MEDICAL SERVICES AGREEMENT
FOR SPECIALTY CARE Radiology (Diagnostic Services)

This Medical Services Agreement is made this _____ day of _____ 2013, and made effective from the **1st** day of **October 2013** ("Effective Date") to **September 30, 2016** by and between Radiology & Imaging Specialists of Lakeland, PA, ("Medical Services Entity"), and Polk County Board of County Commissioners, a political subdivision of the State of Florida ("County") (Medical Services Entity and County jointly the "Parties").

WITNESSETH:

WHEREAS, the County has an indigent health care plan, hereinafter known as the Polk HealthCare Plan ("Plan"), and wishes to arrange for the provision of medical services to eligible county residents ("Members");

WHEREAS, the Medical Services Entity is comprised of, or contracts with, one or more qualified Providers capable of meeting the credentialing criteria of the County;

WHEREAS, the County desires to engage the Medical Services Entity to deliver, or arrange for the delivery of medical services to the Members of its Plan; and

WHEREAS, the Medical Services Entity is willing to deliver or arrange for the delivery of such services on the terms specified herein.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, and other good and valuable consideration, the parties hereby agree as follows:

ARTICLE I
DEFINITIONS

1.1 Claim. A statement of services submitted to the County by the Medical Services Entity following the provision of Covered Services to a Member that shall include the members demographics, diagnosis or diagnoses (ICD9 Codes), date(s) of service, CPT/HCPCS codes, place of service, authorization number, referring provider if applicable, treating provider and the member name, member address, member date of birth, Polk HealthCare Plan eleven-digit member identification number and provider to be paid for services rendered to the Member submitted on an approved CMS 1500 Form.

1.2 County. The designated division of the county government of Polk County, Florida, Polk HealthCare Plan, Indigent Health Care Division.

1.3 County Notice. A communication by the County to the Medical Services Entity informing the Medical Services Entity of the terms of the Plan, modifications to the Plan, and any other information relevant to the provision of Covered Services pursuant to this Agreement.

1.4 Compensation. The Total Compensation, as defined herein (EXHIBIT A), plus that portion designated by the Plan as a Co-payment.

1.5 Co-payment. A charge which may be collected directly by a Medical Services Entity or Medical Services Entity's designee from a Member in accordance with the Plan.

1.6 Covered Services. Health care services to be delivered by or through Medical Services Entity to Members pursuant to this Agreement, as further defined in ARTICLE II.

1.7 Urgent Care. Care provided for members who have an injury or illness that is not life – threatening but could result in serious injury or disability unless medical attention is immediately received. These conditions are not serious enough to require a visit to the Emergency Room.

1.8 Routine Care /Well Care. Care provided for members as follow-up to a previously treated condition or illness and care for the diagnosis and treatment of acute and chronic illnesses, as well as preventive treatment, including patient counseling/education.

1.9 Emergent Care. Emergent conditions are those conditions where there is the potential for life-threatening or limb threatening complications, or where those complications are reasonably perceived by the member. The treatment of such perceived conditions should be severe enough that these could not have been treated in the Provider office or urgent care setting.

1.10 Polk HealthCare Plan Members. Any individual(s) who has/have been determined eligible by the County and is/are enrolled in the Plan or individuals covered by Polk County's Indigent Health Care Tax "Medically Needy – Medicaid Share of Cost" program.

1.11 Medically Necessary. Health care services that a reasonably prudent Provider would deem necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a Member.

1.12 Medical Services Entity. An individual or group of qualified Providers, who are capable of meeting the credentialing criteria of the Plan.

1.13 Covered Services. Health care services that are Covered Services, as defined by the Plan.

1.14 Payer. The entity or organization directly responsible for the payment of Covered Services to the Medical Services Entity under the Plan.

1.15 Payer of Last Resort. Should a Plan member be determined to have other coverage for services provided by [Medical Services Entity] under any other contractual or legal benefit, including, but not limited to, Medicaid, Medicare, worker's compensation insurance, motor vehicle insurance or a private group or indemnification program, [Medical Services Entity] is expected to bill the said entity as the primary payer before billing the Polk HealthCare Plan.

1.16 Polk HealthCare Plan. A government assistance program similar to a "managed care" product funded by a discretionary sales surtax (F.S. 212.055[7]) and administered by the County for the benefit of Members, as it may be modified from time to time, and all the terms, conditions, limitations, exclusions, benefits, rights and obligations thereof to which County and Members are subject.

1.17 Protected Health Information (PHI). Information that is (a) created or received by a Medical Services Entity; (b) relates to: (1) the past, present, or future physical or mental health or condition of an individual; (2) the provision of health care to an individual; or (3) the past, present, or future payment for the provision of health care to an individual; and (c) identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. PHI does not include information excluded from HIPAA's definition of "protected health information" in 45 C.F.R. 160.103.

1.18 Qualified Provider. A doctor of medicine or osteopathy licensed to practice in the State of Florida, who possesses an unencumbered Florida license, and has agreed in writing, either through this Agreement or through another comparable written instrument, to provide Covered Services to Members.

1.19 Quality Management. The process designed by the County to monitor and evaluate the quality and appropriateness of care, pursue opportunities to improve care, and resolve identified problems in the quality and delivery of care.

1.20 Total Compensation. The total amount payable by Payer and Member for Covered Services furnished pursuant to this Agreement.

1.21 Medical Management. The process by which the County, or a duly appointed and authorized entity to which such responsibility has been delegated, together with the Medical Services Entity, will determine the medical appropriateness of Covered Services furnished to Members and the processes that will govern utilization, including concurrent review, case management, disease management, and all other processes affecting the medical care of plan members.

ARTICLE II
DELIVERY OF SERVICES

2.1 Covered Services. The Medical Services Entity shall provide or through its Qualified Providers arrange for the Members the provision of Covered Services that are identified in EXHIBIT B, attached hereto and made a part of this Agreement by reference. All Covered Services shall be provided in accordance with generally accepted clinical and legal standards, consistent with medical ethics governing the Qualified Provider.

2.2 Verification of Members. Except in the case of emergency in order to guarantee payment, the Medical Services Entity shall utilize a member's identification card, which has been chosen by the County to verify and confirm that Members eligibility for Plan Services, prior to rendering any Covered Services. (See EXHIBIT C)

2.3 Integrated, Coordinated Service Delivery Model. In order to allow additional numbers of Polk County citizens to receive health care at a reduced-cost rate while still ensuring comprehensive integrated, quality care, Polk County's Board of County Commissioners has agreed to arrange for and finance care for additional numbers of Polk County citizens through Florida Medicaid's "Medically Needy" (or Medicaid Share of Cost) program. To ensure integration and quality of care, each Medical Services Entity will be responsible for either (a) identifying other area options for Medicaid service provision, (b) referring patients to another provider of the type provided by the Medical Services Entity, or (c) being a licensed, practicing Florida Medicaid provider who is actively taking Medicaid patients .

ARTICLE III
COMPENSATION AND RELATED TERMS

3.1 Compensation. The Medical Services Entity, or its designee, shall accept, as full payment for the provision of Covered Services, the Total Compensation identified in the fee schedule attached as EXHIBIT A, and made a part of this Agreement by reference.

3.2 Billing for Covered Services. The Medical Services Entity shall submit a Claim to the County and, in the event Claim is consistent with the compensation terms under EXHIBIT A, the County shall pay the Medical Services Entity for Covered Services rendered to Members as well as Medically Needy, in accordance with the terms of this Agreement. The Medical Services Entity shall arrange for all Claims for Covered Services to be submitted to the County within one hundred and eighty (180) days from the date of service. If additional information is required or needed by the County to evaluate or validate the original Claim submitted by the Medical Services Entity for payment, the provider will have an additional ninety (90) days from the date of the initial claim denial to resubmit a corrected claim. The Medical Services Entity shall submit such claims on a billing form CMS-1500 or on any other form that the County directs the Medical Services Entity, in writing, to utilize. If the Medical Services Entity does not bill the County in a timely manner, the County may, at its discretion, deny payment.

3.3 Co-payments to be Collected from Members. When the Plan requires Members to make Co-payments, such Co-payments shall be collected from the Member at the time the service is rendered by the Medical Services Entity or one of its Qualified Providers. The County shall inform or educate Members that

Members must make a Co-payment at the time the service is rendered and that this practice is mandatory for all Members. At no time shall the Medical Services Entity "balance bill" a Plan Member. (Additional copays may apply to Medically Needy Population and are governed by the Medicaid Rules).

3.4 Promptness of Payment. The County shall remit to the Medical Services Entity the County Compensation within forty-five (45) days of receipt of a Claim by the Medical Services Entity. This Claim shall be sufficient in detail so that the County is able to reasonably determine the amount to be paid. If additional information is required or needed by the County to evaluate or validate the original Claim submitted by the Medical Services Entity for payment, the provider will have an additional ninety (90) days from the date of the initial claim denial to resubmit a corrected claim.

The County shall affirm and pay any valid claims within forty-five (45) days of receipt of such additional information. All payments to the Medical Services Entity shall be considered final unless adjustments are requested, in writing to the County by the Medical Services Entity within ninety (90) days following receipt of the payment explanation from the Payer.

If payment has been made to the Medical Services Entity by the County for a non-covered service, the Medical Services Entity shall promptly refund such payment provided written notice of payment for such non-covered service has been made by the County within ninety (90) days of receipt of the Medical Services Entity's Claim.

For purpose of payment, "prompt payment" may be defined as "within ninety (90) days." The Medical Services Entity agrees that it shall not bill and collect any amount pursuant to this Agreement for charges incurred by Members to the extent that such charges result from an error made by the Medical Services Entity. An error shall include, but not be limited to, duplicate billing for a Covered Service provided only once and any services which were not actually rendered. If the County concludes that such an erroneous billing or collection has been made, the County shall notify the Medical Services Entity of the error. Upon receipt of this notification, the Medical Services Entity shall promptly withdraw the billing or that part which is in error, or reimburse the County for such amounts already paid to the Medical Services Entity pursuant to the erroneous billing.

3.5 Payer of Last Resort. The Polk HealthCare Plan will be billed only if all other avenues for payment have been exhausted. Should a Plan member be determined to have other coverage for services provided by [Medical Services Entity] under any other contractual or legal benefit, including, but not limited to, Medicaid, Medicare, worker's compensation insurance, motor vehicle insurance or a private group or indemnification program, [Medical Services Entity] is expected to bill the said entity as the primary payer. If the Polk HealthCare Plan paid for services and other coverage is later discovered, the Medical Services Entity must reimburse the County by recoup, refund or adjustments.

3.6 Sole Source of Payment. After other payer sources have been exhausted, [MEDICAL SERVICES ENTITY] will look to the County for payment of medically necessary covered services of eligible members. [MEDICAL SERVICES ENTITY] shall make no charges or claims against Polk HealthCare Plan members for covered services except for copayments as previously authorized.

ARTICLE IV
MEDICAL SERVICES ENTITY'S OBLIGATION

4.1 Licensed/Good Standing. The Medical Services Entity represents that each of its Qualified Providers (Physicians, PAs, ARNPs), are and shall remain licensed and/or registered who possesses an unencumbered Florida license to practice medicine and, if such Medical Services Entity is an entity, such entity is registered and in good standing in the State of Florida. Failure to maintain licensure will be grounds for immediate termination of this contract under Section 8.3.

4.2 Nondiscrimination. The Medical Services Entity agrees that it and each of its Qualified Providers shall not differentiate or discriminate in its provision of Covered Services to Members because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, income, health status, disability or age. Further, the Medical Services Entity agrees that its Qualified Providers shall render

Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as such services are offered to patients not associated with the County or any Plan and consistent with medical ethics and applicable legal requirements for providing continuity of care.

4.3 Standards. Covered Services provided by or arranged for by the Medical Services Entity shall be delivered only by professional personnel qualified by licensure, training or experience to discharge their responsibilities and operate their facilities in a manner that complies with generally accepted standards in the industry.

4.4 Credentialing of Qualified Providers. The Medical Services Entity acknowledges that the County may delegate to it, at the County's discretion, all credentialing responsibilities and authority with respect to Qualified Providers, and/or other Practitioners. This delegation will be accepted by the Medical Services Entity, if so directed by the County.

4.5 Authority. The Medical Services Entity shall, and hereby does, represent and warrant that it has full legal power and authority to bind its Qualified Providers to the provisions hereof. The Medical Services Entity shall communicate with its Qualified Providers regarding all matters relating to this Agreement and the services to be performed hereunder.

4.6 Administrative Procedures. The Medical Services Entity and each of its Qualified Providers shall comply with the policies and procedures established by the County or of this Plan, to the extent the Medical Services Entity has received notice of the same, consistent with the terms of this Agreement.

4.7 Use of Names for Marketing. The Medical Services Entity and each of its Qualified Providers shall permit the County to utilize the name, address, and telephone number of it or its Qualified Providers, in the County's list of Medical Services Entities, which will be distributed to Members. Such rights shall not extend to the listing of such Qualified Providers or Medical Services Entity in any newspaper, radio, or television advertising without receiving the prior written consent of said Medical Services Entity. Time is of the essence and approval will not be unreasonably withheld.

4.8 Provision of Covered Services. The Medical Services Entity agrees to provide or arrange for the provision of Covered Services EXHIBIT B, from Monday through Friday, 8:00 am to 5:00 pm. This service includes after-hours telephone access to a professional who is qualified to aid the members in medical decision making regarding urgent/emergent care and to make any of the following recommendations to a Member who needs Emergency Care experiencing pain or other unusual symptoms: a.) treat pain or symptoms at home and come in to see the Medical Services Entity on the next day; b.) go to an urgent care center; c.) go to an emergency room.

4.9 Noninterference with Medical Care. Nothing in this Agreement is intended to create (nor shall be construed or deemed to create) any right of the County to intervene in any manner in the methods or means by which the Medical Services Entity renders health care services or provides health care supplies to Members. Nothing herein shall be construed to require the Medical Services Entity to take any action inconsistent with professional judgment concerning the medical care and treatment to be rendered to Members.

4.10 Best Efforts. The Medical Services Entity shall use best efforts to participate in such utilization review programs, medical necessity reviews, coordination of benefit activities, and cost containment activities, as are provided under the Plan.

4.11 Evaluation and Quality Management. The Medical Services Entity is expected to have their own Quality Management programs in place. These programs should include ongoing monitoring of quality of care, documentation, qualifications for professional staff and requirements for ongoing training of professional and support staff. The quality management process is expected to include annual satisfaction surveys of adults receiving primary care services. The Plan will conduct ongoing process evaluation activities for the program. The Plan's designee or the Plan's Medical Management Section will visit

providers to conduct paper chart reviews onsite or offsite to ensure that performance specifications are met. The Plan will review claims data, and Medical charts. Plan may request to schedule activities in advance.

4.12 Health Insurance Portability and Accountability Act (HIPAA). As a covered entity, the Medical Services Entity warrants that it is in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the provisions of the Privacy and Security Rule adopted by the Department of Health and Human Services (HHS). The Medical Services Entity further agrees that it shall restrict disclosure or usage of Protected Health Information (PHI) it obtains or creates through its business association with the County to the exclusive purposes established by this Agreement, except as otherwise allowed by law and as defined in the Business Associate Agreement (revised BAA HITECH), EXHIBIT D.

ARTICLE V
COUNTY'S OBLIGATIONS

5.1 Deemed Notification. The County shall notify the Medical Services Entity in writing of all policies, procedures, rules, regulations, and schedules, that the County considers material to the performance of this Agreement and relevant amendments. Except in the event of emergency, or unless the Board of County Commissioners directs otherwise, thirty (30) days from the date of notification will be considered sufficient notice to effect a change in policy under the plan.

5.2 Appeal of a Pre-Service Denial. The County shall provide the Medical Services Entity or Qualified Provider with a right and a process to appeal any denial of a Pre-Service Request for authorization of services by the Medical Management Section. There shall be a general Appeals Process for items of a routine nature, and an Expedited Appeals Process for items of an urgent/emergent nature. The final decision of whether to expedite the appeal will be made by the County. There will be one level of appeal for denials made on a clinical basis. For Clinical Appeals, the Medical Services Entity will have sixty (60) days to appeal from the date of denial of the initial service request.

5.3 Appeal of a Claim Denial. For Claims (payment) appeals, the Medical Services Entity will have sixty (60) days from the date of the final denial of a claim. ("Final denial" of the claim will occur upon the completion of the ninety (90) days a provider is allowed to resubmit a corrected claim). The appeals decision whether to uphold or overturn a claims appeal will be communicated to the provider within forty-five (45) days from the appeals date and communicated using an "Explanation of Payment" (EOP).

5.4 Provider Grievances. The County shall establish and maintain systems to process and resolve any grievance a Qualified Provider has against the County.

5.5 Quality Management Monitors. As the Plan is committed to the quality of care provided to its members, the Plan has identified preventive health services and certain medical conditions to be reviewed as quality indicators. These guidelines, adopted by the Plan's Medical Management Committee, will be used to develop key indicators which will be monitored by the Plan for primary care and select specialty providers. The provider, at the Plan's request will furnish data to the Plan for review. The data will be analyzed and compared to peer and national standards. This data will be discussed with the provider and the Medical Management Committee. Any provider who falls outside the range for these indicators may be put on a corrective action plan by the Health Plan and monitored on a more rigorous basis. If the provider fails to show significant improvement, the provider may be terminated from the Plan.

5.6 Health Insurance Portability and Accountability Act (HIPAA). As a covered entity, the County warrants that it is in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the provisions of the Privacy and Security Rule adopted by the Department of Health and Human Services (HHS). The County further agrees that it shall restrict disclosure or usage of

Protected Health Information (PHI) it obtains or creates through its business association with the Medical Services Entity, to the exclusive purposes established by this Agreement, except as otherwise allowed by law. As defined in the Business Associate Agreement, (revised BAA HITECH) EXHIBIT D.

ARTICLE VI
INSURANCE

6.1 Medical Services Entity Insurance. The Medical Services Entity shall require each Qualified Provider to maintain, at all times, in limits and amounts as required by Florida law, a professional liability insurance policy and other insurance or other liability bond as shall be necessary to insure such Qualified Provider against any claim for damages arising directly or indirectly in connection with the performance or nonperformance of any services furnished to Members by such Qualified Provider. In the event that the Medical Services Entity discovers that such insurance coverage is not maintained, the Medical Services Entity shall immediately, upon making such discovery, ensure that such Qualified Provider discontinues the delivery of Covered Services to Members until such insurance is obtained and notify the Plan in writing of the same. A Certificate of Insurance, reflecting the minimal insurance coverage shall be provided to the County and Medical Services Entity prior to commencement of the contract.

ARTICLE VII
INDEMNIFICATION

7.1 Indemnification. The Medical Services Entity shall indemnify and hold harmless the County, its agents, and employees, from all suits, actions, claims, demands, damages, losses, expenses, including attorney's fees, costs and judgments of every kind and description to which the County its agents or employees may be subjected to by reason of injury to persons or death or property damage, resulting from or growing out of any action of commission, omission, negligence or fault of the Medical Services Entity, or its Qualified Providers committed in connection with this Agreement, the Medical Services Entity's performance hereof or any work performed hereunder. The Medical Services Entity shall indemnify and hold harmless the County, its agents and employees, from all suits, actions, claims, demands, damages, losses, expenses, including attorney's fees, costs and judgments of every kind and description arising from, based upon or growing out of the violation of any Federal, State, County or City law, ordinance or regulation by the Medical Services Entity, or its Qualified Providers.

ARTICLE VIII
TERM AND TERMINATION

8.1 Term. This Agreement shall commence on October 1, 2013 and extend until September 30, 2016 provided funds are budgeted in the subsequent fiscal years, or until terminated pursuant to this ARTICLE.

8.2 Negotiation of Renewal of EXHIBITS. With the exception of EXHIBIT B which is related to medical procedure codes and must be updated on a regular basis throughout the contract period, either party wishing to revise any EXHIBITS, or any of the attached schedules, shall serve notice in writing of such intention and clearly state the new terms offered. Within sixty (60) days thereafter, the parties shall agree to adopt the new EXHIBIT or schedule. In the event the parties are unable to come to such agreement, either party may notify the other within ten (10) days following the deadline for such agreement that it intends to terminate this Agreement in whole or in part with respect to a specific Plan reflected on a disputed EXHIBIT or schedule. In such event, this Agreement or the Agreement with respect to that particular EXHIBIT or schedule shall be terminated sixty (60) days after such notice.

8.3 Termination for Cause. In the event either party shall fail to keep, observe or perform any covenant, term or provision of this Agreement applicable to such party, the other party shall give the defaulting party notice that specifies the nature of said default. If the defaulting party fails to cure such

default within thirty (30) days after receipt of such notice, the non-defaulting party may terminate this Agreement upon five (5) days' notice. It shall be grounds for immediate termination if the County loses its ability to underwrite or administer the County Plan or if any Qualified Provider suffers a loss or suspension of medical license, a conviction of a felony, or a loss of credentials for stated quality reasons under the County's Plan.

8.4 Voluntary Termination. At any time during the term of this Agreement, this Agreement may be terminated for any reason, with or without cause, by either party upon written notice given at least sixty (60) days in advance of the effective date of termination.

8.5 Termination for Failure to Satisfy Financial Obligations. If either party or a Payer is (a) more than sixty (60) days behind in its financial obligations to its creditors, or (b) files in any court of competent jurisdiction: (1) a petition in bankruptcy, or (2) a petition for protection against creditors, or (c) has such a petition filed against it that is not discharged within ninety (90) days, or (d) files or makes an assignment for the benefit of creditors, this Agreement may be terminated by the other party in its entirety or with respect to the Payer upon five (5) days' written notice.

8.6 Effect of Termination. This Agreement shall remain in full force and effect during the period between the date that notice of termination is given and the effective date of such termination. As of the date of termination of this Agreement, this Agreement shall be of no further force and effect, and each of the parties hereto shall be discharged from all rights, duties, and obligations under this Agreement, except that the County shall remain liable for Covered Services then being rendered by Qualified Providers to Members who retain eligibility under the applicable Plan or by operation of law until the episode of illness then being treated is completed and the obligation of the County to pay for Covered Services rendered pursuant to this Agreement is discharged. Payment for such services shall be made pursuant to the fee schedule contained in EXHIBIT A.

ARTICLE IX
DISPUTE RESOLUTION

9.1 Initial Mediation of Dispute. In the event of a dispute between the parties to this Agreement, the following procedure shall be used to resolve the dispute prior to either party pursuing other remedies:

a. A meeting shall be held within seven (7) business or calendar days at which all parties or party representatives will be present or represented by individuals (the "Initial Meeting").

b. If, within thirty (30) days following the Initial Meeting, the parties have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator mutually agreeable to the parties and not regularly contracted or employed by either of the parties ("Mediation"). Each party shall bear its proportionate share of the costs of Mediation, including the mediator's fee.

c. The parties agree to negotiate in good faith in the Initial Meeting and in Mediation.

9.2 Legal Remedies. If, after a period of sixty (60) days following commencement of Mediation, the parties are unable to resolve the dispute, either party may pursue all available legal and equitable remedies. "Each party shall be responsible for its own attorneys' fees and costs, including attorneys' fees, costs, and expenses incurred for any appellate proceedings."

ARTICLE X
MISCELLANEOUS

10.1 Nature of Medical Services Entity. In the performance of the work, duties and obligations of the Medical Services Entity under this Agreement, it is mutually understood and agreed that the Medical Services Entity and each of its Qualified Providers are at all times acting and performing as independent contractors, practicing medicine or providing for the delivery of medical services.

10.2 Public Entity Crimes. Medical Services Entity certifies compliance with Paragraph (2)(a) of Section 287.133, Florida Statutes, which states that a "person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a bid on a contract to provide any goods or services to a public entity, may not submit a bid on a contract with a public entity for the construction or repair of a public building or public work, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, for CATEGORY TWO for a period of 36 months from the date of being placed on the convicted vendor list." The Medical Services Entity acknowledges that the agreement will be void if they have violated the Statute. Additionally, the Medical Services Entity shall ensure compliance with the U.S. Department of Health Office of Inspector General Medicare/Medicaid fraud, waste, and abuse requirements.

10.3 Public Meetings and Records. If applicable, Medical Services Entity agrees to comply with Section 286.011, F.S., relating to public meetings and records, and Chapter 119, F.S., relevant to public records.

10.4 Additional Assurances. The provisions of this Agreement shall be self-operative and shall require no further agreement by the parties except as may be specifically provided in this Agreement. However, at the request of either party, the other party shall execute such additional instruments and make such additional acts as may be reasonably requested in order to effectuate this Agreement. Additional instruments require agreement by both parties.

10.5 Governing Law. This Agreement shall be governed by and construed in accordance with the applicable Federal laws and regulations, laws of the State of Florida and local ordinance. "Venue will be in Polk County, Florida, or in the United States District Court, Middle District of Florida located in Hillsborough County, Florida."

10.6 Assignment. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors, and assigns. The County may not assign this Agreement without the Medical Services Entity's prior written consent except that the County may assign this Agreement to an entity related to the County by ownership or control or to any successor organization without the Medical Services Entity's prior written consent. The Medical Services Entity may not assign this Agreement without the County's prior written consent, except that the Medical Services Entity may assign this Agreement to an entity related to the Medical Services Entity by ownership or control or to any successor organization without the County's prior written consent.

10.7 Waiver. No waiver by either party of any breach or violation of any provision of this Agreement shall operate as, or be construed to be, a waiver of any subsequent breach of the same or any other provisions.

10.8 Force Majeure. Neither party shall be liable for nor deemed to be in default for any delay or failure to perform under this Agreement deemed to result, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, failure of transportation, strikes or other work interruptions by either party's employees or any other cause beyond the reasonable control of either party.

10.9 Time is of the Essence. Time is of the essence in this Agreement. The parties shall perform their obligations within the time specified.

10.10 Notice. Any notice, demand or communication required, permitted or desired to be given hereunder shall be deemed effectively given when personally delivered or sent by fax with copy sent by overnight courier, addressed as follows:

MEDICAL SERVICES ENTITY:

Radiology & Imaging Specialists of Lakeland, PA
Edward J. Goodemote, PhD, RN CEO
2125 Crystal Grove Drive
Lakeland, FL 33801

Tel: 863 688-2334
Fax: 863 577-1160

COUNTY:
Joy Johnson, Interim Director
Indigent Health Care Division
Polk HealthCare Plan
Polk County, Board of County Commissioners
2135 Marshall Edwards Drive
Bartow, FL 33830-6757
Tel 863.534.5377
Fax 863.519-2045

10.11 Entire Agreement. This Agreement is the entire agreement between the parties, and it may not be modified or amended except by agreement in writing between the parties hereto.

10.12 Severability. The invalidity, illegality, or unenforceability of any provision of this Agreement, or the occurrence of any event rendering any portion or provision of this Agreement void, shall in no way affect the validity or enforceability of any other portion or provision of the Agreement; any void provision shall be deemed severed from the Agreement and the balance of the Agreement shall be construed and enforced as if the Agreement did not contain the particular provision held to be void. The parties further agree to reform the Agreement to replace any stricken provision with a valid provision that comes as close as possible to the intent of the stricken provision. The provisions of this section shall not prevent the entire Agreement from being void should a provision which is of the essence of the Agreement be determined to be void.

IN WITNESS WHEREOF, the parties hereto duly execute this Agreement as of the day and year first written above.

MEDICAL SERVICES ENTITY
Radiology & Imaging Specialists of Lakeland, PA

BY: _____
Edward J. Goodemote, PhD, RN, CEO

DATE: 9/3/13

_____
WITNESS

_____
WITNESS

POLK COUNTY, Florida, a political subdivision of the State of Florida

BY: _____
Melony M. Bell, Chairman

ATTEST: Stacy M. Butterfield, Clerk

BY: _____
Deputy Clerk

Reviewed as to form:

_____
County Attorney Date

EXHIBIT A
TOTAL COMPENSATION

Specialty Care Provider Services
RADIOLOGY (Diagnostic Services)

I. Provider Reimbursement:

a. The Polk HealthCare Plan shall compensate physicians for covered services at the rate of one hundred percent (100%) of the Medicare rate in effect on October 1st of each County fiscal year (October 1st through September 30th), and as set forth in the Physician Fee Schedule, as published and updated by the Center for Medicare and Medicaid Services (CMS), plus the Polk HealthCare Plan Member copay.

b. There will be no adjustments to the fee schedule during the County's fiscal year, October 1st through September 30th.

c. The Medical Services Entity or the Medical Services Entity's Designee may collect a copay from the Member for each office visit. This co-payment amount will not be deducted from the compensation reimbursed by the Plan as defined below.

The following copays currently apply to Polk HealthCare Plan Members. Any other applicable copays may be collected based on the Member's benefits package. The Provider Manual with the complete benefits package can be referenced online at www.polk-county.net. Occasional updates may occur based upon decisions made by the Medical Management Committee and Pharmacy and Therapeutics Committee.

The following copays apply to Polk HealthCare Plan Members.

POLK HEALTHCARE PLAN
MEDICAL CARD

Essential Care Choices Card	Chronic Care Choices Card
$5.00 Office Visit	$3.00 Office Visit
$5.00 copay per CT Scan	$5.00 copay per CT Scan
$10.00 copay per MRI	$10.00 copay per MRI
$5.00 copay per Nuclear Study	$5.00 copay per Nuclear Study
$20.00 copay per PET Scan	$20.00 copay per PET Scan
$5.00 copay per Ultrasound	$5.00 copay per Ultrasound
$3.00 copay per X-ray	$3.00 copay per X-ray

POLK HEALTHCARE PLAN
MEDICALLY NEEDY SHARE OF COST CARD

Essential Care Choices Card	Chronic Care Choices Card
$5.00 Office Visit	$3.00 Office Visit
$5.00 copay per Ultrasound	$5.00 copay per Ultrasound
$3.00 copay per X-ray	$3.00 copay per X-ray

EXHIBIT B
COVERED SERVICES – SPECIALTY CARE PROVIDERS

RADIOLOGY (Diagnostic Services)

List of Services Specialty Care Providers can provide. These do not require Pre-Service approval as follows:

CPT Codes	Test
	Routine/Simple and Bone & Joint Xrays

70140 70150 70160 70200 70210
70220 71010 71020 71100 71101
71110 71111 71120 71130 72010
72020 72040 72050 72052 72069
72070 72072 72074 72080 72090
72100 72110 72114 72120 72170
72190 72200 72202 72220 73000
73010 73020 73030 73050 73060
73070 73080 73090 73100 73110
73120 73130 73140 73500 73510
73520 73550 73560 73562 73564
73565 73590 73600 73610 73620
73630 73650 73660 74000 74010
74020 74022 70250 70260

All other services require prior Plan Authorization.

Disclaimer Provision: These CPT codes are listed as examples of those CPTs that are not required to be authorized. However, this list may be altered from time to time due to updates to the CPT codes.

EXHIBIT C

INSTRUCTIONS FOR VERIFICATION OF ENROLLMENT

The following sources of enrollment verification shall be made when providing services to a Plan Member.

1. Each Member receives an identification card upon enrollment in the Plan. The card should always be presented to the Medical Services Entity when services are requested by Member and prior to receipt of services. The Medical Services Entity shall confirm eligibility by contacting the County. It shall be the responsibility of the Medical Services Entity to confirm active enrollment prior to services being rendered.

2. If inpatient-admission certification is required for Member, the Medical Services Entity shall confirm admission certification approval, including contacting the County's representative, when necessary.

Polk HealthCare Plan – Medical Card

FRONT OF CARD

Polk HealthCare Plan
MEDICAL CARD

Case # _____ Worker Code _____

Member Name _____

ESSENTIAL CARE CHOICES

Co-pays: PCP Office Visit $1.00 ~ Emergency Room $25.00 ~ Pharmacy Co-pays: $1.00 generic $3.00 brand

OTHER CO-PAYS IDENTIFIED IN MEMBER SCHEDULE

Eligibility Period _____ to _____

Primary Care Physician _____ PCP Office Phone # _____

BACK OF CARD

NOTICE TO MEMBER:

Carry this card with you at all times. It must be presented each time you require any medical service. This card is not transferable and is only valid for the eligibility period listed on the front. *Do not share this card with others as you will lose your coverage from the Polk HealthCare Plan.*

NOTICE TO PROVIDERS:

All hospital based services, specialty care visits, and outpatient services procedures require prior authorization. Emergency room visits and emergency admissions require Plan notification within one business day of the treatment and or admission.

FAILURE TO COMPLY WILL AFFECT PAYMENT OF BENEFITS

Polk HealthCare Plan Inquiries: (863) 533-1111 ~ Member Eligibility Appointments: (863) 534-[illegible]

Mail Claims to: Polk HealthCare Plan 2135 Marshall Edwards Drive, Bartow, FL 33830

Polk HealthCare Plan – Medical Card

FRONT OF CARD

Polk HealthCare Plan
MEDICAL CARD

Case # _____ Worker Code _____

Member Name _____

CHRONIC CARE CHOICES

Co-pays: PCP Office Visit $1.00 ~ Emergency Room $25.00 ~ Pharmacy Co-pays: $0.00 generic $3.00 brand

OTHER CO-PAYS IDENTIFIED IN MEMBER SCHEDULE

Eligibility Period _____ to _____

Primary Care Physician _____ PCP Office Phone # _____

BACK OF CARD

NOTICE TO MEMBER:

Carry this card with you at all times. It must be presented each time you require any medical service. This card is not transferable and is only valid for the eligibility period listed on the front. *Do not share this card with others as you will lose your coverage from the Polk HealthCare Plan.*

NOTICE TO PROVIDERS:

All hospital based services, specialty care visits, and outpatient services procedures require prior authorization. Emergency room visits and emergency admissions require Plan notification within one business day of the treatment and or admission.

FAILURE TO COMPLY WILL AFFECT PAYMENT OF BENEFITS

Polk HealthCare Plan Inquiries: (863) 533-1111 ~ Member Eligibility Appointments: (863) 534-[illegible]

Mail Claims to: Polk HealthCare Plan 2135 Marshall Edwards Drive, Bartow, FL 33830

|DISCLAIMER: THIS VERSION OF THE CARD IS EFFECTIVE BEGINNING 10/1/2011 AND MAY BE SUBJECT TO CHANGE. PLEASE WATCH THE POLK HEALTHCARE PLAN WEBSITE.|

Polk HealthCare Plan – Medically Needy Share of Cost

FRONT OF CARD

Polk County Indigent Health Care Tax
MEDICAL CARD – SHARE OF COST MEDICAID

Case #: _____ Worker Code: _____

Member Name: _____

MEDICALLY NEEDY SHARE OF COST - ESSENTIAL CARE CHOICES

Co-pays: Physician/Office Visit $1.00 ~ Pharmacy Co-pays: $1.00 generic $3.00 brand

Eligibility Period _____ to _____

Primary Care Physician _____ PCP Office Phone # _____

EFF 10/1/2011

BACK OF CARD

NOTICE TO MEMBER:
Carry this card with you at all times. It must be presented each time you require any medical service. This card is not transferrable and is only valid for the eligibility period listed on the front. ***Do not allow this card or share this card with others as you will lose governmental assistance provided by Polk County Indigent Health Care Tax.***

NOTICE TO PROVIDERS:
This member has State of Florida, Medically Needy Share of Cost Medicaid. Once this individual meets their Share of Cost, the provider must bill Medicaid. ***This individual is not covered for hospital based services.*** This individual is only covered for PCP visits, Specialty visits and medications up to their Share of Cost Amount.

FAILURE TO COMPLY WILL AFFECT PAYMENT OF BENEFITS

Polk HealthCare Plan Inquiries: (863) 533-1111 ~ **Member Eligibility Appointments:** (863) 534-5387

Mail Claims to: Polk County Indigent Health Care Tax, 2137 Marshall Edwards Drive, Bartow, FL 33830

Polk HealthCare Plan – Medically Needy Share of Cost

FRONT OF CARD

Polk County Indigent Health Care Tax
MEDICAL CARD – SHARE OF COST MEDICAID

Case #: _____ Worker Code: _____

Member Name: _____

MEDICALLY NEEDY SHARE OF COST - CHRONIC CARE CHOICES

Co-pays: Physician/Office Visit $1.00 ~ Pharmacy Co-pays: $0.00 generic $3.00 brand

Eligibility Period _____ to _____

Primary Care Physician _____ PCP Office Phone # _____

EFF 10/1/2011

BACK OF CARD

NOTICE TO MEMBER:
Carry this card with you at all times. It must be presented each time you require any medical service. This card is not transferrable and is only valid for the eligibility period listed on the front. ***Do not allow this card or share this card with others as you will lose governmental assistance provided by Polk County Indigent Health Care Tax.***

NOTICE TO PROVIDERS:
This member has State of Florida, Medically Needy Share of Cost Medicaid. Once this individual meets their Share of Cost, the provider must bill Medicaid. ***This individual is not covered for hospital based services.*** This individual is only covered for PCP visits, Specialty visits and medications up to their Share of Cost Amount.

FAILURE TO COMPLY WILL AFFECT PAYMENT OF BENEFITS

Polk HealthCare Plan Inquiries: (863) 533-1111 ~ **Member Eligibility Appointments:** (863) 534-5387

Mail Claims to: Polk County Indigent Health Care Tax, 2137 Marshall Edwards Drive, Bartow, FL 33830

|DISCLAIMER: THIS VERSION OF THE CARD IS EFFECTIVE BEGINNING 10/1/2011 AND MAY BE SUBJECT TO CHANGE. PLEASE WATCH THE POLK HEALTHCARE PLAN WEBSITE.|

EXHIBIT D
BUSINESS ASSOCIATE AGREEMENT

Business Associate Agreement (the "Agreement") is effective as of _____, and is entered into by and between Polk County Board of County Commissioners ("Covered Entity") and Radiology & Imaging Specialists of Lakeland, PA, ("Business Associate") (individually, a "Party" and collectively, the "Parties").

WHEREAS, Covered Entity has engaged Business Associate to perform services on its behalf;

WHEREAS, Covered Entity possesses Individually Identifiable Health Information that is protected under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act as set forth in Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 ("HITECH" Act), the HIPAA Privacy Regulations, the HIPAA Security Regulations and the HITECH Standards, and is permitted to use or disclose such information only in accordance with such laws and regulations;

WHEREAS, Business Associate may receive such information from Covered Entity or create and receive such information on behalf of Covered Entity;

WHEREAS, Covered Entity wishes to ensure that Business Associate will appropriately safeguard Individually Identifiable Health Information;

NOW THEREFORE, for good and valuable consideration, the sufficiency of which we hereby acknowledge, the Parties agree as follows:

Article 1
Definitions
Terms used but not otherwise defined in this Agreement shall have the same meaning as the meaning ascribed to those terms in HIPAA, the HITECH Act, and any current and future regulations promulgated under HIPAA or HITECH.

1.1 "Breach" shall mean the acquisition, access, use or disclosure of Protected Health Information in a manner not permitted under 45 C.F.R. Part 164, Subpart E (the "HIPAA Privacy Regulations") which compromises the security or privacy of the Protected Health Information. Breach shall not include:

(a) Any unintentional acquisition, access, or use of Protected Health Information by a workforce member or person acting under the authority of Covered Entity or Business Associate, if such acquisition, access or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HIPAA Privacy Regulations; or

(b) Any inadvertent disclosure by a person who is authorized to access Protected Health Information at Covered Entity or Business Associate to another person authorized to access Protected Health Information at Covered Entity or Business Associate, respectively, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HIPAA Privacy Regulations; or

(c) A disclosure of Protected Health Information where Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Except as provided in 45 C.F.R. 164.402(1), an acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under 45 C.F.R. Part 164, Subpart E is presumed to be a

Breach unless the Business Associate demonstrates that there is a low probability that the Protected Health Information has been compromised based on a risk assessment of at least the following factors: (1) the nature and extent of the Protected Health Information involved, including the types of identifies and the likelihood of re-identification; (2) the unauthorized person who used the Protected Health Information or to whom the disclosure was made; (3) whether the Protected Health Information was actually acquired or viewed; and (4) the extent to which the risk to the Protected Health Information has been mitigated.

1.2 "Designated Record Set" means a group of records maintained by or for a Covered Entity that is (a) the medical and billing records about Individuals maintained by or for a covered healthcare provider; (b) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan, or (c) information used in whole or in part by or for the Covered Entity to make decisions about Individuals.

1.3 "Electronic Protected Health Information" or "Electronic PHI" means Protected Health Information that is transmitted by or maintained in electronic media as defined by 45 C.F.R. 160.103.

1.4 "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. 164.502(g).

1.5 "HIPAA Privacy Regulations" shall mean the Standards for Security of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E.

1.6 "HIPAA Security Regulations" shall mean the Standards for Security of Individually Identifiable Health Information at 45 C.F.R. part 160 and subparts A and C of part 164.

1.7 "HITECH Standards" means the privacy, security and security Breach notification provisions applicable to a Business Associate under Subtitle D of the HITECH Act and any regulations promulgated thereafter.

1.8 "Individually Identifiable Information" means information that is a subset of health information, including demographic information collected from an individual, and:

(a) is created or received by a health care provider, health plan, employer or health care clearinghouse; and

(b) relates to past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and:

(i) that identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

1.9 "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 C.F.R. 160.103 (as amended by the HITECH Act), limited to the information created or received by Business Associate from or on behalf of Covered Entity including, but not limited to Electronic PHI.

1.10 "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

1.11 "Unsecured Protected Health Information" shall mean Electronic PHI that is not secured through the use of technology or methodology specified by the Secretary in regulations or as otherwise defined in 45 C.F.R. 164.402.

1.12 "Security Incident" shall have the same meaning given to such term in 45 C.F.R. 164.304.

Article 2

Obligations of Business Associate

2.1 Limited Use or Disclosure of PHI. Business Associate agrees to not use or further disclose PHI other than as permitted or required by the Agreement or as required by law. Business Associate may (1) use and disclose PHI to perform the services agreed to by the Parties; (2) use or disclose PHI for the proper management and administration of Business Associate or in accordance with its legal responsibilities; (3) use PHI to provide data aggregation services relating to health care operations of Covered Entity; (4) use or disclose PHI to report violations of the law to law enforcement; or (5) use PHI to create de-identified information consistent with the standards set forth at 45 C.F.R. 164.514. Business Associate will not sell PHI or use or disclose PHI for marketing or fund raising purposes as set forth in the HITECH Act.

2.2 Subcontractors. In accordance with 45 C.F.R. 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, Business Associate agrees to require any subcontractor to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, to agree, in writing, to the same restrictions and conditions that apply throughout this Agreement to Business Associate with respect to such information. Business Associate shall provide copies of such agreements to Covered Entity upon request.

2.3 Safeguards. Business Associate agrees to use appropriate administrative, physical and technical safeguards, and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information, to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

2.4 Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Association in violation of this Agreement.

2.5 Notice of Use or Disclosure, Security Incident or Breach.

(a) As required by 45 C.F.R. 164.410, Business Associate agrees to notify the designated Privacy Officer of the Covered Entity, in writing, of any use or disclosure of PHI by Business Associate not permitted by this Agreement, any Security Incident involving Electronic PHI, and any Breach of Unsecured Protected Health Information without unreasonable delay, but in no case more than thirty (30) days following discovery of the use, disclosure, Security Incident, or Breach. Business Associate shall provide the following information in such notice to Covered Entity:

(i) the identification of each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, or disclosed during such Breach;

(ii) a description of the nature of the Breach including the types of unsecured PHI that were involved, the date of the Breach and the date of discovery;

(iii) a description of the type of Unsecured PHI acquired, accessed, used or disclosed in the Breach (e.g., full name, social security number, date of birth, etc.);

(iv) the identity of the person who made and who received (if known) the unauthorized acquisition, access, use or disclosure;

(v) a description of what the Business Associate is doing to mitigate the damages and protect against future breaches; and

(vi) a description of whether the PHI was actually acquired or viewed; and

(vii) any other details necessary for Covered Entity to assess risk of whether PHI has been compromised, including identification of each Individual whose unsecured PHI has been Breached and steps such Individuals should take to protect themselves.

(b) Covered Entity will be responsible for providing notification to Individuals whose unsecured PHI has been disclosed, as well as the Secretary and the media, as required by the HITECH Act.

(c) Business Associate agrees to establish procedures to investigate the Breach, mitigate losses, and protect against any future Breaches, and to provide a description of these procedures and the specific findings of the investigation to Covered Entity in the time and manner reasonably requested by Covered Entity.

(d) The Parties agree that this section satisfies any notice requirements of Business Associate to Covered Entity of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to Covered Entity shall be required. For purposes of this Agreement, "Unsuccessful Security Incidents" include activity such as pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Electronic PHI.

2.6 Access. Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner reasonably requested by Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual. Business Associate may charge Covered Entity or Individual for the actual labor cost involved in providing such access.

2.7 Amendments. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees, upon request of Covered Entity or an Individual.

2.8 Disclosure of Practices, Books and Records. Business Associate agrees to make internal practices, books and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, available to Covered Entity or the Secretary in a time and manner designated by the Covered Entity or Secretary, for the purposes of the Secretary in determining the Parties compliance with HIPAA, the HITECH Act and corresponding regulations.

2.9 Accounting. Business Associate agrees to provide to Covered Entity an accounting of PHI disclosures made by Business Associate, including disclosures made for treatment, payment and health care operations. The accounting shall be made within a reasonable amount of time upon receipt of a request from Covered Entity.

2.10 Security of Electronic Protected Health Information. Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of Covered Entity; (2) ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and (3) report to the Covered Entity any security incidents of which it becomes aware.

2.11 Minimum Necessary. To limit its uses and disclosures of, and requests for, PHI (a) when practical, to the information making up a Limited Data Set; and (b) in all other cases subject to the requirements of 45 C.F.R. 164.502(b), to the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

2.12 Indemnification. Business Associate shall indemnify and hold harmless Covered Entity and its affiliates, directors, officers, employees, partners, contractors or agents, from and against any and all claims, actions, causes of action, demands, or liabilities of whatsoever kind and nature, including judgments, interest, reasonable attorneys' fees, and all other costs, fees, expenses, and charges (collectively, "Claims") to the extent that such Claims arise out of or were caused by the (i) the use or disclosure of PHI by Business Associate or its agents or subcontractors other than as provided in this Agreement; (ii) a breach of this Agreement by Business Associate.

2.13 Permitted Uses and Disclosures. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity provided that such use or disclosure would not violate HIP AA or the HITECH Act if done by the Covered Entity.

2.14 Electronic Data Interchange. Inasmuch as Business Associate transmits or receives Transactions (as that term is defined in 45 C.F.R. 160.103) on behalf of the Covered Entity, Business Associate shall comply with any applicable provisions of the Electronic Data Interchange Requirement (as set forth in 45 C.F.R. parts 160 and 162) and shall ensure that any subcontractors or agents that assist Business Associate in conducting Transactions on behalf of Covered Entity agree in writing to comply with the Electronic Data Interchange Requirements.

2.15 Business Associate's Additional Obligations. To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, Business Associate will comply with the requirements of Subpart E that apply to the covered Entity in the performance of such obligation(s).

2.16 HITECH Act Business Associate Agreement Requirements. The Parties intended for this Agreement to satisfy the requirements of sections 13401(a) and 13404(a) of the HITECH Act that specified security and privacy provisions requirements be incorporated into business associate agreements. This Agreement shall be interpreted in a manner consistent with this intention.

Article 3
Obligations of Covered Entity

3.1 Notice of Privacy Practices of Covered Entity. Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 C.F.R. 164.520, as well as any changes to such notice.

3.2 Restrictions in Use of PHI. Covered Entity shall notify Business Associate of any changes restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

3.3 Changes in the Use of PHI. Covered Entity agrees to notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent such changes or revocation affects Business Associate's use or disclosure of PHI.

3.4 Appropriate Requests. Except as otherwise provided in this Agreement, Covered Entity will not ask Business Associate to use or disclose PHI in any manner that would violate the HIPAA Privacy Regulations or the HITECH Act of done by Covered Entity.

Article 4
Term and Termination

4.1 Term. The Term of this Agreement shall be effective as of the date listed above and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this section.

4.2 Termination for Cause. Upon either Party's determination that the other Party has committed a violation or material breach of this Agreement, the non-breaching Party may take one of the following steps:

(a) Provide an opportunity for the breaching Party to cure the breach or end the violation, and if the breaching Party does not cure the breach or end the violation within a reasonable time, terminate this Agreement;

(b) Immediately terminate this Agreement if the other Party has committed a material breach of this Agreement and cure of the material breach is not possible; or

(c) If neither cure nor termination is feasible, elect to continue this Agreement and report the violation or material breach to the Secretary in accordance with the requirements set forth in the HITECH Act.

4.3 Effect of Termination.

(a) Upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors of Business Associate.

(b) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

Article 5
Miscellaneous

5.1 Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for covered Entity to comply with the requirements of HIPAA or the HITECH Act and any applicable regulations in regard to such laws.

5.2 Survival. The respective rights and obligations of Business Associate shall survive the termination of this Agreement.

5.3 Prior Agreement. This Agreement shall replace and supersede any prior Business Associate Agreement between the Parties.

5.4 Ambiguity. Any ambiguity of this Agreement shall be resolved to permit the Parties to comply with the HITECH Act, HIPAA, and the Privacy and Security Rules and other implementing regulations and guidance.

5.5 Governing Law. This Agreement shall be construed and enforced according to HIPAA, and any applicable Florida law to the extent not preempted by HIPAA or other federal law.

5.6 Successors and Assigns. This Agreement will inure to the benefit of and be binding upon the successors and assigns of the Parties. However, this Agreement is not assignable by either Party without the prior written consent of the other Party.

5.7 No Third Party Beneficiaries. Business Associate and covered Entity agree that nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than Business Associate and Covered Entity, and their respective successors or assigns, any rights, remedies, or obligations or liabilities whatsoever.

5.8 Notice. All notices, requests, consents, and other communications hereunder will be in writing, and in accordance with the Medical Services Agreement.

5.9 No Waiver of Rights, Powers, and Remedies. No failure or delay by a Party hereto in exercising any right, power or remedy under this Agreement, and no course of dealing between the Parties hereto, will operate as a waiver of any such right, power or remedy of the Party.

IN WITNESS WHEREOF, the Parties hereby execute this Agreement to be effective as of the date written above.

BUSINESS ASSOCIATE:

Radiology & Imaging Specialists of Lakeland, PA

BY: _____
Edward J. Goodemote, PhD, RN, CEO

DATE: 9/3/13

_____
WITNESS

_____
WITNESS

COVERED ENTITY:
POLK COUNTY, Florida, a political subdivision of the State of Florida

BY: _____
Melony M. Bell, Chairman

ATTEST: Stacy M. Butterfield, Clerk

BY: _____
Deputy Clerk

Reviewed as to form:

_____
County Attorney Date

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Radiology & Imaging Specialists of
Lakeland, PA
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	5/15/2000
TOTAL LIMITS	1,000,000/ 3,000,000	

This document is issued as a matter of information only and confers no rights upon the document holder. This document does not amend, extend, or alter the coverage, terms, exclusions, conditions, or other provisions afforded by the policies referenced herein.

Please inquire directly with the insured for individual restrictive endorsements that may apply. In the event of cancellation of the described policy, MAG Mutual will make reasonable effort to notify the party at whose request this certificate was issued, but MAG Mutual shall not be liable in any way for failure to give such notice.

Lisa M. Cappelli

Authorized Representative

May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Darren P. Chapman, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	7/01/2010
TOTAL LIMITS	1,000,000/ 3,000,000	

This document is issued as a matter of information only and confers no rights upon the document holder. This document does not amend, extend, or alter the coverage, terms, exclusions, conditions, or other provisions afforded by the policies referenced herein.

Please inquire directly with the insured for individual restrictive endorsements that may apply. In the event of cancellation of the described policy, MAG Mutual will make reasonable effort to notify the party at whose request this certificate was issued, but MAG Mutual shall not be liable in any way for failure to give such notice.

Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CINS Ed. 6/94

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Gary J. Chappel, M.D.
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014

	Limits Each loss Aggregate limit	Retroactive Date:
	500,000/ 1,500,000	3/21/1986
	500,000/ 1,500,000	6/01/2010
TOTAL LIMITS	1,000,000/ 3,000,000	

This document is issued as a matter of information only and confers no rights upon the document holder. This document does not amend, extend, or alter the coverage, terms, exclusions, conditions, or other provisions afforded by the policies referenced herein.

Please inquire directly with the insured for individual restrictive endorsements that may apply. In the event of cancellation of the described policy, MAG Mutual will make reasonable effort to notify the party at whose request this certificate was issued, but MAG Mutual shall not be liable in any way for failure to give such notice.

Lisa M. Cappelin

Authorized Representative

May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Larry M. Dietrich, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	7/01/1986
TOTAL LIMITS	1,000,000/ 3,000,000	

This document is issued as a matter of information only and confers no rights upon the document holder. This document does not amend, extend, or alter the coverage, terms, exclusions, conditions, or other provisions afforded by the policies referenced herein.

Please inquire directly with the insured for individual restrictive endorsements that may apply. In the event of cancellation of the described policy, MAG Mutual will make reasonable effort to notify the party at whose request this certificate was issued, but MAG Mutual shall not be liable in any way for failure to give such notice.

Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CINS Ed. 6/94

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Fakhir F. Elmasri, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33803

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	9/26/2005
TOTAL LIMITS	1,000,000/ 3,000,000	

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Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CINS Ed. 6/94

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Michael B. Esposito, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	7/01/1996
TOTAL LIMITS	1,000,000/ 3,000,000	

This document is issued as a matter of information only and confers no rights upon the document holder. This document does not amend, extend, or alter the coverage, terms, exclusions, conditions, or other provisions afforded by the policies referenced herein.

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Lisa M. Cappelin
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Scott A. Fargher, M.D.
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	7/01/2003
TOTAL LIMITS	1,000,000/ 3,000,000	

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Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

John T. Giuffrida, M.D.
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	6/30/2008
TOTAL LIMITS	1,000,000/ 3,000,000	

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Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CINS Ed. 6/94

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Husam Habboub, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	3/21/2005
TOTAL LIMITS	1,000,000/ 3,000,000	

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Please inquire directly with the insured for individual restrictive endorsements that may apply. In the event of cancellation of the described policy, MAG Mutual will make reasonable effort to notify the party at whose request this certificate was issued, but MAG Mutual shall not be liable in any way for failure to give such notice.

Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CINS Ed. 6/94

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Robert R. Harriage, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	9/01/1990
TOTAL LIMITS	1,000,000/ 3,000,000	

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Please inquire directly with the insured for individual restrictive endorsements that may apply. In the event of cancellation of the described policy, MAG Mutual will make reasonable effort to notify the party at whose request this certificate was issued, but MAG Mutual shall not be liable in any way for failure to give such notice.

Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CINS Ed. 6/94

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Bret D. Henricks, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	6/17/1996
TOTAL LIMITS	1,000,000/ 3,000,000	

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Lisa M. Cappelin
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Khurram Javed, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	8/27/2012
TOTAL LIMITS	1,000,000/ 3,000,000	

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Please inquire directly with the insured for individual restrictive endorsements that may apply. In the event of cancellation of the described policy, MAG Mutual will make reasonable effort to notify the party at whose request this certificate was issued, but MAG Mutual shall not be liable in any way for failure to give such notice.

Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CINS Ed. 6/94

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Magge V. Lakshmi, M.D.
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	7/01/2010
TOTAL LIMITS	1,000,000/ 3,000,000	

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Please inquire directly with the insured for individual restrictive endorsements that may apply. In the event of cancellation of the described policy, MAG Mutual will make reasonable effort to notify the party at whose request this certificate was issued, but MAG Mutual shall not be liable in any way for failure to give such notice.

Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CINS Ed. 6/94

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Martha I. Lima, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	4/01/2002
TOTAL LIMITS	1,000,000/ 3,000,000	

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Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Charley T. Myrick, D.O.
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	7/01/2003
TOTAL LIMITS	1,000,000/ 3,000,000	

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Lisa M. Cappelin
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Russell N. Nusynowitz, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	4/01/2012
TOTAL LIMITS	1,000,000/ 3,000,000	

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Lisa M. Cappelli

Authorized Representative

May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Kevin J. Sawyer, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	7/01/2012
TOTAL LIMITS	1,000,000/ 3,000,000	

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Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CINS Ed. 6/94

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Christian T. Schmitt, M.D.
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	2/01/2005
TOTAL LIMITS	1,000,000/ 3,000,000	

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Lisa M. Cappelli

Authorized Representative

May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Angela E. Sroufe, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	7/01/2008
TOTAL LIMITS	1,000,000/ 3,000,000	

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Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CINS Ed. 6/94

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Venkat P. Tummala, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	7/01/2011
TOTAL LIMITS	1,000,000/ 3,000,000	

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Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CINS Ed. 6/94

CERTIFICATE OF INSURANCE

MAG Mutual Insurance Company

Certificate issued to:

Name and mailing address of insured:

James M. Welden, III, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014

	Limits Each loss Aggregate limit	Retroactive Date:
	1,000,000/ 3,000,000	5/15/2010
TOTAL LIMITS	1,000,000/ 3,000,000	

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Lisa M. Cappelli

Authorized Representative

May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CINS Ed. 6/94

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Lawrence R. Whitney, III, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	7/08/2009
TOTAL LIMITS	1,000,000/ 3,000,000	

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Lisa M. Cappelin
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

James F. Zimmer, M.D.
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014
	Limits **Each loss Aggregate limit**	**Retroactive Date:**
	1,000,000/ 3,000,000	9/01/2011
TOTAL LIMITS	1,000,000/ 3,000,000	

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Please inquire directly with the insured for individual restrictive endorsements that may apply. In the event of cancellation of the described policy, MAG Mutual will make reasonable effort to notify the party at whose request this certificate was issued, but MAG Mutual shall not be liable in any way for failure to give such notice.

Lisa M. Cappelli
Authorized Representative
May 23, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:
Regina Ason, MD
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Insurance Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	**Effective Date:**	**Expiration Date:**
PSL 1602675 06	6/1/2013	6/1/2014
	Limits of Liability: (Each loss /Aggregate limit)	**Retroactive Date:**
	$1,000,000/$3,000,000	7/1/2013

Total Limits: $1,000,000/$3,000,000

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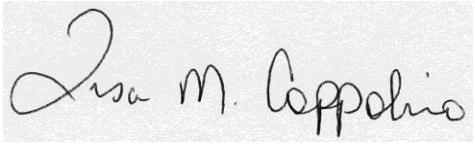

Lisa Coppolino
Authorized Representative
July 12, 2013
M**AG Mutual Insurance Company**
P.O. Box 52979
Atlanta, GA 30355-0979

CINS Ed. 2/11

CERTIFICATE OF INSURANCE **MAG Mutual Insurance Company**

Certificate issued to:

Name and mailing address of insured:

Howard W. Sterling, M.D.
2120 Lakeland Hills Blvd.
Lakeland, FL 33805

This is to certify that MAG Mutual Insurance Company has issued a claims-made Physicians and Surgeons Professional Liability Policy to the insured listed above, subject to the provisions of the current policy contract and any endorsements.

Policy Number:	Effective Date:	Expiration Date:
PSL 1602675 06	6/01/2013	6/01/2014

	Limits Each loss Aggregate limit	Retroactive Date:
	1,000,000/ 3,000,000	6/01/2013
TOTAL LIMITS	1,000,000/ 3,000,000	

This document is issued as a matter of information only and confers no rights upon the document holder. This document does not amend, extend, or alter the coverage, terms, exclusions, conditions, or other provisions afforded by the policies referenced herein.

Please inquire directly with the insured for individual restrictive endorsements that may apply. In the event of cancellation of the described policy, MAG Mutual will make reasonable effort to notify the party at whose request this certificate was issued, but MAG Mutual shall not be liable in any way for failure to give such notice.

Lisa M. Cappelli

Authorized Representative

July 10, 2013

MAG Mutual Insurance Company
PO Box 52979
Atlanta, GA 30355-0979