Letter of Agreement for Health Center Services
Provided by
Pacific Central Coast Health Centers, Inc., (Health Center)

Dignity Health.
Pacific Central Coast Health Centers
Med Plus

Effective Date: _____

Employer (Purchaser): _____

Address: _____

Services Covered Under this Agreement (Services): All pre-authorized medical services. See attached Exhibit A as an example of a pre-authorization form that can be used by the purchaser.

Rates for Services to Purchaser (Reimbursement): See attached Exhibit B.

Remit Payment to Health Center: PCCHC — Commercial
504 E. Plaza Drive
Santa Maria, CA 93454

Health Center Tax ID: 77-0447575

1. Health Center shall provide Services to Purchaser's employees. Purchaser shall pay Health Center pursuant to the Reimbursement set forth in Exhibit B.

2. Health Center is duly licensed, certified or accredited to provide the Services, and shall assure that the Services are provided by duly licensed, certified or otherwise authorized or accredited personnel. Services shall be provided in accordance with and Health Center shall comply with, (a) generally accepted standards prevailing in the applicable professional community at the time of treatment; and (b) all federal, state, and local statutes, regulations, ordinances and requirements and accreditation requirements applicable.

3. Health Center shall use its best efforts to submit a claim within ninety (90) days. In the event that Health Center disagrees with a payment amount or denial from Purchaser, Health Center may appeal that payment or denial to Purchaser. Health Center shall submit all appeals and disputes to Purchaser within three hundred sixty-five (365) calendar from the date of receipt of the payment or denial at issue. All appeals and disputes shall be in writing and will identify the Member and the claim involved and set forth the basis on which Health Center believes the payment amount or denial was incorrect. Health Center shall not be barred from seeking any remedies it may be entitled to under applicable law.

4. Purchaser shall reimburse Health Center per Rates outlined in Exhibit B. Any claims paid by Purchaser beyond sixty (60) calendar days from Purchaser's receipt of a claim shall accrue interest at the rate of 15% per annum. Purchaser shall submit any disputes regarding a claim in writing to Health Center within thirty (30) calendar days of receipt of the claim.

5. There shall be no retrospective reviews for medical necessity. All services will be authorized by the purchaser using the pre-authorization form. See Exhibit A.

6. Health Center shall maintain medical records in such form and containing such information as required by State and Federal laws, regulations and regulatory agencies, and Health Center shall maintain the confidentiality of such records in accordance with all applicable laws.

7. Health Center shall not under any circumstances, including without limitation, breach of this Agreement, bill, charge, collect a deposit from, or receive any form of payment, compensation or reimbursement from, or have any recourse against a Purchaser's Employee for Services provided under this Agreement.

8. Each party indemnifies and holds the other party, its parents and subsidiaries, officers, directors, attorneys, employees and agents harmless, individually and collectively, from and against and with respect to any and all claims, demands, judgments, settlements, losses, costs, expenses, liabilities, actions, damages, penalties, attorneys' fees and other costs incurred, directly or indirectly, as a result of the acts or failure to act of the indemnifying party.

9. This Agreement shall commence as of the date of signature by both parties. This Letter of Agreement may be terminated without cause by either party at any time upon 30 days prior written notice to the other party.

10. This Agreement constitutes the entire written agreement between the parties with respect to the subject matter hereof. This Agreement may be amended by the parties only upon mutual written consent. The parties agree to keep the terms of this Agreement confidential and not disclose such terms to any third party.

11. This Agreement may not be assigned to any third party without the express written consent of the other party.

12. The parties are independent contractors, and each is solely responsible for all compensation, withholdings and benefits for its own employees and agents.

13. Should either party institute any action or proceeding in connection with this Agreement or any provision hereof, the prevailing party in any such action or proceeding shall be entitled to receive from the other party all costs and expenses, including reasonable attorneys' fees, incurred by the prevailing party in connection with such action or proceeding.

14. The validity, interpretation and performance of this Agreement shall be governed by and construed in accordance with the laws of the State of California.

15. Any notices required under this Agreement shall be sent to the following addresses noted in the execution section of this Letter of Agreement.

The parties enter into this Agreement by execution below by authorized representatives of the parties.

Employer_____

Address_____

Address_____

Attn:Title_____

Signature:_____

Printed Name:_____

Title:_____

Date:_____

Pacific Central Coast Health Centers

504 E. Plaza Drive

Santa Maria, CA 93454

Attn: Scott Robertson, MD, President and CEO

Signature:_____

Printed Name:_____

Title:_____

Date:_____

Med Plus Atascadero
5920 West Mall, Atascadero, CA 93422
Phone 805.461.2131 • Fax 805.461.2077

Med Plus Central Coast
2271 S. Depot St., Santa Maria, CA 93455
Phone 805.614.9000 • Fax 805.614.9048

Med Plus Pismo Beach
877 N. Oak Park Blvd., Pismo Beach, CA 93449
Phone 805.474.8450 • Fax 805.474.8454

Dignity Health.
Pacific Central Coast Health Centers
Med Plus

Employer Group Pricing

CPT Code	Description	Final Fees	Selection
84460	Alanine Amino Transferase (5GPT)	$ 20	
84075	Alkaline Phosphatase	$ 20	
86735	Antibody – Mumps	$ 40	
86762	Antibody – Rubella	$ 40	
86765	Antibody – Rubeola	$ 40	
82175	Arsenic	$ 30	
92551	Audio Exam	$ 35	
82552	Audio Examination Comprehensive	$ 45	
80320	BAT DOT/Non-DOT	$ 45	
83655	Blood Lead	$ 75	
86900	Blood Typing/ABO	$ 10	
86901	Blood Typing/RH	$ 10	
83018	Bromide Test	$ 75	
82300	Cadmium Exposure Panel	$190	
85025	CBC	$ 25	
82480	Cholinesterase Monitoring	$ 75	
80053	Comprehensive Metabolic Panel	$ 29	
99000	Collection & Handling	$ 30	
82565	Creatinine – Blood	$ 20	
82570	Creatinine – Other Source	$ 16	
DMVNC	DMV Non-Commercial Exam	$ 75	
DOTCT	DOT Physical Exam	$150	
99450	EDD Medical Exam	$ 83	
93000	EKG (12 Lead)	$ 75	
80051	Electrolyte Panel	$ 25	
80375	Escreen (Drug Screen)	$ 45	
80377	Escreen (Drug Screen) DOT	$ 65	
80305	Escreen 10 Panel Non-DOT	$ 65	
80305	Escreen Non-DOT 10-Panel & K2 Escreen Code 1455	$100	
92283	Farnsworth Lantern Test	$ 75	
Q2039	Flu Vaccine (including Administration)	$ 40	
82947	Glucose	$ 15	
97750	Harvard Step Test	$ 45	
83015	Heavy Metal Screen Urine (A,L,C,M)	$175	
90632	HEP A Vaccine (Series of 2)	$ 85	
86706	HEP B Titer	$ 60	
80076	Hepatic Panel	$ 32	
86709	Hepatitis A Antibody	$ 19	
86705	Hepatitis B Antibody	$ 19	
90746	Hepatitis B Immunization	$ 85	
IMMPHY	Immigration Physical	$257	

CPT Code	Description	Final Fees	Selection
97750	Jamar Grip Test	$ 15	
83615	Lactate-Dehydrogenase (LDH)	$ 20	
97750	Lifting Test	$ 30	
80061	Lipid Panel	$ 40	
83825	Mercury Quantative	$ 25	
90707	MMR Vaccine	$120	
86615	Pertussis Titer	$100	
97750	Physical Abilities Test	$125	
86580	PPD/TB test (including Administration)	$ 25	
EMPPH	Pre-Employment Physical/Annual Physical Exam	$100	
84155	Protein – Total except refractometry	$ 15	
86480	QFT Quantiferon Gold Test	$180	
90375	Rabies Vaccine	$310	
94799	Respiratory Clearance/Questionnaire	$ 25	
94617	Respiratory Fit Test	$ 30	
99455	Return to Work/Fit for Duty	$250	
85660	Screening for Hemoglobin S	$ 20	
85652	Sedimentation Rate ESR	$ 9	
84255	Selenium	$ 45	
84702	Serum Beta HCG	$ 50	
82040	Serum Total Protein plus Albumin	$ 20	
94010	Spirometry/Pulmonary Function Test	$ 65	
SPCMP	Sports & Camp Physical Exam	$ 50	
93015	Stress EKG	$230	
86580	TB Skin Test	$ 25	
90714	TD (including Administration)	$ 45	
90715	TDAP (including Administration)	$ 90	
93351	Treadmill Stress Test	$250	
81000	Urinalysis	$ 21	
84520	Urea Nitrogen Quantative (BUN)	$ 15	
86787	Varicella Titer	$ 35	
90716	Varicella Vaccine	$195	
36415	Venipuncture Fee	$ 20	
99172	Vision Screen Comprehensive Exam	$ 45	
72100	X-RAY Lumbar Spine	$ 90	
71045	X-RAY Chest (1 View)	$ 50	
71046	X-RAY Chest (2 Views)	$ 85	

Exhibit A

Employer Authorization Form

☐ Injury Exam ☐ TB Placement ☐ Other	☐ Annual Exam ☐ Drug Screening	☐ DMV Exam ☐ Breath Alcohol Screening	☐ Respirator Exam ☐ Chest X-Ray	☐ Pre-Employment
Date of Injury				
Employee Name				
Employee Phone Number				
Sex: ☐ **Male** ☐ **Female**		**Date of Birth**		
Employer Name				
Employer Phone Number				
Employer Address		**City**	**State**	**Zip**
Supervisor Name		**Supervisor Contact**		

☐ **Med Plus Atascadero**
5920 West Mall
Atascadero, CA 93422
Phone 805.461.2131
Fax 805.461.2077

☐ **Med Plus Central Coast**
2271 South Depot St.
Santa Maria, CA 93455
Phone 805.614.9000
Fax 805.614.9048

☐ **Med Plus Pismo Beach**
877 Oak Park Blvd
Pismo Beach, CA 93449
Phone 805.474.8450
Fax 805.474.8454

Pacific Central Coast Health Centers is authorized to perform the services selected for the above named employee(s).

Authorized Personnel_____

Signature _____ **Date**_____

Dignity Health.
Pacific Central Coast Health Centers
Med Plus

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

Pacific Central Coast Health Centers

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☑ Other (see instructions) ▶ 501(c)(3)

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

P.O. Box 748573

6 City, state, and ZIP code

Los Angeles, CA 90074-8573

Requester's name and address (optional)

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			-			-				

or

Employer identification number

7	7	-	0	4	4	7	5	7	5

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here Signature of U.S. person ▶ [signature] Date ▶ 1/11/19

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*