***Provider Agreement Terms & Conditions Booklet* accompanies the *Provider Participation Agreement*.**

Provider Participation Agreement Terms & Conditions Booklet

www.primehealthservices.com

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Provider Participation Agreement Terms & Conditions Booklet - Version 15.1
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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 a WTC Health Program Nationwide Provider Network and/or any other applicable state or federal laws, rules, or regulations, including HIPAA.

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 **"Covered Person"** means a WTC Health Program Nationwide Provider Network survivor, screening-eligible survivor, and certified survivor or certified-eligible survivor; and all enrolled responders whether certified or not.

1.4 **"Covered Services"** means medical services and/or supplies to which Covered Persons are entitled by the terms and conditions of the WTC Health Program Nationwide Provider Network under which they are covered or enrolled.

1.5 **"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.

1.6 **"Medically Necessary"** means the services provided to a WTC Health Program Nationwide Provider Network Covered Person by physicians and other health care providers, including diagnostic and laboratory tests, prescription drugs, inpatient and outpatient hospital services, and other care that is appropriate, to manage, ameliorate, or cure a World Trade Center related health condition or a health condition medically associated with a World Trade Center related health condition, and which conforms to medical treatment protocols developed by the Data Centers, with input from the WTC Health Program Nationwide Provider Network, and approved by CDC/NIOSH and any governing body. 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.

1.7 **"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.

1.8 **"Participating Provider"** means a primary care physician, specialist physician, ancillary provider, or any other health care provider or facility 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.

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

1.10 **"Payor"** means the entity financially responsible for payment of medical benefits and claims for Covered Persons under the WTC Health Program Nationwide Provider Network.

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

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

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) notify PHS in writing within 30 days of any change in Provider address/location, name, tax ID, or ownership and any addition or deletion of names or professionals subject to this Agreement;
(b) 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;
(c) 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;
(d) 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;
(e) follow instructions and protocols, including those in PHS's Provider Manual or those supplied by PHS, Payor, or case managers or adjustors at the time of treatment (where applicable);
(f) notify PHS sixty (60) days prior to the closing of his/her/its practice or facilities to new patients;
(g) submit any reports per the designated schedule for Payors 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;
(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.

2.2 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 its provision of 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 UB-04 or 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 45 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., workers' compensation 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:

4.1 **World Trade Center (WTC) Health Program Nationwide Provider Network.** Covered Persons accessing the PHS Network for WTC Health Program Nationwide Provider Network services will be identified upon payment on the accompanying EOB. 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.

Provisions of Care: Covered Services will be rendered to a Covered Person in the most cost-effective manner and in the least costly setting while rendering the highest quality of care required for the appropriate treatment of the condition for which treatment is required. In some instances, services may require preauthorization from the WTC Health Program Nationwide Provider Network governing body, CDC/NIOSH.

Limited Care Benefit Program: The WTC Health Program Nationwide Provider Network is a limited care benefit program established by the James Zadroga 9/11 Health and Compensation Act of 2010 (the Act), Pub. L. 111-347, as amended. 42 U.S.C. §§ 300mm – 300mm-61. It provides monitoring and treatment for a specified list of health conditions established by law. Care provided in the WTC Health Program Nationwide Provider Network must adhere to Applicable Law governing the protocols, policies, and procedures established by the Payor Program.

Statutory and Regulatory Compliance: Provider agrees to comply with all Applicable Law related to the Payor Program and the James Zadroga Health and Compensation Act.

Authorization of Services: All services rendered by a provider must be preauthorized in accordance with WTC Health Program Nationwide Provider Network requirements.

Standard for Determining Medical Necessity: The WTC Health Program provides medically necessary monitoring and treatment for certified WTC-related health conditions. The Program also covers medically associated conditions, which are conditions that result from the treatment or progression of a certified condition.

To be covered by the Program, a condition must be certified by the WTC Health Program and treated through

a Program-affiliated provider. Certification is an official decision by the Program that a condition is related to a 9/11 exposure and meets Program certification policies and criteria (https://www.cdc.gov/wtc/conditions.html). Provider acknowledges and agrees that all Medically Necessary services or diagnostic testing rendered to a WTC Health Program Nationwide Provider Network Covered Person must adhere to a standard that: (i) is reasonable and appropriate, as based on scientific evidence and professional standards of care, including but not limited to National Comprehensive Cancer Network (NCCN) guidelines for cancer services and expert opinion or any other relevant information; and (ii) has been included in the medical treatment protocols developed or promulgated by the WTC Health Program Nationwide Provider Network.

Review of Claims for Reimbursement of Medically Necessary Treatment: The WTC Health Program Nationwide Provider Network and its clients will review each claim for reimbursement of treatment or services rendered to a Covered Person. If PHS or its clients determine that such treatment is not Medically Necessary, or not otherwise eligible for reimbursement under the Payor Program, Provider will not be entitled to reimbursement. Provider shall be responsible for providing to the Payor Program all consult reports, legible progress notes, and test results, and any other requested medical records or documentation necessary to adjudicate claims and determine eligibility for reimbursement. The Payor Program has an appeal process for denied claims.

Coordination of Benefits (COB): Covered Persons who are deemed eligible for benefits under the WTC Health Program Nationwide Provider Network are classified under one of the following membership groups:

(1) Fire Department of New York (FDNY) responders and surviving FDNY family members,
(2) general responders,
(3) survivors, and
(4) Pentagon and Shanksville, Pennsylvania responders.

For survivors, Provider is required to submit claims to the Covered Person's private and/or public insurance before submitting the claim to the Payor Program. Provider must also send the insurer's EOB to the Payor Program along with the claim. **For Survivors, the WTC Health Program is the payor of last resort with no out of pocket fees, copays, deductibles, or balance billing to the Survivor member**. For responders (FDNY, general, and Pentagon and Shanksville), the Payor Program is the primary payer, although costs may be recouped by the Payor directly from a workers' compensation insurer when applicable. Please visit the Program Administrative Manual at https://www.cdc.gov/wtc/ppm.html for more information about member eligibility and COB.

4.2 **Covered Person Verification.** PHS and/or Payor will furnish a telephone number for use by Provider when an individual is seeking treatment under a 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 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.

4.3 **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.

4.4 **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.

4.5 **Provider Manual.** Provider acknowledges that PHS represents clients that cover a variety of Payor models (primarily TPAs and insurance companies). 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.

4.5.1 **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.

4.6 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 or 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.

4.7 Confidential and Proprietary Information. "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.

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.

4.8 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 penalties accrued during payment resolutions.

5.2 Hold Harmless/No Recourse Against Covered Persons/No Balance Billing. Payment for Covered Services will come from Payors participating with PHS to utilize the PHS Network for the WTC Health Program Nationwide Provider Network. 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, impose a surcharge on, seek compensation, remuneration or reimbursement for Covered Services from, or have any recourse against, a WTC Health Program Nationwide Provider Network Covered Person receiving Covered Services or any other person who may be acting on a Covered Person's behalf, other than Payor. Provider (or its agent, 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 WTC Health Program Nationwide Provider Network in excess of that provided by the applicable reimbursement schedule or cause the credit of any Covered Person to be impaired by reason of the failure to pay the excess charge. Provider must not collect or attempt to collect from a Covered Person: (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. Provider will accept WTC Health Program Nationwide Provider Network reimbursement terms as payment in full for treatment and services rendered to a Covered Person under the WTC Health Program Nationwide Provider Network. Provider will not bill or collect from a WTC Health Program Nationwide Provider Network

member any deductibles, coinsurance, or copayments. The terms of this section 5.2 will survive termination of the Agreement.

5.3 **Liability for Claims Decisions and Reimbursement.** Provider acknowledges and agrees that reimbursement under the WTC Health Program Nationwide Provider Network is subject to the James Zadroga 9/11 Health and Compensation Act and the discretion of the administrator of the Payor Program. Provider shall not be entitled to reimbursement for services from the Payor Program if the Provider fails to abide by the terms and conditions of this Agreement, the Act, or program regulations, protocols, policies, and procedures. In no event shall Provider seek payment of claims from the PHS Network as PHS is not responsible for payment under the Payor Program and shall not be held liable for any claims decisions or the payment of any claims submitted by Provider for services rendered to a WTC Health Program Nationwide Provider Network Covered Person.

6.0 INSURANCE AND NOTICE OF CLAIMS:

6.1 **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 its 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 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. 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. 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 4.5.1 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 email 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, 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.

Provider acknowledges and agrees that PHS has the right, at PHS's discretion, to lease the PHS Network, of which Provider is a part pursuant to this Agreement, to other entities and/or to enter into agreements with other entities under which such entities, employers, subscribers, members, insureds and/or members shall be entitled to some or all of the rights/benefits/obligations of this Agreement, as solely determined by PHS.

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

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 mandated arbitration procedures 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 **Counterparts, Severability, and Waiver.** 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. 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. 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.

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.