno PACE

Effective: January 1, 2018

Rate: 115% of the current Medicare fee schedule for Fresno County

Website Link: https://www.fresnopace.org/

Fresno PACE provides a comprehensive program of health care and wellness services for the county's frail, low-income senior population. Our services include primary, preventative, and acute medical care as well as social, recreational, nutritional and personal care services in our very conveniently located Day Center. Our Interdisciplinary Team (IDT) collaborates to manage an effective care plan to support our senior members in living happily, healthily, and independently at home as an alternative to nursing care.

Our program allows seniors to receive all necessary services under one convenient plan rather than those only reimbursable by Medicare and Medicaid fee-for-service plans. Once enrolled, PACE is the sole source of healthcare benefits for senior participants.

- PACE is the Plan or payor
- All specialty medical providers are coordinated by Fresno PACE
- All specialty medical authorizations are made by Fresno PACE
- PACE can provide transportation for participants to and from specialty medical appointments
- Claims payment is typically made within 30 days of a clean claim

WelbeHealth Sequoia PACE

Effective: September 1, 2020

Rate: 115% of the current Medicare fee schedule for Fresno County

Website Link: https://welbehealth.com/

WelBeHealth Sequoia PACE Agreement Amendment January 1, 2024 to increase payment rate to align with our other PACE program (Fresno PACE) at **115% of Medicare** for all participants.

This increase is to improve access to Santé Specialists.

WelBeHealth Sequoia PACE provides **INTEGRATED MEDICAL AND SOCIAL SERVICES FOR SENIORS** designed to keep them living in their homes. Their goal is to serve the seniors in our community with better quality and compassion by developing care plans specific to their needs and giving them peace of mind knowing that there is a full team supporting them and their family to reach their care goals. **The PACE program is the sole source of benefits for PACE participants.**

WelBeHealth Sequoia PACE is **not a traditional HMO or PPO**, it is a government program providing coordinated, comprehensive medical care across specialties as well as social services to frail, community-dwelling elderly individuals. The program **allows providers to deliver all services participants need rather than only those reimbursable under Medicare and Medicaid** fee-for-service plans.

- **Patients assign their Medicare or Medi-Cal to PACE who becomes the actual "plan" and is responsible for paying claims. The PACE program is the sole source of benefits for PACE participants.**
- PACE is the member's PCP; the site is staffed by a Primary Care physician who refers patients to Santé **SPECIALISTS** for medically necessary services.
- All specialty medical referrals are coordinated by WelBeHealth staff.
- All specialty medical authorizations are made by WelBeHealth staff.
- WelBeHealth also offers a portal for providers to submit:
    - Authorization requests
    - Claims, and
    - Check claims status.
- PACE is responsible for transporting patients to and from their appointments **(eliminating "no-shows")**
- Claims payment is typically made within 30 days of receipt of a clean claim.

HMO's NOT SERVICED THROUGH SANTÉ

HMO's not serviced through Santé means that the PLAN pays the claims.

Reciprocity "Out of Area" Contract Rates

AETNA HMO/POS

(effective May 1, 2006)
101% OF THE CURRENT Aetna Market Fee Schedule as may be modified from time to time. You may obtain the allowable by calling 888-MDAETNA *(you will need your tax identification number*). At no time will the rate exceed the Provider's actual billed charges.

BLUE CROSS CaliforniaCare

(effective July 1, 2004)
Blue Cross shall pay at the rate negotiated between Blue Cross and said provider. In thecase of non-contracting providers, Blue Cross shall pay the lesser of the actual billed charges or the maximum allowable rate according to the Blue Cross "customary and reasonable charges" or the rate arranged for by a CaliforniaCare Case manager.

BLUE SHIELD HMO/POS/Healthy Families

(effective April 1, 2004)
The lesser of 110% of the Blue Shield PPO Physician Allowances in effect on the date ofservice, or the amount paid by the Group (or Group Provider) for the services. Further detail regarding Blue Shield's proprietary fee schedule is provided upon request.

All injectable drugs excluded from Group risk, shall be reimbursed by Blue Shield at "cost".Cost is defined as AWP less 15%.

CIGNA HMO/POS

(effective February 1, 2003)
The lesser of billed charges or the following:

Services other than Pathology and Anesthesia = 100% of that version of the RBRVS in effect at Cigna. In those circumstances where there is no RBRVS value, that version of theSt. Anthony's Complete RBRVS value in effect at Cigna will be utilized.

Pathology = 100% of the Medicare National Limits in effect at Cigna.

Anesthesia = $39.00 per unit of the American Society of Anesthesiologists (ASA) RelativeValue Guide.

Where there is no defined value, procedures will be paid at 70% of billed charges or up tothe 70th percentile of reasonable and customary, whichever is less.

Drugs will be reimbursed at AWP.

HMO's NOT SERVICED THROUGH SANTÉ

Reciprocity "Out of Area" Contract Rates *(continued)*

Health Net HMO/POS
Lesser of 123% of the Medicare allowable charges based on the Medicare RBRVS unit values and CMS Geographical Practice Cost Indices as published in the most current published edition of the Federal Register or 100% of allowable billed charges.

For "by report" procedures, procedures not listed, or procedures with relativities notestablished in RBRVS, reimbursement shall be at 75% of billed charges.

Assistant Surgeons: 20% of surgeon's reimbursement as determined above. Immunizations,

Injectables and HMO Designated Vendor: 100% of AWP.

Obstetrical Care:

59400-22	$2,570	59410-22	$1,782
59510-22	$3,265	59515-22	$2,513
59610-22	$2,739	59614-22	$1,980
59618-22	$3,465	59622-22	$2,712
76810-22	$329	76815-22	$102
76816-22	$329		

Anesthesiology: Lesser of $51.00 per unit value in accordance with the American Society of Anesthesiology (ASA) unit scale, or 75% of usual billed charges.

OB Epidural shall be compensated under the unit value conversion factor stated above forAnesthesiology and applied to the ASA Base Units and Time Units as set forth below:

BASE UNITS:		
01967	- Continuous epidural, labor & vaginal delivery	5 units
01967 & 01968	- Continuous epidural, labor & C-section	7 units
01961	- Planned C-Section	7 units
TIME UNITS:		
Start-up time:	Up to 3 units for 1st hour of labor time, plus	
Labor time:	2 units for each additional hour of labor time, plus	
Surgery time:	1 unit for each 15 minute interval of surgical time, If labor goes into C-section, or of planned C-section	

UNITED HEALTHCARE

The Santé provider may negotiate the reimbursement rate with the referring capitated IPA/Medical Group that the member is assigned to. If no rate is negotiated, reimbursement shall be at the lesser of billed charges or 100% of Medicare's geographically adjusted fee schedule according to the Medicare payment locality the Santé provider resides in. In non-emergency situations, the Santé provider is not obligated to accept the referral.

Santé NON-HMO CONTRACTS

*** Contracted Payor List**

Health Plan	Phone	Website	PPO	EPO	POS	Wkrs' Comp
Aetna	(888) 632-3862 or # on ID card	www.aetna.com			√*	
Anthem Blue Cross Plus					√*	
Beech Street (Multi-Plan)	(800) 877-1444	www.beechstreet.com	√			√
Blue Shield	# on back of card	www.blueshield.com			√*	
CIGNA	(800) 244-6224	www.cigna.com	√	√ (PPO panel)	√	
Community Care Network (Coventry) (Aetna)	(800) 247-2898	www.aetna.com	√			√
First Health (Coventry)	(800) 937-6824	www.firsthealth.com	√	√		√
Fortified Provider Network	(866) 955-4376		√			√
Galaxy Health Network	(800) 975-3322	www.galaxyhealth.net	√			
Health Net	(800) 641-7761	www.healthnet.com	√	√	√*	√
HealthSmart (Interplan)	(209) 473-0811	www.healthsmart.com	√	√		√
Humana ChoiceCare	(800) 457-4708	www.humana.com	√		√	
Multiplan	(800) 546-3887	www.multiplan.com	√			√
Networks by Design	(209) 229-8537	www.networksbydesigncorp.com	√			√
Partners Direct Health	(888) 573-3186	https://partnersdirecthealth.com/	√			
Private Healthcare Systems (Multiplan)	(800) 950-7040	www.multiplan.com	√			
Three Rivers Provider Network (TRPN)	(800) 966-8776	www.contigohealth.com	√			√
TRICARE West (Health Net – West Region Contractor)	(844) 866-9378	www.tricare-west.com	√			
Tristar Managed Care	(855) 626-7827	http://www.tristarmanagedcare.com/		√		
UC Davis Health System			√			
United Healthcare	(877) 842-3210	www.unitedhealthcareonline.com	√		√	
USA Managed Care Organization	(800) 872-0820	www.usamco.com	√			

**Submit claims to Santé when patient is utilizing the HMO side of these POS plans.*
**Refer to your individual Santé Physicians agreement for fee schedule.*

SANTÉ NON-HMO CONTRACTS

*** Contract Rates**

Beech Street

(PPO & Worker's Compensation)

Effective: December 1, 2009

Reimbursement: The lesser of 80% of billed charges or:

Rate E&M Codes	125% Beech RBRVS
Surgery Codes	135% Beech RBRVS
All Other Codes	130% Beech RBRVS
Anesthesia	$55 per unit ASA
Auto Medical	Excluded
HCPCS & Unlisted Codes:	Reimbursed at the lesser of usual billed charges or the applicable fee under the Beech Market Fee Schedule, less applicable Copayments, Deductibles and Coinsurance.

Timeliness of Claims Submission: Within 180 days from the date services were rendered if primary. 180 after receipt of EOB if secondary.

Timeliness of Claims Payment: Except where Coordination of Benefits applies, Payor shall make all payment due to Provider within 30 days following receipt of a complete and proper claims form and other information required to determine that the claim is payable under the Plan.

Late Payment Penalty: Not addressed.

Direct Billing of Member: Physician shall be entitled to bill and collect from a Preferred Patient that amount specified in a Beneficiary Agreement or Plan as Preferred Patient's deductible and co-insurance amounts, as well as Physician's usual and customary chargesfor non-covered services provided to a Preferred Patient.

Coordination of Benefits: Payment in full is further defined as the total amount to be received for Covered Services by Physician from the Preferred Patient, and any other source (such as, for example, supplementary insurance plans), and shall not exceed the amount specified in Exhibit B. The dollar amounts listed in Exhibit A represent payment infull for all Workers' Compensation medical services.

Medical Record Copy: $.50 per page not to exceed $25.00 per record.

Worker Compensation

Reimbursement: The lesser of 100% of the fee under the state workers' compensation fee schedule (If applicable) or the health benefit Plan rate as specified above.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

Cigna
(PPO)

Effective: June 1, 2002

Reimbursement: Lesser of billed charges or the rates specified below less applicable Copayments, Deductibles or Coinsurance.

Cardiology Services	130%	of the RBRVS in effect at Cigna
Cardiovascular Services	130%	of the RBRVS in effect at Cigna
Cardiothoracic Surgery Svcs	130%	of the RBRVS in effect at Cigna
General Surgery Services	120%	of the RBRVS in effect at Cigna
Orthopedic Services	125%	of the RBRVS in effect at Cigna
Neurosurgery Services	130%	of the RBRVS in effect at Cigna
Radiology Services	140%	of the RBRVS in effect at Cigna
Pathology Services	120%	of the RBRVS in effect at Cigna
Anesthesia	$39	Per ASA Unit
All other services	115%	of the RBRVS in effect at Cigna
Drugs		Reimbursed at AWP

Please check with Cigna Network Relations to verify RBRVS in effect at Cigna for date of service/ claims.

In those circumstances where there is no defined value, procedures will be paid at 70% of billed charges.

Immunization	Rate	Immunization	Rate	Immunization	Rate
90281	$34.46	90700	$28.76	90717	$70.44
90585	$202.00	90701	$23.17	90718	$6.42
90632	$78.70	90702	$11.14	90719	$9.16
90633	$39.34	90703	$4.34	90720	$46.37
90634	$39.34	90704	$22.96	90721	$51.17
90645	$34.06	90705	$19.92	90725	$11.63
90646	$26.80	90706	$20.87	90727	$9.00
90647	$29.15	90707	$49.81	90732	$23.50
90648	$30.11	90708	$30.66	90733	$90.00
90657	$6.38	90709	$21.97	90735	$117.46
90658	$12.76	90710	$52.61	90744	$33.24
90659	$12.76	90712	$24.54	90746	$81.58
90690	$10.67	90713	$34.74	90743	$33.24
90691	$55.56	90716	$74.93	90748	$62.74
				90669	$70.50

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

First Health

(Formerly CNN)
(PPO & Worker's Compensation)

Effective: October 1, 2009

Reimbursement: Based on Current Medicare fee Schedules as adjusted and supplemented by Coventry. Current Medicare schedules will be updated no later than 120 days from the final published CMS ruling.

Evaluation and Management Services		115%
Surgery		135%
Anesthesia (CPT range 00000-01999)		$55.00 per unit
Maternity Normal Delivery	Billed as global services	$2,200
Maternity C Section	Billed as global services	$2,495
Other Services:		130%

Reimbursement for services that are billed with a procedure code for which there is no assigned value as outlined above shall be reimbursed at 75% of Provider's billed charge.

J Codes and Immunizations shall be reimbursed at 100% of the 2009 1st quarter AWP allowable amounts as adjusted and supplemented by Coventry

Reimbursement for Fertility Codes with Modifier -22

58970-22	$325	59614-22	$1,400
58974-22	$130	59618-22	$2,800
59400-22	$2,460	59622-22	$1,820
59410-22	$1,300	75810-22	$220
59510-22	$2,800	76815-22	$98
59515-22	$2,405	76816-22	$220
59610-22	$2,530	89280-22	$370

Workers Compensation Reimbursement: 95% of Workers Compensational Fee Schedule.

95% of the amount specified as the maximum amount payable under any state or federal law or regulation pertaining to payment for such services or 95% of the First Health Non-Network Fee Schedule if a mandated fee schedule for the serviced billed is not applicable.

95% of providers billed charges for services that are billed with a procedure code where there is not an assigned value for the product.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

First Health *(continued)*

Auto Insurance Payors

Reimbursement: Lesser of the PPO Rates listed above, or the amount payable under any state of federal law or regulation pertaining to payment for such services. These rates shallapply whether such rules or guidelines are in existence at the time of execution of this agreement or established later.

Procedures Requiring CCN Pre-procedure Review	
1. Arthroscopy (knee)	2. Blepharoplasty
3. Cardiac Catheterization	4. Carpal Tunnel Release
5. Colonoscopy	6. CT Scan (brain, sinus, pelvis, bone density)
7. Diagnostic Laparoscopy (pelvic)	8. EMG (upper extremities)
9. Laparoscopic Cholecystectomy	10. Laparoscopic Vaginal Hysterectomy
11. MRI (all)	12. Myelogram
13. Percutaneous Coronary Angioplasty	14. Percutaneous Diskectomy
15. Reduction Mammoplasty	16. Septoplasty/Rhinoplasty
17. Resection/Rhinoplasty	18. Stem Cell Transplant
19. Upper GI Endoscopy	20. Uvulopalatopharyngoplasty

Timeliness of Claims Submission: Provider to bill within 2 months of providing services.

Timeliness of Claims Payment: Payor has 30 days to remit payment to Provider.

Late Payment Penalty: If payor fails to make timely payments, CCN shall review the applicable Payor Agreement and take appropriate action. Please notify the contracting department.

Coordination of Benefits: Not addressed in the agreement. However, may be addressed inyour CCN Provider Manual. If you need an updated manual, please call CCNs Network Services at (800) 247-2898.

Direct Billing of Member: May bill member for copayment, coinsurance, deductible, or services that are not a covered benefit.

Medical Record Copy: Not addressed. You may bill for medical record copies at your normal billing charge.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

Fortified Provider Network

(PPO & Worker's Compensation)

Effective: December 1, 2002

Reimbursement:

- **PPO -** 85% of billed charges.
- **Worker's Compensation** - In cases where state-mandated fee schedules are in effect, provider will receive 100% of the state-mandated fee schedule amounts.

Timeliness of Claims Submission: No later than 90 days from the date of service.

Timeliness of Claims Payment: Within 30 days of receipt of clean claim.

Late Payment Penalty: 100% of billed charges is due if not paid timely, plus interest per state law.

Coordination of Benefits: Provider shall be entitled to receive 100% of their billed charges when combining payments from both primary and secondary payors.

Direct Member Billing: Provider may bill members for all deductibles, copayments, and coinsurance.

Medical Record Copy: Not addressed.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

Galaxy Health Network

(Formerly Managed Care, Inc.)
(PPO)

Effective: January 1, 2011

Reimbursement: 80% of billed charges as indicated on the HCFA-1500 or other approved form. This shall include amounts paid by the covered person, such as Copayments, Deductibles and other Coinsurance.

Timeliness of Claims Submission: Within 30 days of the date of service, but in no event later than 1 year after service. Claims should not be denied for untimely submission unless they have been submitted after 1 year from the date of service.

Timeliness of Claims Payment: Within 45 days from the date of receipt of a clean and uncontested claim.

Late Payment Penalty: If payment not received within 45 days, provider may bill member forpayment.

Coordination of Benefits: In the event a Covered Individual has dual insurance coverage, Physician shall be entitled to bill and collect up to his/her usual and customary rates for services rendered in accordance with generally accepted industry procedures.

Direct Billing of Member: Physician shall bill and collect from the member those amounts that are members' responsibility (i.e., copays, deductibles, and non-covered services).

Medical Record Copy: Not addressed. Utilize your normal billed charges.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

Health Net

(PPO & EPO)

Effective: January 1, 2010

Lesser of 123% (commercial members) / 100% (Medicare eligible members) of the Medicare allowable charges based on the Medicare RBRVS unit values and CMS Geographical Practice Cost Indices as published in the most current published edition of the Federal Register or 100% of allowable billed charges.

For "by report" procedures, procedures not listed, or procedures with relativities not established in RBRVS, reimbursement shall be at 75% of billed charges.

Assistant Surgeons: 20% of surgeon's reimbursement as determined above.

Obstetrical Care:

59400-22	$2,570	59410-22	$1,782
59510-22	$3,265	59515-22	$2,513
59610-22	$2,739	59614-22	$1,980
59618-22	$3,465	59622-22	$2,712
76810-22	$329	76815-22	$102
76816-22	$329		

Anesthesiology: Lesser of $51.00 per unit value in accordance with the American Society of Anesthesiology (ASA) unit scale, or 75% of usual billed charges.

OB Epidural shall be compensated under the unit value conversion factor stated above for Anesthesiology and applied to the ASA Base Units and Time Units as set forth below:

BASE UNITS:

01967	-Continuous epidural, labor & vaginal delivery	5 units
01967 & 01968	-Continuous epidural, labor & C-section	7 units
01961	-Planned C-section	7 units

TIME UNITS:

Start up time:	Up to 3 units for 1st hour of labor time, plus
Labor time:	2 units for each additional hour of labor, plus
Surgery time:	1 unit for each 15 minute interval of surgical time If labor goes into C-section, or of planned C-section

Injectable & Infused Drugs: 100% of AWP

Timeliness of Claims Submission: Within 90 days of providing services. Effective July 1, 2006 the deadline has been extended to 120 days.

Timeliness of Claims Payment: According to State law.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

Health Net *(Continued)*

(PPO & EPO)

Late Payment Penalty: If clean claims are not paid within ninety (90) days, payment will revert to billed charges unless prohibited by law. Prior to claims reverting to billed charges, provider will give Health Net or Payor ten (10) days prior notice to pay the claim. Such written notice shall be sent to the attention of the claims manager of the appropriate Payor and carbon-copied to the Provider Network Management contact.

Payment Appeals: Per AB-1455 (365 days to appeal incorrect payment)

Direct Billing of Member: Members should only be billed for copayments, deductibles,coinsurance, or non-covered services.

Medical Record Copy: When requested by Foundation Health Systems, Provider shall produce copies of any such records at a cost to Foundation of $0.15 per page not to exceed $15.00 per record.

Worker's Compensation

Effective: January 1, 2009

Reimbursement: Reimbursements under the Agreement shall be at one hundred percent (100%) of the Fee Schedule adopted by the applicable state workers' compensation regulatoryagency.

Timeliness of Claims Submission: Within 90 days of providing services.

Timeliness of Claims Payment: According to State law.

Payment Appeals: Provider shall submit requests for adjustments and/or appeals regarding claim payments to Foundation Health Systems within 60 calendar days after the date of the payment of such claim to Provider. In the event Provider fails to appeal a claim within such time period, Provider shall not have the right to appeal such claim.

Coordination of Benefits: When Health Net is secondary under the Coordination of Benefits rules, Health Net shall pay Provider only those amounts which when added to the amount paid to Provider from other sources, equals the amount due Provider under this agreement in the absence of other sources of payment. Any legal rights to collection of overpayments from Health Net, which may occur under this Section, shall be deemed to be transferred from PPG toHealth Net if PPG has been paid in full according to the primary carrier's contracted rate.

Direct Billing of Member: Members should only be billed for copayments, deductibles,coinsurance, or non-covered services.

Medical Record Copy: When requested by Foundation Health Systems, Provider shall produce copies of any such records at a cost to Foundation of $0.15 per page not to exceed $15.00 per record.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

HealthSmart

(Formerly Interplan)
(PPO, EPO & Worker's Compensation)

Effective: December 1, 2009

Reimbursement:
Workers' Compensation – For states with fee schedule established by a state of governmental entity, reimbursement shall be at 100% of the rate or fee established or the negotiated rates whichever is less.

PPO/EPO: The lesser of 20% off billed charges or the rates as stated below:

Evaluation and Management	115% of 2009 RBRVS Locality 99
Pathology	130% of 2009 RBRVS Locality 99
Radiology	130% of 2009 RBRVS Locality 99
Surgery	135% of 2009 RBRVS Locality 99
Anesthesia	$52 per ASA Unit
Unlisted Codes	80% of Billed Charges
All Other Codes	130% of 2009 RBRVS Locality 99

Timeliness of Claims Submission: 365 days from the date of service.

Timeliness of Claims Payment: Within 30 days of receipt of clean & complete claim.

Late Payment Penalty: Provider may notify Interplan. Interplan will then have 15 days to resolvethe matter. If not resolved within 15 days, reimbursement shall be at 100% of the Provider's billed charges for undisputed amounts on the claim.

Coordination of Benefits: When Interplan is secondary, the payment shall be up to the amount which when added to amounts received by Provider from other sources equals the lesser of the applicable rates according to this agreement or the contract rate applicable to the primary payer. Therefore, if primary pays more than Interplan would have as primary, Interplan will pay nothing assecondary. However, is primary payor pays less than Interplan would have paid as primary, Interplan will pay the difference between the primary payment and reimbursement owing under thisAgreement.

Direct Billing of Member: Physician may bill the patient only for charges or services verified by the Payor as not covered by the benefit plan; or after the health plan's payment only for any balance dueas shown on Payor's EOB for any deductibles or copayments.

Medical Record Copy: First 10 pages at no charge. Over 10 pages shall be reimbursed up to $0.05 per page.

Physician Individual Agreement Note: *Some of the SANTÉ physicians are currently contracted with Interplan directly. Therefore, this agreement will supersede any prior agreements with physicians.The only exception to this is the CMP Agreement. Once the CMP initial year is up, then the CMP physicians will fall under this Agreement.*

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

Humana ChoiceCare

(PPO & POS)

Effective: September 1, 2008

Reimbursement:

Service Type	Reimbursement
Professional Services (not listed below)	135% of ChoiceCare's Professional Fee Schedule (005/952/135
Drug, Immunizations & Biologicals	100% of ChoiceCare's Proprietary Fee Schedule Fee (201/544-100)
Laboratory Reimbursement for the following Codes: 36415, 80048, 80049, 80053, 80076, 81000, 81002, 82040, 82105, 82232, 82232, 82247, 82248, 82270, 82272, 82274, 82310, 82378, 82435, 82465, 82565, 82575, 82670, 82728, 82746, 82947, 82962, 82977, 83540, 83550, 83615, 83735, 84066, 84100, 84132, 84134, 84153, 84155, 84295, 84436, 84439, 84443, 84460, 84466, 84520, 84550, 84555, 84702, 85002, 85007, 85008, 85014, 85018, 85023, 85024, 85025, 85027, 85044, 85048, 85060, 85210, 85590, 85610, 85651, 85730, 86300, 86301, 86304, 86316, 86415, 86540, 99000	120% of ChoiceCare's Professional Fee schedule (005/952/120)

Timeliness of Claims Submission: Within 90 days of providing services.

Timeliness of Claims Payment: According to State Law

Appeals Process: Disputes that are not settled by mutual agreement shall be resolved by binding arbitration.

Coordination of Benefits: Payments for covered Services provided to each Member are subject to coordination with other benefits payable or paid to or on behalf of the Member in accordance with applicable statues, laws, rules and regulations and in accordance with its plans. In cases where a Member has coverage, which requires or permits coordination of benefits with another third party payor, Payors will coordinate their benefits with such other payor(s). In the event Medicare is the primary payor,Payors shall pay IPA the amount if deductable, coinsurance and/or other plan benefits which are not covered services. In instances where Payor is secondary, IPA shall be entitled to receive up to 100% of its normal billed charges when combining reimbursement from both primary and secondary sources.

Direct Billing of Member: Members are not responsible for any payments to IPA except for applicable Copayments and non-covered services.

Medical Record Copy: Copies of records not required for claims processing shall be charged at $0.25 per page not to exceed seventy-five ($75.00) for the entire medical record. Copies of records required forthe processing of claims shall be made and provided by the IPA at no cost to ChoiceCare, payor or the member.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

Multiplan, Inc.

(PPO, Workers Compensation and Auto Insurance)

Effective: March 1, 2002

Reimbursement: Least of the following less any applicable deductible, co-payment and/or co-insurance or Practioner's usual and customary charge

- 130% of the 2002 RBRVS Participating Provider CMC Medicare fee schedule
- $50.00 ASA for Anesthesia- 15 minute intervals
- 75% of billed charges for HCPCS and non-listed codes

Effective June 15, 2006: Vaccines & non-vaccines shall be reimbursed at 75% of billed charges

Effective July 1, 2006: J / Q Codes shall be reimbursed at 100% of AWP

Timeliness of Claims Submission: Not addressed

Timeliness of Claims Payment: Payments will be sent to provider within 30 business days from the date the clean claim is received. For disputed claims, providers will need to addressMultiplan within 60 calendar days of the date the payment was received.

Late Payment Penalty: If a clean claim is not paid within 30 days and has not been disputed bythe payor, contract rates will be null and void and the payor will owe the provider normal billed charges.

Coordination of Benefits: When a Multiplan client is primary, provider will accept the contracted rates listed above as payment in full less applicable deductibles and co-payments and co-insurance. If a Multiplan client is secondary, the provider shall accept from the Client aspayment for covered services the difference between the contract rates listed above minus the sum of the amount paid by the primary payor(s) and any applicable deductibles, co-payments, and co-insurance.

Direct Member Billing: Providers shall not balance bill or attempt to collect compensation fromparticipants except for applicable co-payments, deductibles and co-insurance or as permitted by law.

Medical Record Copy Fees: $.50 per page, not to exceed $25.00 per record.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

Networks by Design

(PPO & Worker's Compensation)

Effective: August 1, 2011

Reimbursement:
The Reimbursement Amounts are established by NBD and accepted by NBD's Payors. The NBD Reimbursement Amounts are based on the Resource Based Relative Value Scale (RBRVS) for locality 99. The Reimbursement Amount shall be a percentage of the current yearRBRVS allowable for services identified in the categories as shown below:

Evaluation and Management	115%
Pathology	130%
Radiology	130%
Surgery	135%
Immunizations	105% of AWP

For any/all unlisted procedures, the Reimbursement Amount shall be 85% of Provider[1]s usualand customary billed charges which may be reviewed and/or audited by Payor.

Note: The CMS Ground Rules shall be applied in calculating the Reimbursement Amounts when warranted.

Anesthesia Services: Anesthesia services shall be based on the most recently published Relative Value Guide-American Society of Anesthesiologists (ASA) at $54.00 per unit (a unit isdefined as 15-minute increments).

Workers' Compensation: For services applicable to the California State Official Medical Fee Schedule (OMFS), the reimbursement shall be 100% of the OMFS. If the OMFS doesn't apply,the negotiated rates above shall apply.

Timeliness of Claims Submission: Billing to be submitted within 180 days of date of service.

Timeliness of Claims Payment: Payment to be made within 30 working days of receipt ofclean claim.

Appeals: Within 365 days from date of service.

Coordination of Benefits: Primary equals 100% of fee schedule. Secondary equals Primary plus Networks by Design payment, should equal 100% of fee schedule.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

Three Rivers Provider Network (TRPN)

(PPO & Worker's Compensation)

Effective: August 12, 2009

Reimbursement: 90% of billed charges, less any applicable Copayments, Deductibles orCoinsurance.

Timeliness of Claims Submission: Not addressed.

Timeliness of Claims Payment: Payment shall be made within 30 calendar days of receipt of clean claim. For those Clients that are not subject to any state or federal law with respect to timely payment of claims, Client will, within 30 days of receipt of a clean claim, pay or arrange to pay Provider, as full compensation, at the preferred payment rates above.

Late Payment Penalty: Interest rate of equal to the state mandated rate beginning 30 days after receipt of a clean claim.

Appeals / Refunds: Provider & Client shall each have 365 days after the date payment is received by Provider in which to give notice of any underpayment or overpayment. Provider &Client agree that neither will claim, offset, or attempt to recover any underpayment or overpayment more than 365 days after payment for that claim has been received by Provider,and both hereby waive any right that may otherwise have to do so after the passing of time period identified herein.

Eligibility Guarantee: If Provider has verified eligibility, then payment shall be guaranteed.There shall be no retro denials for claims on which authorization has been granted.

Coordination of Benefits: When Client is secondary, Provider shall be entitled to receive up to100% of negotiated contract rate when combining reimbursement from both primary and secondary payors. However, Client shall not be responsible for any amount in excess of the negotiated contract rates.

Direct Member Billing: Members may be billed for collection of copayments, coinsurance and/or deductibles. Only those services that are not covered services may be billed directly tothe Member.

Medical Record Copy: Not addressed.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

TriStar Managed Care

(EPO – Lyons Magnus Employees)

Effective: January 1, 2016

Reimbursement: The lesser of 80% of billed charges or:

Rate E&M Codes	120% of Medicare (locality 99)
Surgery Codes	135% of Medicare
Pathology	130% of Medicare
Radiology	130% of Medicare
Anesthesia	$65 per ASA Unit
Immunizations	80% of billed charges
Drugs and Biologicals	100% ASP
Non Listed Services	80% of billed charges

Timeliness of Claims Submission: Within 120 days after providing covered services.

Timeliness of Claims Payment: Except where Coordination of Benefits applies, Payor or its paying agent, shall use all reasonable efforts to make all payments due to Participating Providerwithin thirty (30) days or as otherwise required by law following receipt by Payor or its paying agent, of a clean claim. “Clean Claim” shall mean a complete and proper claims form and other information required to determine that the claim is payable under the Plan.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

UC Davis Health System

(PPO)

Effective: April 1, 2013

Reimbursement:

Evaluation and Management	115% of Current Medicare Area 99
Pathology and Radiology	130% of Current Medicare Area 99
Surgery	135% of Current Medicare Area 99
Immunizations	105% of AWP
Unlisted	85 % of Billed Charges
Anesthesia	$54 per ASA Unit

Timeliness of Claims Submission: Within 120 days from the date services were rendered if primary. 120 after receipt of EOB if secondary.

Timeliness of Claims Payment: Payor shall make all payment due to Provider within 45 days following receipt of a complete and proper claims form and other information required to determine that the claim is payable under the Plan.

Late Payment Penalty: Not addressed.

Direct Billing of Member: Participating Provider agrees to accept such compensation as payment in full except for co-payments, coinsurance or deductibles.

Coordination of Benefits: Not addressed.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

United Healthcare

(Formerly Pacificare)
(PPO & POS)

Effective: April 1, 2009
Converted SP contract rate to current year CMS RBRVS

Plans: Sante's fee-for-service agreements are PAR for the below plans:

- Bind
- Choice/Choice Plus
- Core/Core Essential
- Edge
- Navigate
- Nexus
- Options PPO
- Select/Select Plus
- UnitedHealthcare Dual Complete (HMO-DSNP)

Reimbursement: Professional fees included under the Medicare RBRVS fee schedule with the exception of surgical professional services.

Non-Surgical Codes	*111.455% Current Year CMS RBRVS less applicable Copayments, Deductibles or Coinsurance
Surgical Professional Services	*126.368% Current Year CMS RBRVS less applicable Copayments, Deductibles or Coinsurance
Office Lab & Clinical Lab	112% Current Year CMS Clinical Lab Schedule- National Limit less applicable Copayments, Deductibles or Coinsurance
Immunizations & Injectables	112% CMS Drug Pricing less applicable Copayments, Deductibles or Coinsurance
DME & Supplies	112% Current Year CMS DME Ceiling less applicable Copayments, Deductibles or Coinsurance
Ambulance	112% Current Year CMS Ambulance Schedule - Urban less applicable Copayments, Deductibles or Coinsurance
Anesthesiology	$41.00 per ASA unit

*Reimbursement calculation is based on the prevailing rates as set forth in the national (non-geographically adjusted) Medicare Fee Schedule.

Reimbursement based on all other health care services not included in the RBRVS but included in a Medicare Fee schedule reimbursement will be 110% of the Medical rate for the current period as released by HCFA in the preceding year.

Any other covered services included under a Plan which does not fall within any of the above specified categories other than inpatient and outpatient provider services reimbursement shall be the lesser of 75%of billed charges.

Timeliness of Claims Submission: Claims need to be submitted no later than 90 calendar days from the date services are provided. COB billings must be submitted no later than 180 calendar days from the date services are provided.

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

United Healthcare *(Continued)*

(PPO & POS)

Timeliness of Payment: For clean claims, provider will be reimbursed within 30 business days followingreceipt of the clean claim by United Healthcare. If the claim is not eligible for payment United Healthcare will specify the additional information needed to pay the amount due. United Healthcare shall pay said claims no later than 30 days following receipt of the additional information.

Appeals: Must be submitted within 180 calendar days from receipt of the applicable claimsdetermination.

Late Payment Penalty: Not addressed.

Coordination of Benefits: Lesser of the amount payable to provider under this agreement, reduced bythe amount of payment due from the primary carrier; or the member's liability left from primary payor.

Direct Member Billing: Provider shall not charge member for medical services denied by UnitedHealthcare for reason of not being Medically Necessary unless member has, with knowledge of UnitedHealthcare's determination of a lack of Medical Necessity, agreed in writing to be responsible forpayment of those charges.

Medical Record Copy: Upon request and with at least 3 business days of notice, Provider shall provide to UnitedHealthcare copies of medical records of members. Such copy expense will be borne by the requesting party.

CPT Code	Global Fee	CPT Code	Global Fee	CPT Code	Global Fee
90847	$100.00	99211	$27.00	99284	$116.00
93526-26	$421.00	92082-26	$29.00	99394	$118.00
97530	$36.00	94664	$16.00	99232	$67.00
90853	$28.00	99212	$47.00	99285	$182.00
94010-26	$10.00	92083-26	$34.00	99395	$119.00
99201	$45.00	94720-26	$16.00	99233	$96.00
90862	$45.00	99213	$64.00	99291	$312.00
94060-26	$19.00	92225	$28.00	99431	$73.00
99202	$79.00	94761	$5.00	99238	$86.00
92002	$87.00	99214	$101.00	99292	$138.00
94240-26	$16.00	92235-26	$55.00	99433	$39.00
99203	$118.00	95004	$5.00	99242	$112.00
92004	$158.00	99215	$146.00	99381	$127.00
94375-26	$19.00	99222	$136.00	99440	$182.00
99204	$167.00	99245	$271.00	99243	$149.00
92012	$80.00	99392	$108.00	99385	$146.00
94640	$15.00	99223	$190.00	99244	$210.00
99205	$211.00	99283	$74.00	99391	$96.00
92014	$118.00	99393	$106.00		
94657	$86.00	99231	$41.00		

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

USA Managed Care Options

(PPO)

Effective: February 23, 1999

Reimbursement: Provider fees shall be based on the following Relative Value conversionfactors:

Surgery	$90.00
Medicine	$5.00
Radiology	$16.00
Pathology	$15.00
Anesthesia*	$37.00/unit

The above conversion factors shall be applied to *St. Anthony's Relative Values for Physicians*, published by St. Anthony's Publishing, Inc. (formerly McGraw-Hill Company), copyright January1997. Reimbursement for a M.D. or D.O. billing with psychiatric CPT Codes requiring a time unit are calculated on a 50-minute session.

* Based on American Society of Anesthesiologists 15-minute increments. Reimbursement for anesthesiologists billing with codes listed in the Relative Value Guide, as published by ASA, will be determined by adding a Basic Value, which is related to the complexity of the service, plus Modifying Units (if any) plus Time Units, if applicable. The sum of which will then be multiplied by the anesthesia unit value listed above.

Clinical Care Services: All Doctoral and Masters Level Clinicians shall be reimbursed thefollowing fees as payment in full for services rendered.

Doctoral Level	$65.00/per session
Masters Level	$55.00/per session

SANTÉ NON-HMO CONTRACTS

*** Contract Rates** *(continued)*

USA Managed Care Options *(Continued)*

(PPO)

Exceptions: The following codes shall not be subject to the fee schedule and shall bereimbursed at the rates listed below:

CPT	FEE	CPT	FEE	CPT	FEE	CPT	FEE
29881	$ 1,620	88312	$ 27	90716	$ 50	90727	$ 28
43239	390	90704	28	90717	17	90728	28
45330	120	90705	28	90719	17	90730	61
45385	1,245	90706	28	90721	51	90746	66
56316	1,245	90711	41	90725	17	99202	50
63047	3,593	90713	22	90726	28	99244	143
88160	28						

If reimbursement meets or exceeds billed charges, a 20% (twenty percent) courtesy discount will apply to billed charges.

“BR” (By Report), “RNE” (Relative Value Not Established), and all other procedure codes not included in this fee schedule, including drugs, will be reimbursed at 80% (eighty percent) of billed charges.

Timeliness of Claims Submission: Promptly after rendering services. No time limit specified.

Timeliness of Claims Payment: Insurer will make payments within thirty (30) days of receipt of a properly submitted claim.

Late Payment Penalty: If the claim is not paid within thirty (30) days on undisputed claims and ninety (90) days on disputed claims, providers have the right to deny the negotiated rates and seek full-billed charges.

Coordination of Benefits: In instances where insurer is secondary, Member Provider shall beentitled to seek up to 100% of billed charges when combining reimbursement from both primaryand secondary sources. However, insurer shall not be responsible for amounts in excess of the negotiated rates.

Direct Member Billing: May bill member for applicable copayments, deductibles, and coinsurance amounts which member is responsible for.

Medical Record Copy: Member providers shall be reimbursed at $0.25 per page per request.

FHCA PPO/EPO CONTRACTS

***Contract Rates**

Foundation Health Care Administrators (FHCA), part of California Foundation for Medical Care (CFMC)

California Foundation for Medical Care (CFMC) is a large independent PPO/EPO network with 10 Foundations partners. Foundation Health Care Administrators (FHCA) is the Fresno partner for CFMC.

FHCA PPO/EPO CONTRACT RATE SCHEDULE

Rates Effective 12/1/2005

Rates are Medicare RBRVS		
Rates by Contract Type	**MD Rate**	**NonMD, Path/Lab Rate**
PPO	120%	110%
EPO	110%	110%

Service Category	Rate
Anesthesiology	$39.07

The Physician Fee Schedule is in compliance with the United States Supreme Court Decision in the Maricopa Case. An independent third party was utilized in the development of these fees.