PROVIDER PARTICIPATION AGREEMENT

THIS PROVIDER PARTICIPATION AGREEMENT ("Agreement") is by and between **Prime Health Services, Inc.** ("PHS"), a Tennessee corporation, and **Provider** (listed below and hereinafter "Provider"), duly licensed to practice medicine and/or operate under the laws of Provider's state of practice, as signatories listed below. The Agreement will be effective on the date executed by Provider.

WHEREAS PHS contracts with providers and medical facilities in various states to offer its clients access to provider services as part of its Preferred Provider Network ("PHS Network"); and

WHEREAS Provider is contracting with PHS to participate in the PHS Network and to assist PHS in promoting Provider's services for all product offerings offered by PHS (unless otherwise agreed) that are described in the Provider Agreement Terms & Conditions Booklet (the "Booklet"); and **THEREFORE, AND IN CONSIDERATION** of the foregoing promises, mutual covenants, and agreements as set forth herein, PHS and Provider agree to the following terms and conditions:

1. **Provider Reimbursement Rates** (for all applicable Payor Programs)**:** Provider agrees to accept reimbursement for Covered Services rendered to Covered Persons at the following rates for each of the product lines described in §4.0 of the Booklet:

   Automobile Liability: the lesser of 90% of the Billed Charge, 100% of the current Medicare fee schedule, or 90% of any maximum allowable rate specified by federal or state fee schedule or law or usual and customary rate.

2. **Optional Program Rates:** (To opt in to the following programs, you must initial the line provided.)

   _____**Personal Injury:** For Covered Services rendered to Covered Persons related to a personal injury claim (see §4.0 of the Booklet), Provider agrees to accept the following reimbursement rate: 20% of the Billed Charge.

   _____ **Independent Medical Examination (IME):** Provider will be paid a flat rate of $700.00 per IME (see §4.0 of the Booklet).

3. **Standard Terms and Conditions:** The terms and conditions of the Booklet are incorporated herein by reference and apply to this Agreement. If Provider does not have a copy of the Booklet, **Provider's may go to www.primehealthservices.com for a copy of the Booklet.** Provider must log in to the site to review PHS's Client Directory, as it may change periodically. Any capitalized term not defined herein shall have the meaning given such term in the Booklet.

4. **Execution:** All providers using the federal TIN or NPI number indicated below are subject to the terms of this Agreement. The signatories to this Agreement have read this document and the accompanying Booklet in full and agree with the terms set forth.

IN WITNESS WHEREOF, this Agreement and the *Provider Agreement Terms & Conditions Booklet* (referenced herein and additionally available at www.primehealthservices.com) are hereby executed by the following signatories, who represent and warrant that they have the authority to bind the respective parties under this Agreement and under the terms and conditions in the Booklet:

For Prime Health Services:

By: _____ Officer: Jenifer Mariencheck, VP of Network Development **Date**: _____
331 Mallory Station Rd., Franklin, TN 37067 **Phone:** (615) 329-4098 or (866) 348-3887 contracting@primehealthservices.com

For Provider: By signing on behalf of a corporation, partnership, facility, group practice, or other legal entity, I hereby certify that (i) I have *full authority* to bind each individual member of such entity listed here (or on "Participating Provider Roster" attached or on any provider roster or provider TIN listing submitted by Provider, as may be modified periodically following execution of this Agreement); and (ii) contracted rates will apply to all practitioners submitting claims under the stated entity and contracted rates will apply to all practitioners billing with the tax ID number or NPI number provided below.

Printed Name: _____ **Signature:** _____

Date Signed: _____ **Title:** _____ **TAX ID#:** _____

Show in Database as: _____ **NPI#:**_____ **CAQH#:** _____

Legal Entity Name on W-9: _____ **Phone:**_____

Address: _____ **City:** _____ **State:**_____ **Zip:** _____

Specialty 1: _____ **Specialty 2:** _____

Email (required):_____ **Social Media (if available):** _____

PLEASE NOTE: *Please be sure to update us if any of the above contact information changes. Provider agrees to receive notices and newsletters from PHS.*

Please see the Provider Agreement Terms & Conditions Booklet for sections referenced above.

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

Provider Participation Agreement Terms & Conditions Booklet

www.primehealthservices.com

331 Mallory Station Rd. Franklin, TN 37067

Provider Participation Agreement Terms & Conditions Booklet - Version 15.3
(updated 05/06/2025)

This **Provider Agreement Terms & Conditions Booklet** (the "Booklet") accompanies the Provider Participation Agreement and contains the details relevant to the relationship between Provider and Prime Health Services, Inc. ("PHS") and the various product offerings for which Provider has 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 to be fully informed of the specific expectations of the Provider Participation Agreement and maintain a copy of this Booklet for future reference. **Please periodically log in 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 PHS on X @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. For questions or concerns regarding the following terms, PHS will be happy to assist at our toll-free telephone number at 1-866-348-3887 or via our website at https://primehealthservices.com/contact/.

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 Covered Services and any other applicable state or federal laws, rules, or regulations applicable to the terms in this Booklet or the Agreement.

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

1.3 **"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.

1.4 **"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, rates, 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.

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

1.6 **"Covered Services"** means services for automobile liability, state no-fault benefits, personal injury, general liability, casualty, federal programs, or additional network products and services offered by PHS, which Covered Persons are entitled to receive through Participating Providers according to Applicable Law and under the terms in this Booklet.

1.7 **"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 an individual's health (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.

1.8 **"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 in and offer access to certain other programs offered by or through PHS whereby benefits of such programs would be paid for by employees.

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

(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.

1.10 **"Medically Necessary"** means 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.

1.11 **"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.

1.12 **"Participating Provider"** means a Primary Care Physician, Specialist Physician, ancillary provider, or any other health care provider or facility 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.

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

1.14 **"Payor"** means the entity financially responsible for paying claims, which may include, but is not limited to, one of the following: an insurance company or other paying entity that underwrites or makes payments for Covered Services under a benefit program for first party auto medical liability, no fault benefits, third party auto medical liability, personal injury, general liability, casualty, or additional network services offered by PHS or a benefit program on behalf of Covered Persons.

1.15 **"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.

1.16 **"Primary Care Physician"** means a physician credentialed by PHS or its delegate 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 the practice of medicine for at least two years to general practice, internal medicine, pediatrics, family medicine, or occupational medicine.

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

2.0 PARTICIPATING PROVIDER RESPONSIBILITIES AND SERVICES:

2.1 Provider Services. Participating Provider agrees to:
(a) provide Covered Persons with Covered Services in Provider's 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 twenty-four (24) hours per day, seven (7) 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 Provider's practice or facility to new patients;
(f) submit any other reports per the designated schedule for Employers requesting such service;
(g) provide or arrange for non-urgent services within seven (7) days of the request for such services and make subsequent referrals on a timely basis;
(h) make referrals for required specialty care within forty-eight (48) hours of the identification of such need;
(i) 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
(j) 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 Provider's 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. Provider acknowledges and agrees that:
(a) Provider will be solely responsible for the medical care and 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 the professional responsibility to provide appropriate medical care to Covered Persons.

2.3 Covered Person Verification. Provider must verify that the individual is a Covered Person and the services to be provided are Covered Services. PHS 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 if 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. Provider must notify the patient in writing where it is determined that the services are not Covered Services or that the individual is not a Covered Person.

2.4 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 reasonable 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.

2.5 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 Provider's absence or unavailability. However, where another Participating Provider is not available, Provider must use reasonable 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.

2.6 **Timely Response.** 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 five (5) business days) 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.

2.7 **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, status as a protected veteran, genetic information or history, English proficiency or reading skills, source of payment for the services rendered, or other impermissible ground under Applicable Law. Provider must observe, protect, and promote the rights of Covered Persons or Enrollees as patients and provide treatment equal to that of other patients, including respect, dignity, and consideration for their privacy.

2.8 **National Provider ID Number.** Provider agrees to supply an NPI number with the Agreement.

3.0 PHS AND PROVIDER RESPONSIBILITIES:

3.1 **Credentialing Services.** PHS or its delegate credentials Participating Providers in accordance with PHS's policies and procedures. 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 or location.

Credentialing by PHS or its delegate may include, but is not limited to, the following:

(a) primary verification of current valid state medical license;
(b) review of past or current state sanctions, restrictions on licensure and/or limitations on scope of practice by query of the State Medical Boards;
(c) primary verification of clinical privileges from admitting facilities;
(d) verification of Board certification (or residency if not Board certified);
(e) review of work history by application or curriculum vitae (CV);
(f) query of Inspector General's Office for Medicaid/Medicare sanctions;
(g) primary verification of ECFMG if not Board certified;
(h) primary verification of adequate malpractice insurance and malpractice history;
(i) review and approval of provider files by the PHS Credentialing Committee; and
(j) other items as may be required by URAC (or other similar) 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 or an intensivist at the discretion of the PHS Credentialing Committee.

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 reasonable 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 all of 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 ninety (90) 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 thirty (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 thirty (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 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;
(h) Under no circumstance will Provider be reimbursed above 100% of any fee schedule (e.g., 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.
(j) Provider must submit any claim or bill reconsiderations within 180 days of Provider's initial submission.

3.4 Underpayments/Overpayments. In the event PHS or Payor determines that payment for services rendered has been made in error, Provider will be directly responsible for return of the payment, in part or in whole, to Payor upon written notice by PHS or Payor, so long as such notice is within one (1) year from the date of service. Likewise, if payment for services rendered has resulted in an underpayment to Provider, Payor will be directly responsible for additional payment upon written notice by Provider to Payor, so long as such notice is within one (1) year from the date of service.

4.0 <u>COVERED SERVICES, PRODUCTS, AND IDENTIFICATION</u>: Provider acknowledges that PHS will market Provider's services to PHS clients through a variety of product offerings, which include the following:

4.1 Automobile Liability. Automobile 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 auto liability; and
(c) third party auto liability; and
(d) auto casualty and liability

4.2 Personal Injury. Personal injury claims include, but are not limited to, a Covered Person's physical or emotional injuries caused by another individual or entity. Most of these services are non-directed upon the initial injury. In these cases, access to the provider network will be clearly identified on the EOB accompanying the payment to Provider. In many cases, the Payor is a finance company that provides funding for the personal injury claims.

4.2.1 Personal Injury Assignment of Lien and/or Security Interest. Upon receipt of payment from a Payor for Covered Services rendered to a Covered Person related to a personal injury claim, Provider assigns, and is deemed to have assigned, its right to payment of all billed charges and all other amounts payable in connection with, on account of, or arising out of, such Covered Services, as well as Provider's right, title, and interest to all liens or security interests subject thereto, to such Payor.

4.3 **Independent Medical Examination (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) minor office tests (e.g., x-ray or blood work, as Provider deems necessary);
(d) producing a written report of findings

The case rate does not include deposition costs or litigation testimony. Provider will make reasonable efforts to supply testimony if it is necessary, and 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.

4.4 **Telemedicine.** The PHS Network includes Participating Providers that render certain Covered 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 (e.g., two-way video and email). Provider agrees that the Agreement applies to Covered Services provided to Covered Persons via telemedicine.

4.5 **Metrics.** Provider acknowledges that PHS clients may require PHS to conduct metric analyses comparing one provider to another provider in the PHS Network or outside the network.

4.6 **Other PHS Network Programs.** New or updated product offerings and programs will, at a minimum, be published on PHS's website or in a mailing from PHS or PHS client, described in the Provider Manual, or identified upon receipt of the Explanation of Benefits noting that payment was processed accessing the PHS Network relationship. If Provider chooses to be removed from participation in any new or existing PHS product or program, Provider will submit written notice to PHS and such product or program will be terminated pursuant to section 7.0 of this Booklet.

4.7 **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.

4.8 **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.

4.9 **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 continued 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.

4.10 **Provider Manual.** PHS clients 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 Provider after execution of the Agreement. In some instances, PHS clients develop specific protocols to be used with patients. In most cases, such protocols will be supplied at the time of treatment. Additionally, case management may require specific protocols to be supplied to Provider by

case managers or adjustors (depending on the product line being accessed) during or at the time of treatment. Such requested protocols shall 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.

4.10.1 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.

4.11 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. 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 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 advance written 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.

4.12 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 reasonable efforts, consistent with the manner in which it protects its own Confidential and Proprietary Information, to preserve the confidentiality of any information 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.

4.13 Trademarks and Copyrights. Neither Party may use the other Party'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 Payor's agent for Covered Services provided to Covered Persons in accordance with the "Provider Reimbursement" and rate provisions of the Agreement. In all cases, PHS will not be responsible for Provider's compensation, including any disputed amounts or state penalties accrued during payment resolutions.

5.2 No Balance Billing and No Recourse Against Covered Persons/Hold Harmless. Payment for Covered Services will come from Payors utilizing 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 auto medical liability products, Provider may collect co-payments and/or deductibles as may be appropriate for the particular product or program being accessed or as may be indicated by the identification card presented. 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 an insurance plan for treatment in excess of that provided by the applicable reimbursement schedule. Provider must not collect or attempt to collect: (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 will survive termination of the Agreement, regardless of the reason for the termination.

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 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 greater 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 Provider contracts will maintain the professional liability coverage required by PHS or Applicable Law.

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 Provider, and its initial term will continue in effect until December 31st. Thereafter, the Agreement and all Payor Programs then in effect will be automatically renewed for successive one-year terms ending December 31st of each year. Subject to Provider's obligations to continue to provide services pursuant to §7.4 of this Booklet, either Provider or PHS may, without cause (where Applicable Law allows), 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, 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 a right to prescribe controlled substances or DEA number;
(c) Provider's indictment, arrest or conviction of a felony or of any criminal charge related to Provider's practice in the healthcare profession or business;

(d) cancellation or term of professional liability insurance, without obtaining replacement coverage;
(e) termination or suspension of Provider's hospital 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. 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 AND ASSIGNMENT:

8.1 Amendments. The Agreement may be amended only by written agreement of the Parties. However, PHS reserves the right, as detailed in sections 4.13 and 4.17.1 above and unless Applicable Law requires otherwise, to amend and alter product offerings of the Agreement through mailings or by updating the Provider Manual (a copy of which must be sent to Provider's attention). Provider may contest any such changes in writing within thirty (30) days of receipt. If not contested by Provider, the changes will be effective for the product offerings thirty (30) days following Provider's receipt. Notwithstanding the foregoing, PHS may amend the Agreement or Booklet to comply with Applicable Law.

8.2 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, which shall not be unreasonably withheld. 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, automobile 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.

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 thirty (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; however, in all cases Provider must submit all requests for bill or claim reconsiderations within one (1) year of the date of service at issue. PHS will maintain records for at least two (2) 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 to PHS by mail or via email at customerservice@primehealthservices.com. 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 **Non-Exclusive Agreement.** Nothing in the Agreement will prevent Payor, PHS, or Provider from participating or contracting with any other Payor, employer, insurer, provider organization, health maintenance organization, or other alternative health delivery or insurance program.

10.2 **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 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.

10.3 **Entire Agreement, Counterparts, and Interpretation.** The Agreement 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. 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. 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.

10.4 **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 will survive termination of the Agreement.

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

10.6 **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.

10.7 **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.

PARTICIPATING PROVIDER ROSTER:

(Complete for group practices or ancillary organizations.)

Tax ID	Group NPI	Provider NPI	Group Name	Provider Name	CAQH #	Specialty 1	Specialty 2

PRACTICE LOCATION INFORMATION:

Location Address	City	State	Zip	County	Phone	Fax	Email

PRACTICE BILLING INFORMATION:

Billing Address	City	State	Zip	Phone	Fax	Email

PRACTICE CONTACT INFORMATION:

Contact Name	Title	Phone	Email	Fax

To submit provider group demographics via a roster download if you have greater than 10 providers or if you prefer an electronic download, please use the following link: https://bit.ly/primeroster.

Or you may use the web form at https://bit.ly/primerosteronline to submit a provider roster.