***Provider Agreement Terms & Conditions Booklet* accompanies**
the *Provider Participation Agreement* and is supplied for your reference only.
<u>This is NOT the Agreement.</u>

Provider Participation Agreement Terms & Conditions Booklet

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Provider Participation Agreement Terms & Conditions Booklet - Version 14.1
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INTRODUCTION: This **Provider Agreement Terms & Conditions Booklet** (the "Booklet") accompanies the Provider Participation Agreement and contains the details relevant to the relationship between you as the Provider and Prime Health Services, Inc. ("PHS") and the various product offerings for which you have agreed to provide Covered Services (see §4.0). (PHS and Provider each may be referred to herein as a "Party" and collectively as the "Parties".)

Please review the following standard terms and conditions in order to be fully informed of the specific expectations from the Provider Participation Agreement, and maintain a copy of this Booklet for future reference. **Remember to periodically login to our website at www.primehealthservices.com to view our most current Client Directories, which are continually updated on a monthly basis.** Also, please follow Prime Health Services on Twitter @PrimePPO for additional announcements regarding our clients and other related news items.

It is not necessary to return a copy of this Booklet with the Provider Participation Agreement. If you have any questions or concerns after reviewing the following terms, we will be happy to assist you at our toll-free telephone number at 1-866-348-3887 or via our website at http://primehealthservices.com/contact_us.aspx.

1.0 DEFINITIONS: Unless Applicable Law requires otherwise, the below terms have the following meanings herein:

1.1 **"Applicable Law"** means laws, rules, or regulations applicable to Medicare, group health, workers' compensation, auto medical liability, state no-fault benefits, and/or any other applicable state or federal laws, rules, or regulations.

1.2 **"Client Directory"** means PHS's client listing, and depending on the state in which Provider is located, it may be accessed online at PHS's website or through email upon Provider's request.

1.3 **"Confidential and Proprietary Information"** means certain non-public information disclosed in confidence by one Party to the other or its designee including, but not limited to, information concerning a utilization review or case management program, credentialing criteria, as well as:

(a) patient care, records, and finances; marketing information (surveys, reports, etc.); and
(b) financial information, including but not limited to earnings, volume of business, pricing methods, systems, practices, and strategic plans; and
(c) other commercially valuable information, including but not limited to mailing lists, client lists, patient lists, programmatic information and structure, and related information and documents.

1.4 **"Covered Person"** (or **"Enrollee"** where applicable to Medicare health plans) means an employee or insured party who is eligible for and entitled to receive Covered Services under a Payor Program.

1.5 **"Covered Services"** means services for Medicare, group health, workers' compensation, first party auto medical liability, state no-fault benefits, and third party auto medical liability or additional network services offered by PHS, which Covered Persons are entitled to receive through Participating Providers according to Applicable Law and as explained under the terms in this Booklet.

1.6 **"Emergency"** means an emergency medical condition manifesting itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the individual (or a pregnant woman's unborn child) in serious jeopardy;
(b) serious impairment of bodily functions; or
(c) serious dysfunction of any bodily organ or part.

1.7 **"Employer"** means: (i) an insured employer on whose behalf a Payor underwrites and makes payments for Covered Services; or (ii) an employer self-funded for benefits for its employees. An Employer may also participate and offer access to certain other programs offered by or through PHS whereby benefits of such programs would be paid for by employees.

1.8 **"Management Company"** means a program or company that may provide the following services:

(a) a utilization review program ("UR Program") that is licensed or otherwise authorized to the extent required in the state of residence to perform utilization review, credentialing verification, third party administration, or billing and claims processing services; or
(b) utilization management or case management services.

1.9 **"Medically Necessary"** means the services provided by a Participating Provider that are:

(a) consistent with the symptoms, diagnosis, and treatment of a Covered Person's illness, disease, medical condition or medical problem; and
(b) commonly and customarily recognized in Provider's profession or area of health care services as appropriate in the treatment of a Covered Person's diagnosed illness, injury, or condition; and
(c) not primarily for the convenience of the Covered Person or the Participating Provider.

However, any services that are determined not Medically Necessary pursuant to a Payor Program or Management Company's UR Program shall not be Medically Necessary for purposes of the Agreement.

1.10 **"Participating Hospital"** means a hospital licensed to the extent required in its state of residence to provide health care services that has entered into an agreement with PHS to provide Covered Services.

1.11 **"Participating Provider"** means a Primary Care Physician, Specialist Physician, ancillary provider, or any other health care provider that is licensed to the extent required in its state of residence to practice its profession or otherwise to provide health care services, and:

(a) has entered into a Participation Agreement with PHS to provide Covered Services; or

(b) is a physician, employee, or partner of a physician group or has entered into an agreement with a physician group to provide Covered Services to Covered Persons.

1.12 **"Participation Agreement"** means a written agreement between PHS and a Participating Provider, under which Provider agrees to render Covered Services to Covered Persons.

1.13 **"Payor"** means the entity financially responsible for paying claims, which can be one of the following: an Employer self-funded for group health or workers' compensation benefits; an insurance company that underwrites and makes payments for Covered Services under a benefit program for group health, workers' compensation, Medicare, Medicare supplemental, first party auto medical liability, no fault benefits, third party auto medical liability, or additional network services offered by PHS or a benefit program on behalf of Covered Persons; or federal, state, or municipal governments administering referrals for Covered Persons eligible for care under the terms herein.

1.14 **"Payor Program"** means the program under which a Payor designates Covered Services to be provided by Participating Providers as well as the billing and claims processing and other services to be provided by PHS, Payor, or PHS client.

1.15 **"Primary Care Physician"** means a physician credentialed by PHS or its delegates to serve as a Primary Care Physician or has been delegated as a Primary Care Physician, and who either:

(a) while practicing medicine, at least 50% of the time supervises, coordinates, and provides initial and basic care to patients, initiates specialist referrals, and maintains continuity of care; or

(b) prior to contracting, has limited his or her practice of medicine for at least two years to general practice, internal medicine, pediatrics, family medicine, or occupational medicine.

1.16 **"Specialist Physician"** means either a provider that practices a medical specialty other than those referred to in Section 1.15 above or a provider that has been credentialed by PHS (or its delegates) as a Specialist Physician in one or more designated medical specialties.

1.17 **"Submitted Billed Charge"** means Provider's charge per individual submitted CPT code.

1.18 **"Work Status Report"** means a report to PHS and/or Payor designed to provide evaluation specifically in regards to workers' compensation cases for workers' compensation patients only.

2.0 **PARTICIPATING PROVIDER SERVICES:** This section covers PHS's and PHS clients' expectations of Provider.

2.1 **Provider Services.** Participating Provider agrees to:

(a) provide Covered Persons with Covered Services in his/her/its specialties in accordance with applicable standards of care and Applicable Law and during normal business hours;

(b) take necessary and appropriate steps to arrange for immediate provision of Emergency, urgent care, or hospital Covered Services to Covered Persons 24 hours per day, seven days per week;

(c) maintain any required state license and to notify PHS immediately whenever there is a loss or change in licensure or certification status or if Provider's performance becomes impossible;

(d) follow instructions and protocols, including those in PHS's Provider Manual or those supplied by PHS or PHS clients' case managers or adjustors at the time of treatment (where applicable);

(e) notify PHS sixty (60) days prior to the closing of his/her/its practice or facilities to new patients;

(f) submit a Work Status Report (for workers' compensation patients) by close of business on the day of the Covered Person's visit, for those Employers that requested such service;

(g) submit any other reports per the designated schedule for Employers requesting such service;

(h) provide or arrange for non-urgent services within 7 days of the request for such services and make subsequent referrals on a timely basis; however, for workers' compensation services, access to initial treatment must be available to injured workers within 24 hours of a request;

(i) make referrals for required specialty care within 48 hours of the identification of such need;

(j) communicate with PHS by submitting referrals to PHS or its designated representative to utilize Participating Providers in the PHS Network (whenever applicable and available); and

(k) acknowledge that PHS does not—by the Agreement or otherwise—promise, warrant, or guarantee Provider any minimum number of Covered Persons as patients.

2.1.1 **Specialist Physician Services.** A Participating Provider serving as a Specialist Physician also agrees to provide access to Covered Services in his/her/its specialty by seeing Covered Persons within four (4) days of receiving a referral from a Primary Care Physician or case manager.

2.2 Provider's Responsibility for Provision of Services. Neither PHS nor Payor will be liable for, nor will they exercise control or direction over, the manner or method by which Provider renders medical services to Covered Persons as set forth in this Booklet. Provider acknowledges and agrees that:

(a) Provider will be solely responsible for the medical care and other health care services provided to Covered Persons, and for the maintenance of relationships with Covered Persons; and

(b) only as consistent with Applicable Law, Payor is entitled to deny payment to Provider for services to a Covered Person for any of the following: if Provider did not obtain prior authorization; if Payor determines the services are not Medically Necessary or are not Covered Services; or if services are not otherwise provided in accordance with the provisions in this Booklet or according to Payor policies and procedures or those communicated to Provider; and

(c) such denial does not absolve Provider of his/her professional responsibility to provide appropriate medical care to Covered Persons.

2.3 Admissions and Referrals. Provider agrees to accept referrals from PHS, PHS clients, or other Participating Providers within the PHS Network, and whenever possible and medically appropriate, to refer Covered Persons to Participating Providers. Further, Provider agrees to use best efforts to submit any specialty referrals to PHS or PHS's Participating Providers and to only admit inpatient Covered Persons as required by PHS or PHS clients' protocols and procedures, consistent with appropriate patient care, and only to other Participating Providers, except: (i) in cases of Emergency; (ii) cases specifically certified for payment by Payor or its designee; or (iii) as otherwise required by Applicable Law.

2.4 Provider Coverage. Provider must have admitting privileges in at least one Participating Hospital and must notify PHS immediately of any loss or changes in privileges at any hospital or admitting facility. (Reasonable exceptions will be made for Participating Providers who customarily do not have admitting privileges because of their type of practice, clinical specialty, or location.) Provider shall utilize another Participating Provider in the PHS Network whenever possible when arranging for Covered Services to be provided by another provider in his/her absence or unavailability. However, where another Participating Provider is not available, Provider must use best efforts to ascertain and confirm that such covering provider is a member of the medical staff at one or more Participating Hospitals within the PHS Network.

2.5 Timely Response to Case Management. Unless otherwise required by Applicable Law, Provider must respond to all inquiries and requests from PHS clients' case managers or adjustors in a timely manner (less than 72 business hours) and without causing undue delay in a patient's timely return-to-work. PHS's Quality Oversight Committee may investigate complaints regarding excessive delays and as a result may report the incident or terminate Provider's network participation.

2.6 Non-Discrimination. Provider must not discriminate in the provision of health care services and must treat Covered Persons in a manner consistent with professionally recognized standards of health care without regard to their network participation, place of residence, race, religion, sex, ethnicity, national origin, age, sexual preference or orientation, physical or mental services, health status, disability, genetic information or history, English proficiency or reading skills, source of payment, or other impermissible ground under Applicable Law.

3.0 PHS AND PROVIDER RESPONSIBILITIES:

3.1 Credentialing Services. PHS or its delegate credentials Participating Providers in accordance with PHS's internal policies and procedures, which comply with URAC standards. Provider agrees to comply with and remain in compliance with such credentialing or recredentialing programs and criteria, and Provider agrees to respond to requests for additional information in a timely manner. Additionally, Provider must promptly report to PHS a change in its status under PHS's credentialing requirements.

3.2 UR Program. Where applicable and consistent with Applicable Law, PHS will work with a Management Company to make available to Payors the full range of UR Program services required under Payor Program or Applicable Law, including pre-admission services, outpatient and inpatient review services, and case management services for cases involving Covered Services that meet the applicable threshold for the provision of such services. Provider agrees to make best efforts to comply with and remain in compliance with UR Program requirements determined through communication with PHS or PHS client.

3.3 Billing and Claims Processing Services under Payor Program. For PHS's or Payor's billing and claims processing system under the designated Payor Program, Provider agrees to comply with and remain in compliance with such Payor Program for billing and claims processing for Covered Services. Provider acknowledges and agrees with the following:

(a) Provider will bill Payor by submitting claims using CMS 1500 forms (or later versions of the form as dictated by Applicable Law);

(b) any claim submitted within forty-five (45) days after Covered Services are provided, and otherwise in compliance with this section 3.3, will be deemed a "Complete Claim";

(c) Payor will pay each Complete Claim for Covered Services within 30 days, unless otherwise specified or allowed under state law, after receipt by Payor of the claim, which shall be discounted on a line-by-line basis, unless PHS or Payor determines, as consistent with Applicable Law, that the services are not Covered Services or not Medically Necessary or were not provided in accordance with PHS's or Payor's policies (e.g., if no authorization was obtained, the claim is not a Complete Claim and is not compensable);
(d) Within 30 days after Payor's receipt of any claim it has reason not to pay, PHS or Payor will forward a notice of non-payment and its reasoning to Participating Provider;
(e) Payor will have the final responsibility for payment of claims for Covered Services;
(f) PHS is not liable for payment of any claim from its own funds, and PHS is not considered the insurer, guarantor, or underwriter of Payor's liability to provide benefits for Covered Persons;
(g) Payor has the sole discretionary authority and responsibility for final claims decisions; and
(h) Under no circumstance will Provider be reimbursed above 100% of any fee schedule (e.g., state workers' compensation or auto liability fee schedules) or above any maximum allowable rate specified by state or federal law, or above any established usual and customary charges or fair and reasonable charges.
(i) Upon Provider's request, PHS or PHS client will make available payment information, fee schedules, or other information sufficient to enable Provider to determine the manner and amount of payments under Provider's contract prior to the contract's final execution or renewal.

4.0 **PRODUCT OFFERINGS AND IDENTIFICATION:** Provider acknowledges that PHS will market Provider's services to PHS clients through a variety of product offerings, which include the following:

4.1 **Group Health.** For each Covered Person accessing the PHS Network for group health, PHS or PHS's client will provide identification that is specific to that individual. Such identification may indicate that the patient is accessing the PHS Network relationship in one or all of the following manners:
(a) the PHS logo will appear on the card; or
(b) the card will provide a toll-free number to verify the patient is accessing the PHS Network; or
(c) the Explanation of Benefits (EOB) received with payment will note that the payment was processed accessing the PHS Network relationship.

Some group health entitled Covered Persons belonging to federal, state, or municipal accounts may identify themselves in advance by calling and making an appointment, and at that time they will clearly identify the plan or program under which coverage is afforded them. Provider hereby agrees to make best efforts to work with and accommodate such Covered Person to provide the best possible treatment.

4.2 **Workers' Compensation.** Covered Persons accessing the PHS Network for workers' compensation health care services will be identified upon payment on the accompanying EOB. Prior to receipt of the EOB, Provider can verify that the Employer is listed in the PHS Client Directory. Additionally, Provider may call PHS or PHS client's toll-free number for verification of a PHS client. Under no circumstances will Provider withhold or delay in any manner Emergency services pending verification of coverage.

4.3 **Casualty and Liability Product Lines.** Casualty and liability product lines represent a variety of clients offering medical coverage to their members. Most of these services are non-directed upon the initial injury. In these cases, access to the PHS Network will be clearly identified on the EOB accompanying the payment to Provider. This product offering includes:
(a) first party auto medical liability, state no-fault benefits, other auto benefits; and
(b) first party general liability; and
(c) third party auto medical liability.

4.4 **Metrics.** Provider acknowledges and understands that PHS clients may require PHS to conduct metric analysis comparing one provider to another provider in the PHS Network or outside the network.

4.5 **Independent Medical Examinations (IME) or 2nd Opinion Services.** These will include the following services only for the set case rate:
(a) review of medical records, films, and tests on the patient;
(b) office visit with the patient to review condition;
(c) conducting a minor office test (x-ray, blood work, etc., as Provider deems necessary);
(d) producing a written report of findings

The case rate does not include the cost of deposition or litigation testimony, which may be necessary. Provider will make best efforts to supply such testimony should it become necessary; however, Provider may negotiate additional charges with any representative attorney for such fees. PHS will not assist in negotiations for such additional fees. PHS makes no assertion that a Participating Provider participating in the IME program will be utilized. Such utilization is solely at the discretion of PHS clients.

4.6 **Telemedicine.** Where applicable and available, the PHS Network includes Participating Providers that render certain clinical health care services at a distance via telemedicine using telecommunication and

information technologies, including internet, satellite, telephone or wireless media and a growing variety of applications and services such as two-way video and email. Where Provider renders Covered Services to Covered Persons via telemedicine, Provider agrees to accept reimbursement at the Telemedicine Program Rate specified in the Agreement.

4.7 Indigent Care. PHS offers access to the PHS Network for indigent care populations as a service to the community, which may include prison populations needing group health coverage. Provider agrees to accept reimbursement for such Covered Persons at the stated rate in the Agreement. Covered Persons accessing the PHS Network under these programs will be identified while making an appointment or at presentation. Provider agrees to make reasonable efforts to make accessible clinic times to accommodate such patients, at Provider's sole discretion and at times Provider deems appropriate. Following execution of the Agreement, if Provider decides not to treat or no longer treat indigent care populations, Provider agrees to notify PHS sixty (60) days prior to no longer treating such patients.

4.8 Medicare Health Plans. PHS offers access to Participating Providers that offer Covered Services, which may include Medicare, Medicare Advantage, or Medicare private-fee-for-service plans. Provider agrees to accept the negotiated rate from the Agreement as payment for services rendered to these Covered Persons. Provider agrees to provide Medically Necessary Covered Services to all Covered Persons enrolled in such programs, as Provider's staff and facilities permit and in a manner that assures continuity of care. Provider must accept Enrollee's as new patients on the same basis as Provider is accepting non-Enrollees as new patients without regard to type of benefit contract under which the Enrollee has coverage, Enrollee's place of residence, race, religion, sex, ethnicity, national origin, age, sexual orientation, physical or mental services, genetic information or genetic history, English proficiency or reading skills, or source of payment for the services rendered. Provider must observe, protect, and promote the rights of Enrollees as patients and provide treatment equal to that of other patients, including respect, dignity, and consideration for Enrollees' privacy. The provision of Covered Services must be in a manner consistent with professionally recognized standards of health care. Additionally, Provider must comply with the requirements of:

(a) Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 84;
(b) Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91;
(c) Rehabilitation Act of 1973;
(d) Americans With Disabilities Act;
(e) Other Applicable Law to recipients of federal funds;
(f) All Medicare laws, rules and regulations;
(g) Health Insurance Portability and Accountability Act ("HIPAA") of 1996;
(h) Genetic Information Nondiscrimination Act of 2008; and
(i) All other Applicable Law, as it may be amended.

The following sections are in accordance with Title 42, Code of Federal Regulations, part 422:

4.8.1 Utilization Management, Quality Assurance and Performance Improvement. To the extent applicable to Enrollee's plan for Covered Services, Provider must cooperate with all reasonable utilization management, quality assurance, peer review, grievance, prior authorization, prior notification, on-site concurrent review, or other similar programs established by, or on behalf of, the Medicare health plan for Covered Services.

4.8.2 Data Submission and Accuracy. When submitting claims, Provider must provide all CMS required information relating to Covered Services provided. Claims submitted must be accurate, complete, and truthful to the best of Provider's knowledge, information, and belief.

4.8.3 Hold Harmless. Provider agrees that in no event, including but not limited to non-payment by PHS client, including insolvency and/or breach of the Agreement, will Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Enrollee or persons (other than PHS client) acting on their behalf for services provided pursuant to the Agreement. This provision does not prohibit Provider from collecting cost sharing amounts or fees for non-Covered Services delivered on a fee-for-service basis to Enrollees, unless the Enrollee is a dual eligible Enrollee, where the Enrollee will not be responsible for any cost sharing for Medicare part A and B services. Collection of cost sharing amounts will be deemed as waived by Provider, or when the state is responsible for paying those amounts, remuneration will be sought by Provider through the state. These provisions supersede any oral or written agreement now existing or hereafter entered into between Provider and Enrollees (or person acting on their behalf) insofar as such contrary agreement relates to liability for payment or continuation of Covered Services provided under terms and conditions of these clauses. Neither CMS nor any Covered Person will be held liable for any debts of the Medicare health plan or for any services for which the Medicare health plan is liable. The provisions of this section will survive the termination of the Agreement.

4.8.4 Participation Criteria. Provider will take necessary and appropriate steps to arrange for the provision of hospital Covered Services to Enrollees, if deemed appropriate, on a 24 hours per

day, 7 days per week, 365 days per year basis. Provider must also:

(a) Maintain state required licensure and insurance levels of malpractice, general and professional liability and Medicare certification; and

(b) Have in place a quality improvement program that meets the applicable requirements of 42 CFR part 422.152(a) for the services it furnishes to Enrollees.

4.8.5 Appeal and Grievance Procedures. Provider must cooperate with and participate in PHS client's Enrollee appeal and grievance procedures, including expedited appeals procedures. Such cooperation includes gathering, providing copies, and forwarding related information to PHS client, as necessary, within three (3) days of PHS client's request for information.

4.8.6 Medical Records Confidentiality and Access. Medical records must be maintained for a period of no less than ten (10) years, including after termination of the Agreement and must be retained further if records are under inspection, evaluation, or audit until such is completed. Provider must safeguard Enrollee privacy and confidentiality, assure the accuracy of Enrollee medical records, and abide by all Applicable Laws regarding confidentiality and disclosure of medical records. Provider must provide access to records and Confidential and Proprietary Information, upon reasonable notice during normal business hours, to pertinent records and information regarding Covered Services rendered to Enrollees for inspection and copying, at Provider's expense, in such a manner as may be reasonably requested by PHS's client to permit implementation of quality improvement and UR Programs, to perform its administrative obligations, and to verify claims for Covered Services submitted by Provider. All such information must be in a format as is reasonably necessary and appropriate to the purposes referred to above and to comply with CMS audits and requests for information.

4.8.7 Federal Requirements for Medical Records. The Secretary of the Department of Health and Human Services (DHHS), the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of PHS client and/or Provider, related entity, contractor, subcontractor, or transferee that pertains to any aspects of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the Agreement or as the Secretary of DHHS may deem necessary to enforce the Agreement. The Parties agree to make available their premises, physical facilities, equipment, records relating to Medicare Enrollees, and any additional relevant information that CMS may require. DHHS, the Comptroller General, or their designees right to inspect, evaluate, and audit records will extend through ten (10) years from the final date of the contract period or completion of the audit, whichever is later, unless:

(a) CMS determines a special need to retain particular record(s) for a longer period and notifies PHS client or Provider at least 30 days before the normal disposition date;

(b) there has been a termination, dispute, or fraud or similar fault by PHS client or Provider, in which case the retention may be extended to ten (10) years from the date of any resulting final resolution of termination, dispute, or fraud or similar fault; or

(c) CMS determines there is a reasonable possibility of fraud, in which case it may inspect, evaluate, and audit PHS client and/or Provider at any time.

4.8.8 Advance Directives. Provider agrees to comply with Applicable Law respecting advance directives where Covered Services are rendered. Additionally, Provider will provide notice to Enrollees of their advance directive rights when the Enrollee is receiving health care services from Provider as required under Title 42 of the Code of Federal Regulations.

4.8.9 Excluded Persons. Provider must not employ or contract with any individual who has been excluded from participation in Medicare under §§1128 or 1128A of the Social Security Act.

4.8.10 Federal Funds. The Parties acknowledge that PHS client is receiving federal funds under its contract with CMS and monies paid to Provider for Enrollees' Covered Services are federal funds. Provider is subject to Applicable Law related to entities receiving such funds.

4.8.11 Advertising. Except for the provider directory, no promotional material, advertising circulars, radio or TV broadcasts, or other advertising in any form concerning the other Party will be made, published, or circulated without prior written consent. Such consent will not be unreasonably withheld. Additionally, all advertising must be filed with the appropriate regulatory agencies by PHS clients. PHS's clients may include Provider's name in the provider directory and any advertising that lists providers accepting PHS clients' Medicare health plans.

4.8.12 Delegated Administrative Functions. PHS will delegate the administrative functions outlined in an attachment hereto (where applicable). Initial delegation and renewal is subject to review on an ongoing basis, along with approval of Provider's performance of delegated administrative functions and compliance by Provider of all plan and regulatory guidelines. PHS may approve, suspend, or terminate delegated functions. Failure of Provider to perform delegated administrative functions in compliance with PHS's policies and procedures will result in revocation of delegation for one or all of the delegated functions. Provider's agreements with subcontractors are subject to review and approval by PHS, Payor, CMS, and other

applicable state or regulatory agencies regarding activities performed by any related entity, contractor, subcontractor, or first-tier or downstream entity of the Provider, in accordance with the Agreement, regarding compliance with contractual obligations.

4.9 Other PHS Network Programs. PHS reserves the right to develop new product offerings in the future to enhance business relationships with clients. Such programs will, at a minimum, be identified upon receipt of the Explanation of Benefits noting that payment was processed accessing the PHS Network relationship. ***In all cases Provider will not be included in such programs until Provider has been offered an amendment to be included.*** *Provider agrees to make every effort to participate in all programs offered by PHS and agrees that such participation will not be unreasonably withheld.*

4.10 Covered Person Verification. PHS and/or Payor will furnish a telephone number for use by Provider when an individual is seeking treatment under a PHS program or Payor Program. Payor will make payment to Provider in the event that any incorrect verification of eligibility results from any act or omission on Payor's part, including but not limited to, Payor's failure to timely notify PHS or Provider of changes in enrollment or eligibility. Provider agrees to verify coverage through either receipt of an authorization card or by telephone or online verification.

4.11 Recoveries from Third Parties. Provider agrees to cooperate with Payor as reasonable in determining if a Covered Person's injury or illness gives rise to a subrogation claim by Payor. Provider agrees to take reasonable action to assist Payor in obtaining recoveries from third parties, including executing any documents that reasonably may be required to enable Payor to bill and/or collect payments from third parties or to assign payments to Payor, consistent with Applicable Law regarding patient confidentiality.

4.12 Provider Authorization. Provider acknowledges that PHS will send Provider's demographic information to Payors. Provider authorizes PHS and Payors to include Provider's name, address, telephone number, medical specialty, medical training/education information, hospital affiliations and other similar information in PHS's or Payor's roster of Participating Providers, which may be included in various PHS or Payor marketing materials to be conveyed in both print and electronic mediums.

4.13 Compliance and Participation. Provider agrees to comply with and participate in the implementation of protocols, policies and programs, as set forth in this Booklet or communicated through PHS's *Provider Manual* or materials (herein or supplied to Provider at a later date), to promote excellence and continuing improvement in the quality of medical and health care services and to control the cost and utilization of such services, including but not limited to, policies and programs regarding: credentialing and recredentialing, billing and payment, utilization review, quality assurance, case management, case communication, referrals, grievances, and data reporting requirements. Provider agrees to comply with the determination of PHS or Payor regarding all such matters during the term of the Agreement.

4.14 Provider Manual. Provider acknowledges that PHS represents clients that cover a variety of Payor models (primarily TPAs, self-insured Employers, and insurance companies). Consequently, no single manual can detail the specific policy descriptions associated with all PHS clients. However, the information necessary to begin Provider's participation in the PHS Network, specifically regarding accessing and working with PHS clients, will be supplied in the *Provider Manual* and a copy is supplied to the Provider after execution of the Agreement. In some instances, PHS clients have developed specific protocols to be used with their patients. Such protocols will be supplied, in most cases, at the time of treatment. Additionally, case management may require specific protocols that will be supplied to Provider by case managers or adjustors (depending on the product line being accessed) during or at the time of treatment. PHS and PHS's clients acknowledge that such requested protocols will not be unduly burdensome or extreme beyond the normal course of treatment for Provider's specialty and will not remove Provider's ability to treat Covered Persons using commonly accepted standards of practice.

4.14.1 Provider Manual Updates. Provider understands and acknowledges that the *Provider Manual* is an ongoing extension of the Agreement and is considered part of this Booklet's terms and conditions. Further, the *Provider Manual* may be updated periodically to advise Provider of any alterations or additions to specific products or programs offered by PHS.

4.15 Records. Provider must maintain health care, financial and administrative records concerning services provided to Covered Persons that Provider would maintain in the normal course of business. Such records must be retained by Provider for at least seven (7) years, or such other period required by Applicable Law, from the date the service was provided or termination of the Agreement, whichever occurs first. When payments are due to Provider for services rendered to a Covered Person, Provider must maintain and make the Covered Person's medical records available to PHS and/or Payor for the purpose of determining, on a concurrent or retrospective basis, the compensability, medical necessity and appropriateness of the care provided. Medical records must also be made available to appropriate federal and state authorities and their agents, including but not limited to when they are assessing the accessibility, availability, or quality of care or investigating member grievances or complaints. Provider must comply with PHS's confidentiality requirements as well as applicable state and federal laws related

to privacy and confidentiality of medical records, including but not limited to any such laws required by the state Department of Insurance, Division of Insurance, or Department of Health (as applicable in Provider's state). PHS, Payor, and Provider agree that medical records will be treated as confidential and will be retained so as to comply with all Applicable Law, including the Health Insurance Portability and Accountability Act (HIPAA) and any regulations regarding the confidentiality and retention of patient records. PHS, Payor, and any applicable federal or state authority, department, or commissioner have the right to review records related to services provided to Covered Persons, upon reasonable notice, during regular business hours. Provider agrees to obtain any necessary release or consent from Covered Persons with respect to PHS and Payor's review of their records. Notwithstanding termination of the Agreement or termination of Provider's participation in any Payor Program for any reason, access to records as set forth in this section will survive the termination of the Agreement and any Payor Program.

4.16 Confidential and Proprietary Information. Where a Party discloses Confidential and Proprietary Information to the other Party, the disclosing Party at all times owns such information disclosed by it. The receiving Party must use its best efforts, consistent with the manner in which it protects its own Confidential and Proprietary Information, to preserve the confidentiality of any information that it knows or reasonably should know that the disclosing Party deems to be Confidential and Proprietary Information. Neither Party may use for its own benefit or disclose to third parties any Confidential and Proprietary Information of the other Party without the other Party's prior written consent, except as required by Applicable Law or court order.

4.17 Trademarks and Copyrights. Neither Party may use the other's name, symbol, trademark, or service mark in promotional materials or otherwise without the prior written consent of the other Party unless agreed to in this document. Each Party hereby grants the other Party the right to use its name, address and telephone number in connection with their obligations hereunder, including provider directories, notices, and listings.

5.0 PROVIDER FEES AND COMPENSATION:

5.1 Provider Fees and Compensation. Provider will be compensated by Payor or its agent for Covered Services provided to Covered Persons in accordance with the "Provider Reimbursement" provision of the Agreement. In all cases, PHS will not be responsible for Provider's compensation, up to and including any state penalties accrued during payment resolutions.

5.2 Hold Harmless/No Recourse Against Covered Persons. Payment for Covered Services will come from Payors participating with PHS to utilize the PHS Network for the various product offerings detailed in this Booklet. Provider hereby agrees that under no circumstance, including but not limited to nonpayment, a Payor's insolvency, or breach of the Agreement, will Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement for Covered Services from, or have any recourse against, a Covered Person receiving authorized and Covered Services or any other person who may be acting on a Covered Person's behalf, other than Payor. However, for group health and first party auto medical liability products, Provider may collect co-payments and/or deductibles as may be appropriate for the particular product or program being accessed and as may be indicated by the identification card presented. For workers' compensation medical services or treatment, Provider (or its agent, servant, employee, assignee, employer, or independent contractor acting on behalf of Provider) shall not knowingly collect, attempt to collect, coerce, or attempt to coerce, directly or indirectly, the payment of any charge for services covered by a workers' compensation insurance plan for treatment of a work-related injury or occupational disease, in excess of that provided by the applicable reimbursement schedule, or cause the credit of any employee to be impaired by reason of the employee's failure or refusal to pay the excess charge. Provider must not collect or attempt to collect from an injured worker: (i) payment for treatment or services provided by Provider and determined not Medically Necessary or not in accordance with established clinical protocols, or (ii) a financial penalty imposed upon Provider for failure to abide by precertification requirements or any other case management or utilization review requirement. The terms of this section 5.2 will survive termination of the Agreement.

6.0 INSURANCE AND NOTICE OF CLAIMS:

6.1 Provider's Professional Liability Insurance. Provider agrees to maintain, at Provider's sole cost and expense, adequate professional liability and malpractice coverage through insurance, self-funding, or other means acceptable to PHS, insuring Provider and his/her employees for damages related to the provision of, or failure to provide, services to Covered Persons. Provider's professional malpractice coverage limits must be no less than $500,000 for an occurrence of professional negligence, or in such other amount and type as is required by Applicable Law. Provider must notify PHS within ten (10) days of Provider's knowledge or receipt of notice of any suspension, cancellation, or reduction in such coverage. Provider agrees that any associated health professional with whom he/she/it contracts will maintain the professional liability coverage required by PHS for that class of provider.

6.2 Notice of Claims. Provider agrees to notify PHS immediately of the filing of any claim by any Covered Person against Provider, or other person for whose acts or omissions Provider is responsible, or of any pending claim or incident that may give rise to such claim with respect to any Covered Person. Provider agrees to provide PHS with any information that is requested by PHS related to any such claim.

7.0 TERM AND TERMINATION:

7.1 Term and Renewal. The Agreement will commence on the date executed by PHS and its initial term will continue in effect until the next December 31. Thereafter, the Agreement and all Payor Programs then in effect will be automatically renewed for successive one-year terms ending December 31 of each year. Subject to Provider's obligations to continue to provide services (see §7.4 of this Booklet), either Provider or PHS may, without cause, terminate the Agreement at any time upon no less than ninety (90) days prior written notice (unless Applicable Law requires a shorter timeframe for provider termination notices), which notice will be effective on the ninetieth (90th) day after notice is given. Subject to Provider's obligations to continue to provide services according to section 7.4 below, the termination of the Agreement will terminate Provider's participation in all Payor Programs.

7.2 Termination Upon Breach. The Agreement or Provider's participation in a Payor Program may be terminated by either Party by giving thirty (30) days prior written notice to the other Party of a material breach of either the Agreement or the applicable policies and procedures referenced in this Booklet. If the other Party fails to cure the breach prior to the expiration of the thirty (30) day notice period, the termination will be effective on the date stated in the notice.

7.3 Immediate Termination or Suspension. PHS may immediately suspend or terminate the Agreement upon notice to Provider in the case of any of the following:

(a) suspension or revocation of Provider's license to practice medicine;
(b) suspension or revocation of Provider's DEA number or right to prescribe controlled substances;
(c) Provider's indictment, arrest or conviction of a felony or of any criminal charge related to the practice of his/her profession or business;
(d) cancellation or term of professional liability insurance, without obtaining replacement coverage;
(e) termination or suspension of privileges at any hospital where Provider has admitting privileges;
(f) PHS determines that immediate termination is in the best medical interests of Covered Persons.

7.4 Continuation of Services and Continuity of Care. Nothing in this Booklet will be construed as permitting Provider to abandon any Covered Person or patient. Upon termination of the Agreement or participation in a Payor Program, other than for quality of care or fraud, Provider will remain obligated to furnish Covered Services to any Covered Person until their active course of treatment is completed or until their discharge from an inpatient facility (whichever time is greater), in accordance with the terms and conditions of this Booklet and the Agreement (including compensation terms), or as otherwise provided by Applicable Law or regulation. Provider further acknowledges and agrees that PHS must honor its commitments to offer Covered Services through the Payor Program's term. Therefore, at PHS's option, if the Agreement or Provider's participation in a Payor Program is terminated, Provider will remain obligated to furnish Covered Services to any Covered Person for six (6) months from the termination's effective date in accordance with this Booklet, the Agreement (including compensation terms), and as required by the applicable Payor Program. In the case of a pregnant woman, Provider must continue to provide services through the end of the post-partum period. This section 7.4 will survive the Agreement's termination regardless of the cause giving rise to termination.

8.0 AMENDMENTS: The Agreement may be amended only by written agreement of the Parties. However, PHS reserves the right, as detailed in section 4.14.1 above, to amend and alter product offerings of the Agreement by updating the Provider Manual (a copy of which must be sent to Provider's attention). After reviewing the Provider Manual, Provider may contest any such changes in writing within thirty (30) days of receipt. If not contested, changes will be effective for product offerings and Provider thirty (30) days following his/her receipt. Notwithstanding the foregoing, PHS may amend the Agreement or Booklet to comply with Applicable Law.

9.0 GRIEVANCE PROCEDURES: PHS has expeditious, informal procedures to resolve Covered Person or Provider grievances related to the rendition of medical services or claim disputes. A grievance is made when a Covered Person or Provider delivers a written complaint or written request to PHS setting forth the nature of the complaint and remedial action requested. Covered Person or Provider must file a grievance within thirty (30) days of the occurrence of the event giving rise to the dispute. PHS will render a written decision within 30 days of its receipt of the grievance. Provider and PHS agree to attempt in good faith to promptly and informally resolve the dispute first by engaging in detailed communications and making diligent attempts to reach an amicable resolution. Where alternate means of dispute resolution are later elected, including arbitration and mediation, final resolution will not be subject to the time constraints set forth above. PHS will maintain records for two years of each formal grievance, or as otherwise required by Applicable Law. For additional information or assistance with these grievance procedures, PHS's customer service and support staff is available toll-free at (866)348-3887.

9.1 Patient Grievances. Covered Persons may file grievances if they perceive quality of care issues or

improper billing practices, which may be submitted via customerservice@primehealthservices.com or to PHS by mail. In all cases involving urgent treatment issues, resolution mechanisms will include procedures to expedite those issues and prevent undue delay. Provider will not be penalized for acting as an advocate or on behalf of a patient who is seeking Medically Necessary health care services.

9.2 Claim Disputes. PHS's Repricing and Reconsiderations Department works with clients on behalf of Participating Providers to resolve claim disputes resulting from the application of a PHS network reduction. To dispute the application of a network discount or appeal the decision on a claim if Provider is still dissatisfied, Provider must submit all of the following to PHS's Repricing and Reconsiderations Department: (i) a copy of the EOB; (ii) the corresponding claim form; (iii) a brief explanation of the dispute or appeal; and (iv) the contact person handling the dispute. Provider may submit disputes and appeals to PHS via fax at (615)329-4411 or via e-mail at claimdisputes@primehealthservices.com.

10.0 GENERAL PROVISIONS:

10.1 Assignment. The Agreement, being intended to secure the personal services of Provider, must not in any manner be assigned, delegated, or transferred by Provider without PHS's prior written consent. PHS may assign the Agreement, now or in the future, to any entity that controls, is controlled by, or that is under common control with PHS or operating under a mutual agreement with PHS, including other networks, Payors, TPAs, workers' compensation insurers or self-insureds (e.g., to pay Provider's contracted rate). In the event of PHS's bankruptcy or insolvency and at a Payor's request, PHS may assign and delegate PHS's rights and obligations under the Agreement for the applicable Payor Program to Payor.

10.2 Non-Exclusive Agreement. Nothing in the Agreement will prevent Payor, PHS, or Provider from participating in or contracting with any other Payor, employer, insurer, preferred provider organization, health maintenance organization, or other alternative health delivery or insurance program.

10.3 Independent Contractors. None of the provisions in the Agreement or in this Booklet are intended to create any relationship between PHS, Payor, and Provider other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of the Agreement. Neither Party, nor any of its officers, directors, or employees, will be construed to be the agent, employee, or representative of the other Party. PHS, Payor, and Provider are not authorized to speak on behalf of the other Party for any purpose whatsoever without the other Party's prior written consent.

10.4 Entire Agreement. The Agreement and its amendments and the corresponding terms of this Booklet constitute the entire understanding and agreement of the Parties and supersedes any prior written or oral agreement pertaining to the subject matter of the Agreement.

10.5 Interpretation. In the event of a conflict between language of the Agreement or terms in the Booklet and any Payor Program, PHS reserves the right to resolve such differences regarding terms applicable to that Payor Program. Provider agrees to work with and accept such determination of PHS in such cases.

10.6 Arbitration. Any controversy or claim between the Parties arising out of or relating to the Agreement must be settled in accordance with Commercial Arbitration Rules of the American Arbitration Association (unless there are state mandated arbitration procedures that are required for the particular product line or required for the specific type of dispute at issue). Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. Notwithstanding a dispute arising under the Agreement, each Party must continue to perform obligations hereunder pending the arbitrator's decision. This section 10.6 will survive termination of the Agreement.

10.7 Successors. The Agreement and terms of this Booklet will be binding on the Parties and their respective successors and assigns.

10.8 Counterparts. The Agreement may be executed in two or more counterparts, each of which when executed and delivered will be an original, and all of which together will constitute one and the same Agreement.

10.9 Severability. If any provision of the Agreement or this Booklet is held to be invalid, illegal, unenforceable or in conflict with the law of any jurisdiction, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

10.10 Waiver. No covenant, condition, or undertaking in the Agreement or Booklet may be waived except by the written agreement of the Parties. Forbearance or indulgence in any other form by either Party in regard to any covenant, condition, or undertaking to be kept or performed by the other Party will not constitute a waiver thereof.

10.11 National Provider ID Number. Provider hereby agrees to supply an NPI number with the Agreement.

PRIME HEALTH SERVICES
CREDENTIALING POLICY GUIDELINES

PURPOSE: To implement a systematic and consistent process to evaluate providers and to establish guidelines for credentialing in accordance with URAC standards.

POLICY: The Prime Health Services Credentialing Committee is responsible for credentialing and recredentialing all providers every 3 years, unless otherwise required by Applicable Law.

Completed credentialing will consist of the following:

- Primary verification of current valid state Medical license;
- Review of past or current state sanctions, restrictions on licensure and/or limitations on scope of practice by query of the State Medical Boards;
- Primary verification of clinical privileges from admitting facilities;
- Verification of Board Certification (or residency if not Board certified);
- Review of work history by application or Curriculum Vitae (CV);
- Query of Inspector General's Office for Medicaid/Medicare sanctions;
- Query of National Practitioner Data Bank;
- Primary verification of ECFMG if not Board certified;
- Primary verification of adequate malpractice insurance and malpractice history;
- Review and approval of individual provider files by the Prime Health Services Credentialing Committee.
- Such other items as may be required by URAC standards as updated from time to time.

Verification of medical license, DEA, and malpractice insurance will be conducted on an ongoing basis. Providers who do not maintain admitting privileges will be covered by their respective partners and/or an intensivist at the discretion of the Prime Health Services Credentialing Committee.

Participating Provider Roster

(Complete *only* for "Group Practices" or "Ancillary Organizations")

Group(s) Name(s):	Specialty(ies)	Physical Address/Phone	CAQH # (Re-attested within 4 months)	County	Group NPI#	TIN#
(List all Groups to be included under this Provider Participation Agreement)						
Provider Name(s):	**Specialty(ies)**	**Physical Address/Phone**	**CAQH # (Re-attested within 4 months)**	**County**	**Individual NPI#**	**TIN#**
(List all Providers to be included under this Provider Participation Agreement)						