REGISTRO DE CONTRATOS
TOMO 12 PAGINA 96
CONTRATO NUM. 2008-000517

PREFERRED PROVIDER ORGANIZATION (PPO)
MEDICAL GROUP AGREEMENT
PRIMARY CARE PHYSICIANS

THIS AGREEMENT, made and entered into on the date set forth on the signature page hereto, by and between Medical Card Systems, Inc. (hereinafter referred to as MCS), a corporation duly organized under the laws of the Commonwealth of Puerto Rico and Depto. Servicios Médicos R.U.M. (hereinafter referred to as Medical Group).

INTRODUCTION

WHEREAS, MCS provides and/or administers health plans to provide for the payment of health care benefits for individuals subscribed and eligible to receive those health care benefits under the plans (hereinafter, "Insureds"); and

WHEREAS, MCS contracts with health care providers to render services to Insured's (as defined as follows); and

WHEREAS, The Medical Group wishes to contract with MCS to provide services to Insured's under the following terms and conditions.

WHEREAS, The Medical Group agrees to provide covered services to all members, which includes those enrolled in MCS, its subsidiary entities, plans or products.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein and intending to be legally bound hereby, the parties agree as follows:

ARTICLE I

DEFINITIONS

The following terms shall have the meaning given below:

1.1 **Affiliate**. Affiliate, with respect to MCS, shall mean any corporation, partnership or other legal entity (including any plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control of MCS.

1.2 **Claim**. Any document and/or electronic transmission sent by a provider to MCS to ask for the payment of health services provided by the provider to MCS' Insureds.

1.3 **Clean Claim**. Unless defined otherwise pursuant to applicable law, Clean Claim shall mean a claim (a) for which all information, documentation and data required by MCS for processing of a claim for payment has been submitted on or in connection with a HCFA 1500 form or UB92 (as appropriate), and (b) which has been submitted within the applicable timeframes set forth in this Agreement.

1.4 **CMS**: Center for Medicaid and Medicare Services.

1.5 **Coinsurance**. Coinsurance shall mean the percentage of the rates established under this Agreement, which an Insured is required to pay for Covered Services under a Plan.

1.6 **Co-payment**. Co-payment shall mean a charge required under a Plan that must be paid by an Insured at the time of the provision of Covered Services.

1.7 **Covered Services**. Covered Services shall mean those services, which an Insured is entitled to receive under the terms and conditions of a Plan.

1.8 **Deductible**. Deductible shall mean an amount that an Insured must pay out of pocket for Covered Services per specified period in accordance with the Insured's Plan before any insurance coverage applies.

1.9 **Emergency Condition**. Emergency Condition shall mean (a) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that a prudent lay person could think that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or (b) with respect to a pregnant woman who is having contractions that: (i) there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) a transfer may pose a threat to the health or safety of the woman or the unborn child.

1.10 **Emergency Services**. Unless otherwise defined in the applicable Plan, Emergency Services shall mean Medically Necessary Services to treat an Emergency Condition; such services shall be available on an inpatient or outpatient basis, twenty-four (24) hours per day, seven (7) days per week.

1.11 **HIPAA** Public Law 104-91, approved by the U.S. Congress on August 21, 1996 known as the Health Insurance Portability and Accountability Act. The objective of HIPAA is to regulate the continuity and portability of health plans, to mandate the adoption and implementation of administrative simplification standards to prevent fraud and abuse, improve health plan overall operations and guarantee the privacy and confidentiality of individual identifiable health information.

1.12 **Insured**. Insured shall mean any person and/or family dependent covered under a health insurance plan of MCS.

1.13 **Material Breach of Contract**. When any of the parties to this Agreement does not comply with its obligations as set forth in this Agreement and with any regulation implemented pursuant to the Health Insurance Portability

and Accountability Act of 1996 (HIPAA), or any other applicable federal or local regulation.

1.14 **Medical Group.** Two or more physicians who decide to unite in a group so they can share assets, expenses and experience, and distribute income from the practice among members. A Medical Group can consist of one or more specialties.

1.15 **Medically Necessary Services**. Unless otherwise defined in the applicable Plan, Medically Necessary Services shall mean health care services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards and which are likely to result in demonstrable medical benefit, and which are the least costly of alternative supplies or levels of service which can be safely and effectively provided to the patient. Medically Necessary Services do not include custodial or supportive care or rest cures, or services or supplies provided for the convenience of the patient, the patient's family, or the provider. Medically Necessary Services must be related to diagnosis or treatment of an existing illness or injury. Health services are not Medically Necessary Services if they are experimental services. Medical necessity, when used in relation to services, shall have the same meaning as Medically Necessary Services.

1.16. **Medicare** Federal health insurance program for persons 65 or older, persons of any age with permanent kidney failure and certain disabled persons according to Title XVII of the Social Security Act. Medicare has two parts, Part A and Part B. Part A is the hospital insurance that includes inpatient hospital care and certain follow up care. Part B is medical insurance that includes physician services and any other ambulatory medical services.

1.17. **Medicare Beneficiary** Any person who is a Medicare recipient of Part A or Part A and B.

1.18 **MCS Programs**: The utilization management and review, quality assurance, peer review, credentialing, manuals and programs now

present or to be created in the future, including and not limited to, policies and procedures regarding referrals and the reporting of clinical data, established by MCS relating to the provision of covered services to the Insured.

1.19. **Participating Provider**. Participating Provider shall mean any physician, medical group, hospital, skilled nursing facility, or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current valid contract with MCS to provide Covered Services to Insureds, and has complied with MCS' credentialing policies. Certain categories of Participating Providers may be referred to herein more specifically as, e.g., "Participating Physicians," "Provider," or "Participating Hospitals."

1.20. **Plan**. Plan shall mean any health benefit product or insurance policy issued, administered, or serviced by MCS or one of its Affiliates.

1.21. **Proprietary Information**. Proprietary Information shall mean information developed by or belonging to MCS, including, but not limited to, this Agreement, mailing lists, patient lists, employer lists, MCS rates and procedures, product related information and structure, utilization review procedures, formats, structure and related information and documents concerning MCS systems and operations of its Plans.

1.22. **Quality Assurance Program.** Quality Assurance Program shall mean the program established by MCS to objectively and systematically monitor and evaluate the quality and timeliness of health care services furnished by Participating Providers and to identify and resolve problems based on established criteria.

1.23. **Utilization Management Program.** A process designed by MCS to review and determine, on a prospective, concurrent, and/or retrospective basis, whether the medical procedure, evaluation and management provided to an Insured pursuant to the terms of a Plan and this Agreement is a Covered Service.

ARTICLE II

THE MEDICAL GROUP'S OBLIGATIONS

2.1 All medical services available through the Medical Group shall be provided to the MCS beneficiaries covered under any MCS health plan including but not limited to Medicare Advantage agreement between CMS and MCS subsidiaries under Part C of Title XVIII of the Social Security Act.

2.2 The Medical Group shall provide services to the Insured in an economical and efficient manner consistent with professional standards of medical care generally accepted in the medical community.

2.3 The Medical Group shall provide the services set forth in this agreement to the extent that those services are covered under the MCS health programs and within the scope of the Medical Groups physician's licensure and certification.

2.4 The Medical Group will not discriminate against any Insured because of his or her medical condition, disease, diagnose, sex, age, race, color, creed, sexual orientation, national origin or social class.

2.5 The Medical Group shall provide all services in accordance to the policies and procedures of MCS and under the terms of this contract.

2.6 The Medical Group facilities shall be available to the Insured at all times during its normal operating hours and The Medical Group shall not refuse any appropriate service which The Medical Group has the capacity to render.

2.7 The Medical Group may verify the Insured's eligibility for covered services by accessing the eligibility records of the Insured through the electronic means available, by calling MCS during business hours or through the monthly Insured list sent by MCS. As set forth in the policies and procedures of MCS or in the benefit plan, precertification is required for the provision of certain non-emergency covered services to the Insured. If The Medical Group has received precertification from MCS that the procedure constitutes a covered service, MCS shall accept such determination for payment purposes, unless The Medical Group withheld relevant information that would affect such determination, and subject to utilization review.

2.8 The Medical Group acknowledges that it shall be responsible for the professional advice and treatment rendered to the Insured pursuant to this Agreement, and MCS disclaims any liability with respect to such matters. The beneficiary will have the right of deciding who will be their Primary Care Physician within or outside the Medical Group.

2.9 The Medical Group agrees that MCS may use the group's name, address, telephone number and specialty in any printed directory or other roster of participating providers.

2.10 The Medical Group shall cooperate with any grievance procedures or programs sponsored by MCS. The Medical Group must notify MCS promptly upon knowledge of any dispute, complaint, or grievance relating to the patient care or other disputes involving MCS, its Clients or it's Insured.

2.11 The Medical Group agrees to provide to MCS all information necessary for MCS and/or its affiliates to meet its data reporting and submission obligations to CMS, including, but not limited to, the data necessary for MCS and/or its affiliates to meet its reporting obligations under 42 CFR §422.516.

ARTICLE III

MEDICAL RECORDS

3.1 The Medical Group will ensure that it's physicians and allied health professionals maintain with respect to each Insured receiving covered services in the institution, a medical record documenting all medical notes made by the attending physician, consultations, covered services and any and all other information necessary to validate the diagnosis and the treatment that was administered to the Insured.

3.2 The medical record of the Insured and the personal information contained therein will be considered confidential. The Medical Group shall comply with all state and federal laws and regulation and corporate policies of MCS regarding confidentiality of medical records. The confidentiality provision herein contained shall survive the termination of this contract and shall bind the Medical Group as long as they maintain any individually identifiable information relating to the Insured.

3.3 The Medical Group shall preserve in a readily accessible form, for their inspection by CMS, the Office of the Inspector General (OIG), MCS and any other authorized state and federal agency, the medical records of all MCS Medicare Advantage enrollees during the term of this agreement and for a period of six (6) years thereafter unless:

1. It is determined by CMS that a special necessity exists that requires that a medical record or a group of medical records be kept accessible for an additional period and CMS notifies MCS of it, at least thirty (30) days before the conclusion of the initial period of six (6) years.

2. There has been a, dispute, fraud or fault in which case the retention may be extended to three (3) years from the date of any resulting settlement.
3. There has been an audit intervention by CMS, the Comptroller of Puerto Rico, or the OIG, in which case the retention may be extended until conclusion of the audit and publication of the final report.

3.4 The Medical Group agrees to maintain enrollee health records and other information with respect to enrollees in an accurate and timely manner.

ARTICLE IV

BILLING AND COMPENSATION

4.1 The Medical Group shall comply with MCS's billing and claim processing procedures. The Medical Group physicians acknowledge that the Medical Group will be the responsible entity for the billing to MCS for any and all of the charges for medical services rendered to MCS Insureds by the physicians under any MCS program. MCS will pay The Medical Group for the services timely billed and The Medical Group will be responsible for making any payment to the physicians for the services rendered.

4.2 MCS shall pay Provider in accordance with the compensation terms established by MCS from time to time and notified to the Provider via internet or any other form of electronic notification. MCS shall pay Providers for services rendered to MCS Advantage beneficiaries as established in **Exhibit A** of this Agreement. Provider agrees to accept such compensation as payment in full for all Covered Services rendered to Insured's.

4.3 The Medical Group shall submit the claims to MCS within ninety (90) days of the date of service. MCS will not be obligated to pay any claims received after ninety (90) days.

4.4 The Medical Group shall provide any additional information that may be required by MCS to process the claim.

4.5 The Medical Group will be compensated for the covered services provided, on the basis specified in the Compensation Schedule established by MCS. All payments will be made no later than fifty (50) days from the date that a full, complete and ready to process claim is received and accepted by MCS.

4.6 In the event that a claim is totally or partially contested by MCS, The Medical Group shall be notified in writing within forty (40) days that the claim is contested and the reasons that support the denial of payment. The Medical Group agrees to submit request for adjustment of claims within forty five (45) days of receipt of notification of contested claim. Upon receipt of a corrected or supplemented claim, MCS shall pay the claim within thirty (30) days.

4.7 Except for co-payments, coinsurance or deductibles required under the benefit plan, The Medical Group shall accept the compensation payable hereunder as payment in full for all services provided to the Insured.

4.8 The Medical Group acknowledges that no manual claims will be accepted by MCS, unless prior written authorization by MCS.

4.9 MCS will not be responsible for the payment of covered services, which are the responsibility of a primary payer.

4.10 MCS will cover the payment for Medicare Part B co-insurance for services received by the Insured under Medicare Part B when said services are accessed through the Insured's PCP and are covered services.

4.11 MCS shall make payment, if any, of the incentives provided to individual physicians through the Classicare Program, as a global sum to the Medical Group on behalf of the physicians that sign this agreement. All other physicians will receive the payment, if any, of such incentives directly.

4.12 The physicians mentioned in Section 4.11 must be Participating Providers at all times of MCS Inc.

4.13 The physician in the Medical Group which decides to leave the group must notify MCS in writing, sixty days (60) prior to the effective date of abandonment. The physician agrees and accepts that the beneficiaries for whom he/she was the Primary Care Physician will remain with the Medical Group. MCS will assign the beneficiaries to a new Primary Care Physician within the Medical Group.

4.14 Physicians acknowledge that he/she will not be allowed to bill directly to MCS for the services rendered to MCS Insureds. MCS will not pay any amount directly to physician nor will be responsible for any amount owed by the Medical Group to physician. Any payment will be directed through the Medical Group.

ARTICLE V

PAYMENTS IN EXCESS OR MADE IN ERROR

5.1 The Medical Group acknowledges that it could receive payments that exceed the amount that the Medical Group is entitled to bill MCS. The Medical Group further acknowledges that it could receive payments that are addressed to a third party or are not of its property.

5.2 The Medical Group shall inform MCS of any and all payments it receives as described in article 5.1 of this Agreement. Should the Medical Group fail to

notify MCS and appropriates the payments in question, MCS may recover from the Medical Group any amount within a period of six (6) years beginning on the date payment was made. The Medical Group authorizes MCS to offset said payment against any amount MCS owes the Medical Group or any Physician in the group.

5.3 If this contract is terminated and the Medical Group has an outstanding debt with MCS, MCS will retain 100% of the payments owed to the Medical Group until said debt is paid in full. This article does not preclude or limits the right that MCS has to commence legal action against the Medical Group for any outstanding debt.

ARTICLE VI

LICENSURE

6.1 The Medical Group certifies that all their physicians and allied health professionals are qualified to offer the covered services and posses all the licenses and permits required by law to practice in the Commonwealth of Puerto Rico.

6.2 The Medical Group shall notify MCS immediately should any action of any kind be initiated which could result in the suspension or loss of its licensure or certification of its physicians.

6.3 The Medical Group agrees to notify MCS within seventy two (72) hours of any material change in the physician's or allied health professional's credentials, including but not limited to, knowledge of the occurrence of any of the following:

1. The revocation, restriction, termination or voluntary relinquishment of any of the licenses, certification or accreditation's required to practice medicine; or
2. The imposition of any disciplinary action, including censure and reprimand, by any State licensing board; or

3. Any final disposition or settlement of any legal action against the Provider for Professional negligence; or
4. Any conviction for any criminal charge except for minor traffic infractions; or
5. Any lapse, termination or material change in the liability insurance coverage required by this Agreement; or
6. Any restriction, suspension, revocation or voluntary relinquishment of staff membership or clinical privileges at any health care facility; or
7. The existence of an impairment of the Provider's ability to provide professional services caused by alcohol, drugs, physical or mental disability; or
8. Conduct, which has harmed or endangers the health or welfare of a patient.

ARTICLE VII

CREDENTIALING AND RECREDENTIALING

7.1: The Medical Group acknowledges that it is the policy of MCS to have in its network of providers, physicians that comply with its credentialing process established by MCS. In accordance with this policy MCS will verify and will update the Medical Group record to make sure that all information and documents have been updated.

7.2: The Medical Group will make sure that its state and federal licenses, certifications and the required permits to practice medicine in the Commonwealth of Puerto Rico of its physicians will not have any type of restrictions.

7.3: The Medical Group will submit any and all information or documents that MCS may deem necessary in the credentialing or recredentialing process.

7.4: The Medical Group authorizes MCS to contact any state, federal or private entity and request and copy any and all information that is relevant to the recredentialing process.

ARTICLE VIII

COMPLIANCE WITH POLICIES AND PROCEDURES

8.1: The Medical Group shall comply with all policies and procedures established and notified by MCS. Said policies and procedures when notified by MCS, will be automatically incorporated to this Agreement.

8.2 In Particular, the Medical Group agrees to comply with all regulations related to the Medicare Advantage Program, as established from time to time by the centers for Medicaid and Medicare Services (CMS) and with the provisions of set forth by MCS.

ARTICLE IX

HIPAA COMPLIANCE WARRANTY

9.1: The Medical Group acknowledges that during the term of this agreement, it must comply with all statutory requirements as set forth in Subtitle F of HIPAA (Administrative Simplification Act), and the regulatory requirements promulgated by the Secretary of Health and Human Services Department. In the event of noncompliance by the Medical Group with these statutory and regulatory requirements, MCS will require that the Medical Group present evidence of compliance. The Medical Group further acknowledges that if the Medical Group is not in compliance, MCS will consider this conduct as a material breach of contract by the Medical Group. The Medical

Group shall indemnify MCS for all the losses, damages, injuries, harms, costs and expenses caused by such breach of the Agreement.

9.2: MCS acknowledges that during the term of this Agreement, it must comply with all statutory requirements as set forth in Subtitle F of HIPAA (Administrative Simplification Act), and the regulatory requirements promulgated by the Secretary of Health and Human Services Department. In the event of noncompliance by MCS with these statutory and regulatory requirements, the Medical Group will require that MCS present evidence of compliance. MCS further acknowledges that if MCS is not in compliance, the Medical Group will consider this conduct as a material breach of the contract by MCS. MCS shall indemnify the Medical Group for all the losses, damages, injuries, harms, costs and expenses caused by such breach in contract.

ARTICLE X

GENERAL TERMS AND CONDITIONS

10.1: The Medical Group agrees that under no circumstance, including, but not limited to non-payment by MCS, insolvency of MCS or its affiliates or breach of the Agreement shall the Medical Group, or any of its representatives, bill, charge, collect a deposit from or have any recourse against the Insured or any person acting on the Insured's behalf for covered services provided pursuant to this agreement. This provision does not prohibit the collection of coinsurance or co-payments on MCS behalf made in accordance with the terms of the enrollee's evidence of coverage. Further, this provision does not prohibit the collection of payments for services not covered under the enrollees Medicare Advantage plan provided that, prior to furnishing the service, The Medical Group informs the enrollee that the service will not be covered and the enrollee will be financially liable, and The Medical Group obtains the enrollee's written acknowledgement of such financial liability.

10.2: Any denial, unreasonable delay or rationing of services is expressly prohibited.

10.3: The Medical Group shall do all things reasonably necessary to ensure that all information relating to the business of MCS acquired by virtue of this Agreement shall not be disclosed or made use of, outside the scope of the business conducted pursuant to this Agreement. The restrictions of this paragraph shall not apply to information provided to government agencies or third party payers as required by law.

10.4: Any notice required or permitted to be given pursuant to the terms and provisions of this Agreement shall be sent in writing and delivered by the US Post Office or by fax.

10.5: None of the terms or provisions of this Agreement is intended to create nor shall be deemed to create any relationship between MCS and the Medical Group other than that of independent entities contracting with each other hereunder solely for the purpose of complying with the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, employer, employee, or representative of the other.

10.6: The Medical Group guarantees and will verify that all its physicians and allied health professionals have obtained and will maintain throughout the term of this Agreement such policies of general and professional liability as required by law. The Medical Group shall notify MCS with thirty (30) days prior written notice any cancellation or modification of said policies. The Medical Group shall submit evidence of the policies when requested by MCS.

10.7: The Medical Group shall comply with all MCS programs including but not limited to utilization management review and quality assurance programs.

10.8: This Agreement shall be governed by, construed and enforced in accordance with the laws of the Commonwealth of Puerto Rico.

10.9: If any provision, covenant or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remainder of the provisions of this Agreement shall remain in full force and effect and in no way shall be affected, impaired or invalidated.

10.10: The Medical Group shall not assign its rights, duties, or obligations under this Agreement without the express written consent of MCS.

10.11: The Medical Group recognizes that the provision of services in this agreement is The Medical Group's obligation. Furthermore, The Medical Group acknowledges, and agrees not to incur or encourage in any or all violations of legal precepts that prohibit, under administrative, civil or criminal penalty, the illegal remuneration of health services, including but not limited to, kickbacks, self-referrals or false claims. Any and all legal precepts amended or enacted throughout the duration of this agreement are incorporated by reference, and as such, The Medical Group will comply with them as agreed herein. Also, The Medical Group agrees to comply and to require all its subcontractors to comply, with all applicable MCS and affiliate policies that are related to administration of the MCS programs, as well as all applicable Medicare laws, regulations, and CMS instructions in performing its responsibilities under this Agreement. This is an essential obligation, and its breach is cause for immediate termination of the agreement.

10.12 The Medical Group acknowledges that MCS shall oversee and monitor The Medical Group's performance on an ongoing basis. The Medical Group further acknowledges that MCS and/or its affiliates are accountable to CMS for the functions and responsibilities described in the Medicare Advantage contract and regulatory standards and ultimately responsible to CMS for the performance of all services.

10.13 The Medical Group agrees that if The Medical Group enters into subcontracts to perform services under the terms of the Agreement, The Medical Group's subcontracts shall include an agreement by the subcontractor to comply with all of the The Medical Group obligations in this Agreement. The Medical Group further agrees that The Medical Group may not employ or subcontract with an individual who is excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act for the provision of any of the following:

1. health care;
2. utilization review;
3. medical social work; or
4. administrative services.

10.14 MCS retains the right to approve, suspend, or terminate any subcontractor arrangement.

ARTICLE XI

INDEMNIFICATION

11.1: The Medical Group shall defend, indemnify and hold harmless MCS from any and all claims, liability, loss, damage, or expense of any kind, including costs and attorney's fees, arising out of the performance or nonperformance of this Agreement by part of The Medical Group.

11.2: MCS shall defend, indemnify and hold harmless The Medical Group from any and all claims, liability, loss, damage, or expense of any kind, including costs and attorney's fees, arising out of the performance or nonperformance of this Agreement by part of MCS.

ARTICLE XII

TERM AND TERMINATION

12.1: The initial term of this Agreement shall commence on the date set forth on the signature page hereof and shall continue in effect for one (1) year thereafter, unless terminated sooner pursuant to the provisions of this Agreement. This Agreement shall be automatically renew, unless either party notifies the other party of its intention not to renew this Agreement at least sixty (60) days prior to any renewal date.

12.2: Either party may terminate this Agreement, with or without cause, upon sixty (60) days prior written notice to the other.

12.3: This Agreement may be terminated immediately by MCS, without complying with the sixty (60) days prior written notice, if there is a material breach of the terms and conditions of this Agreement by The Medical Group, and said breach has not been cured within thirty (30) days of receipt of written notification specifying the nature of the breach.

12.4: The waiver by either party of any breach of any provision of this Agreement shall not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder shall not operate as a waiver of such right.

12.5: This Agreement may also be terminated if either party is declared bankrupt, becomes insolvent or commences complete liquidation.

12.6: MCS shall have the right to terminate this Agreement immediately if it determines, in its reasonable discretion, that the health or welfare of the Insured is jeopardized by the continuation of this Agreement. In case of such determination by MCS, MCS shall provide written notice to The Medical Group specifying the basis for termination.

12.7: The Medical Group agrees that MCS may terminate this Agreement if the Medical Group does not perform satisfactorily and if any of the Medical Groups reporting and disclosure obligations is not fully met in a timely manner.

12.8 The Medical Group acknowledges that this Agreement shall be terminated immediately and The Medical Group may no longer furnish services to MCS enrollees if The Medical Group is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participating in any other Federal Health care program as defined under Section 1128B(f) of the Social Security Act. The Medical Group affirms that its physicians are not currently excluded from participation in any Federal health care program.

12.9 Any physician signing this agreement which decides to separate itself from the Medical Group accepts and acknowledges that this Agreement will remain active and continue in full force with the other signing physicians from the Medical Group. The leaving physician shall comply with section 4.13 of this Agreement before leaving the Medical Group.

ARTICLE XIII

ATTACHMENT AND ASSIGNMEMT OF THE AGREEMENT

13.1: MCS may modify or amend this agreement upon thirty (30) days written notice to The Medical Group. Any modifications, additions or deletion to these provisions shall become effective on a date no earlier than 15 days after the Administration of CMS has received written notice of such proposed changes.

13.2: This Agreement, being intended to secure the services of The Medical Group, shall not be assigned, sublet, delegated, or transferred by The Medical Group without the prior written consent of MCS.

13.3: This Agreement, together with its Exhibits, constitute the entire agreement between the parties with respect to the subject matter hereof, and as of the date this Agreement is executed by both parties, shall supersede any previous agreements or understandings, written or oral, between parties.

IN WITNESS WHEREOF, the foregoing agreement is entered into, by and between the undersigned parties on _____ 200___.

MEDICAL CARD SYSTEM, INC.

By:_____
Edmundo R. Cabán
Vicepresident, Providers Network
Management Division

DATE:_____

THE MEDICAL GROUP

By:_____
(SIGNATURE)

Dr. Jorge I. Vélez Arocho
(PRINTED NAME)

TITLE: Rector

DATE: June 20, 2008

Select Network:

Yes	No	
☐	☐	Preferred Provider Organization (PPO)
☐	☐	Medicare Advantage (Classicare)