



PROVIDER PARTICIPATION AGREEMENT

THIS PROVIDER PARTICIPATION AGREEMENT ("Agreement") shall be 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 their state of practice, as signatories listed below, and shall be effective on the date executed by PHS.

WHEREAS PHS contracts with providers and medical facilities in various states in order 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 (unless otherwise agreed) described in the Provider Agreement Terms & Conditions Booklet ("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:** Provider agrees to accept reimbursement for Covered Services rendered to Covered Persons at the following tiered rates for the product lines described in §3.5 of the Booklet:
Tier I Rates (For all applicable Payor Programs): Provider will be paid the lesser of 75% of the submitted billed charges; 130% of the current Medicare fee schedule; 95% of any maximum allowable rate as specified by state or federal law.
Tier II Rates (For all applicable Payor Programs): Provider will be paid the lesser of 70% of the submitted billed charges; 125% of the current Medicare fee schedule; 90% of any maximum allowable rate as specified by state or federal law.
- 2. Independent Medical Examination (IME) Program:** State fee schedule minus the applicable processing fees (See §3.5.4 of the Booklet for full details) _____ Initial If Agreed
- 3. Medicare & Medicare Advantage Program(s):** Execution of this Agreement obligates you, if eligible to treat such patients, to participate in Medicare Health Plans and Medicare Advantage Programs as described in the Booklet. Reimbursement for these services will be 100% of the then current Medicare Fee Schedule. Not all providers are certified by CMS to participate in such programs (you must have an active Medicare & UPIN Number). If eligible to treat, PHS desires to make you accessible to these clients so that they may access your services. **Please read carefully §3.5.5 of the Booklet and understand your obligations for such programs as these may apply to your practice.**
- 4. Annual Subscription Fee:** (See §8.9 of the Booklet.) Provider agrees to an annual subscription fee. Provider agrees to submit with this Agreement **\$ WAIVED** per physician or ancillary provider, and Provider agrees to remit invoices for such provided annually in subsequent years. (See §8.9 of the Booklet for full terms and conditions regarding this fee.)
- 5. Standard Terms and Conditions:** The Booklet is incorporated into this Agreement by reference and its terms and conditions are non-negotiable in regards to this Agreement and the relationship established between PHS and Provider. If Provider does not have a copy of the Booklet, **it is Provider's responsibility to go to www.primehealthservices.com to access the Booklet by logging into the secure Provider portal.** Provider is also responsible for logging into the site to review PHS's Client Directory as it may change periodically.
- 6. Miscellaneous:** All Providers using the federal TIN indicated below are subject to the terms of this Agreement. The signatories to this Agreement have read this document and the accompanying Booklet completely and agree with the terms set forth in this mutually beneficial relationship.

EXECUTION AND SIGNATURE: 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:

For Prime Health Services, 7110 Crossroads Blvd., Suite 100, Brentwood, TN 37027 (615) 329-4098 or (866) 348-3887			
By: _____	Officer Name: Brian Sharp, President/CEO	Date: 10/31/11	
For Provider: By signing on behalf of a corporation, partnership, facility, group practice or other legal entity, I hereby certify that I have full authority to bind each individual member of such entity listed here (or on "Directory Listing" attached and as may be modified periodically following execution of this Agreement) and that contracted rates will apply to all practitioners submitting claims under the stated entity and billing with the stated Tax Identification Number provided below.			
Printed Name: _____	Signature: _____		
Date Signed: _____	Title: _____		
Show in Database as: _____	NPI# _____		
Address: _____	City: _____	State: _____	Zip: _____
Specialty 1: _____	Specialty 2: _____		
Tax ID#: _____	Phone: _____		
Please Check One: This is an ☐ Individual Agreement ☒ Group Agreement			
Valid Email Address (Required): _____			
PLEASE NOTE: Please be sure to update us should your email address change.			

THIS PAGE CONSTITUTES THE ENTIRE AGREEMENT: Please see the Provider Agreement Terms & Conditions Booklet for sections referenced above.

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



Provider Participation Agreement Terms & Conditions Booklet

www.primehealthservices.com

INTRODUCTION:

This **Provider Agreement Terms & Conditions Booklet** (the "Booklet") accompanies the **Provider Participation Agreement** and contains the details relevant to the relationship established 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 §3.5). 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.**

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 the website at http://primehealthservices.com/contact_us.aspx.

1.0 DEFINITIONS: In order for Provider and PHS to have a common understanding of the reoccurring terminology in this Booklet, please refer to the following definitions:

- 1.1 "Applicable Law"** means applicable Medicare, group health, workers' compensation, or first party auto medical liability laws, rules, or regulations and/or applicable state or federal laws, rules, or regulations.
- 1.2 "Client Directory"** means PHS's client listing, and depending on the state Provider is located in, may be accessed online at the PHS website or through email upon Provider's request.
- 1.3 "Confidential and Proprietary Information"** means certain non-public information disclosed in confidence by one party to the other or its designee including, but not limited to, information concerning a Utilization Review and case management program, credentialing criteria, as well as:
 - (a) patient care and/or finances; marketing information, including but not limited to brochures, leaflets, surveys, and reports; and
 - (b) financial information, including but not limited to earnings, volume of business, pricing methods, systems, practices, and strategic plans; and
 - (c) other commercially valuable information, including, but not limited to mailing lists, client lists, patient lists, programmatic information and structure, and related information and documents.
- 1.4 "Covered Person"** (also referred to herein as "**Enrollee**" in reference to Medicare Enrollees, only where applicable to Medicare) means any employee or insured party who is eligible for, and entitled to receive Covered Services under a Payor Program.
- 1.5 "Covered Services"** means those Medicare, group health, workers' compensation, or first party auto medical liability, or additional network services offered by PHS, which Covered Persons are entitled to receive through Participating Providers according to Applicable Law and as explained under the terms in this Booklet.
- 1.6 "Emergency"** means an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - (a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
 - (b) Serious impairment to bodily functions; or
 - (c) Serious dysfunction of any bodily organ or part.
- 1.7 "Employer"** may mean any one or all of the following:
 - (a) a Payor;
 - (b) an Employer insured on whose behalf a Payor underwrites and makes payments to Covered Persons for Covered Services or benefits;
 - (c) *Additionally, an Employer may participate and offer access to certain other programs*

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offered by or through PHS whereby benefits of such programs would be paid for by employees.

- 1.8 "Management Company"** means a program or company which may provide the following management services:
- (a) a utilization review program ("UR" or "UR Program") that is licensed or otherwise authorized to the extent required in the state of residence to perform UR services, Provider credentialing verification services, third party administration services, and billing and claims processing services; and
 - (b) utilization management or case management services.
- 1.9 "Medically Necessary"** means, unless defined otherwise under state law, the provision of services by a Participating Provider which are:
- (a) consistent with the symptoms, diagnosis and treatment of a Covered Person's illness, disease or medical condition/problem;
 - (b) commonly and customarily recognized in the Participating 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.
- 1.10 "Participating Hospital"** means a Participating Hospital that:
- (a) is licensed to the extent required in the state of residence to practice or otherwise provide health care services; and
 - (b) has entered into an agreement with PHS to provide Covered Services to Covered Persons.
- 1.11 "Participating Physician"** means a physician duly licensed to practice medicine in the state of residence who:
- (a) has entered into an agreement with PHS to provide Covered Services to Covered Persons; 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; and
 - (c) has been credentialed either by PHS or its delegates as a Primary Care Physician or a Specialist Physician.
- 1.12 "Participating Provider"** means a Primary Care Physician, Specialist Physician, Ancillary Provider, or any other health care provider that:
- (a) is licensed to the extent required in the state of residence to practice their profession or otherwise to provide health care services; and
 - (b) entered into an agreement with PHS 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 a third-party payor, which is one of the following: an Employer that is self-funded for group health or workers' compensation benefits to its employees; an insurance company that underwrites and makes payments for Covered Persons under a group health, workers' compensation, Medicare Health Plan, Medicare Supplemental Plan, or first party auto medical liability benefit program; or federal, state, or municipal governments administering referrals on behalf of Covered Persons eligible for care under the terms of this Booklet; or under such additional network services offered by PHS or 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; and those billing and claims processing, and other services to be provided by PHS.
- 1.16 "Primary Care Physician"** means a Participating Physician who has been Credentialed by PHS, or its delegates, to serve as a Primary Care Physician, and who either:

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- (a) for at least 50% of the time in which he or she engages in the practice of medicine, supervises, coordinates and provides initial and basic care to patients, initiates their referral for specialist medical services, and maintains continuity of patient care; or
- (b) has limited his or her practice of medicine for at least two years prior to contracting to general practice, internal medicine, pediatrics, family medicine, or occupational medicine; or
- (c) has been designated as a Primary Care Physician.

1.17 "Specialist Physician" means a Participating Physician who:

- (a) engages in the practice of one or more medical specialties other than those referred to in Section 1.16 above; and
- (b) has been credentialed by PHS, or its delegates, as a Specialist Physician in one or more designated medical specialties.

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

2.0 PARTICIPATING PROVIDER SERVICES: The following section contains details regarding the expectations of the PHS and PHS's client(s) on you as the Provider.

2.1 Primary Care Physician Services. A Provider credentialed by PHS or its delegates to serve as a Primary Care Physician agrees to:

- (a) provide to Covered Persons primary care services in accordance with the applicable standard of care;
- (b) provide Covered Persons with access to primary care services during normal business hours;
- (c) follow instructions set forth in PHS's Provider Manual, including company protocols supplied to provider at time of treatment (where applicable) or such protocols or instructions supplied by clients' case managers or adjustors at the time of treatment;
- (d) communicate with PHS by submitting referrals to PHS's designated representative to utilize in-network providers (when available);
- (e) forward a completed PHS Work Status Report (for workers' compensation patients) to PHS by the close of the business day of each Covered Person's visit, for those Employers who have requested such service;
- (f) notify PHS should Provider become disabled, or performance become otherwise impossible, within ten (10) business days;
- (g) notify PHS sixty (60) days prior to the closing of his/her practice; and
- (h) 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 Specialist Physician Services. A Provider serving as a Specialist Physician and credentialed by PHS, or its delegates, to serve as a Specialist Physician, agrees to:

- (a) provide Covered Persons with Covered Services in his/her specialty or specialties in accordance with the applicable standard of care and Applicable Law;
- (b) provide Covered Persons with access to Covered Services in his/her specialty or specialties by agreeing to see Covered Persons within four (4) days of receiving a referral from a Participating Primary Care Physician, and to submit a Work Status Report (for workers' compensation patients) to PHS, by the close of that business day for those clients who have requested such service;
- (c) follow all instructions set forth in PHS's Provider Manual, including company protocols supplied to Provider at time of treatment (where applicable) or such protocols or instructions supplied by clients' case managers or adjustors at time of treatment;
- (d) notify PHS should Provider become disabled, or performance become otherwise impossible, within ten (10) business days;
- (e) notify PHS sixty (60) days prior to the closing of his/her practice; and
- (f) acknowledge that PHS does not, by the Agreement or otherwise, promise, warrant, or guarantee physician any minimum number of Covered Persons as patients.

2.3 Ancillary Provider Services. Ancillary Provider agrees to:

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- (a) provide Covered Persons with Covered Services in his, her or its area of practice;
- (b) provide Covered Persons with access to Covered Services during normal business hours;
- (c) follow all instructions set forth in PHS's Provider Manual, including Company Protocols supplied to provider at time of treatment (where applicable) or such Protocols or instructions supplied by clients' case managers or adjustors at time of treatment;
- (d) submit reports to PHS per the designated schedule for those Employers requesting such service; and
- (e) notify PHS should Ancillary Provider become disabled, or performance become otherwise impossible, within ten (10) business days;
- (f) notify PHS sixty (60) days prior to the closing of his/her or its practice or facilities to new patients, provided that the effective date of such closure shall not occur until the last day of any calendar month; and
- (g) acknowledge that PHS does not, by the Agreement or otherwise, promise, warrant, or guarantee physician any minimum number of Covered Persons as patients.

2.4 Provider's Responsibility for Provision of Medical Services. Neither PHS nor Payor shall 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 their relationships with Covered Persons;
- (b) that, only as consistent with Applicable Law, Payor is entitled to deny payment to Provider for services to a Covered Person which Payor determines are not Medically Necessary, are not Covered Services, or are not otherwise provided in accordance with the provisions in this Booklet or in Payor policies and procedures (i.e., those procedures and services for which authorization was not obtained); and
- (c) such denial does not absolve Provider of their professional responsibility to provide appropriate medical care to Covered Persons.

2.5 Admissions and Referrals to Participating Providers. Provider agrees to use best efforts to submit to PHS any specialty referrals and to only admit inpatient Covered Persons as required by PHS protocols, policies, and procedures, consistent with appropriate patient care, and only to other Participating Providers, except:

- (a) in cases of an Emergency;
- (b) in cases specifically certified for payment by Payor or its designee; and
- (c) as otherwise required by Applicable Law.

2.6 Participating Provider Coverage. When Provider arranges for Covered Services to be provided by another provider in his/her absence or unavailability, then Provider shall use best efforts to ascertain and confirm that such covering provider is a member of the medical staff of one or more Participating Hospitals within the PHS Network.

3.0 PHS AND PROVIDER RESPONSIBILITIES: The following section details the mutual expectations between PHS and Provider during the term of the relationship.

3.1 Covered Persons' Utilization of Participating Physicians. PHS will enter into agreements with Payors that include appropriate incentives, in accordance with Applicable Law, for Covered Persons to utilize Participating Providers to provide Covered Services to Covered Persons, as consistent with appropriate patient care. Provider acknowledges that PHS will send its demographic information to its Payors.

3.2 Credentialing Services. PHS credentials all Participating Providers in accordance with PHS's internal policies and procedures, which comply to URAC standards. Provider agrees to comply with and remain in compliance with such credentialing/re-credentialing programs and criteria, and to respond to such requests for additional information as may be needed by PHS in a timely manner.

3.3 UR Program. When UR Program services are available, PHS will work with Management Company

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

3.4 Billing and Claims Processing Services

3.4.1 PHS System. PHS may provide to Payors a PHS billing and claims processing system in accordance with Applicable Law. If the PHS system is selected by a Payor (e.g., bills coming to PHS), Provider agrees to comply with and remain in compliance with the PHS system for billing and processing claims for Covered Services to the Payor's Covered Persons. The PHS system is described as follows:

- (a) Participating Providers will bill Payor by submitting claims to the PHS using CMS 1500 form or later versions as dictated by Applicable Law;
- (b) any claim submitted within one hundred twenty (120) days after such services are provided, and otherwise in compliance with this section 3.4, will be deemed a "Complete Claim;"
- (c) Payor will pay each Complete Claim for Covered Services within forty-five (45) days for workers' compensation patients, or thirty (30) days for all other product lines offered by PHS, after receipt from PHS of the claim, unless Payor determines, as consistent with Applicable Law, that the services are not Covered Services, were not provided in accordance with PHS's policies or not provided in accordance with the policies and procedures set forth in this Booklet (e.g., if no authorization was obtained, then claim is not a compensable claim);
- (d) Within thirty (30) days after Payor's receipt of any claim that it has reason not to pay, and after PHS is notified in writing of the reason for such non-payment ("Non-payment Notice"), PHS or Payor will forward such notice to the Participating Provider.

3.4.2 General Requirements. For both the PHS system and the Payor-designated system for billing and processing claims for Covered Services to Covered Persons, the parties acknowledge and agree that:

- (a) Payor will have the final responsibility for payment of claims for Covered Services;
- (b) PHS will not be liable for payment from its own funds for any claims;
- (c) PHS will not be considered the insurer, guarantor, or underwriter of the liability of Payor to provide benefits to or for Covered Persons; and
- (d) Payor has the sole discretionary authority and responsibility for final claims decisions.

3.5 Product Offerings and Identification: Provider acknowledges that PHS will market Provider's services through a variety of product offerings to PHS clients. Product offerings shall include the following:

3.5.1 Group Health: For each Covered Person accessing the PHS Network for group health, PHS and/or PHS clients will provide identification that is specific to that individual. Such identification will be from PHS's client and will indicate that the patient is accessing the PHS Network relationship in one or all of the following manners:

- (a) the PHS logo will appear on the card; or
- (b) the card will provide a toll-free phone number to verify that the patient is accessing the PHS Network; or
- (c) the Explanation of Benefits (EOB) received with payment will note that payment was processed accessing the PHS Network relationship.

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

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

3.5.3 Casualty and Liability Product Lines: Casualty and liability product lines represent a variety of clients offering medical coverage to their members. Most of these services are non-directed upon the initial injury. In these cases, access to the PHS Network will be clearly identified on the Explanation of Benefits (EOB) accompanying the payment to Provider. This product offering includes:

- (a) First Party Auto Medical Liability, and
- (b) First Party General Liability

3.5.4 Independent Medical Examinations (IME) or 2nd Opinion Services. These shall include the following services only for the set case rate:

- (a) Review of medical records, films, and tests on patient;
- (b) Office visit with patient to review condition;
- (c) Conducting a minor office test (x-ray, blood work, etc. as Provider deems necessary);
- (d) Producing a written report of findings

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

3.5.5 "PHS+": PHS offers specific clients access to the PHS+ product. The "PHS+" classification is intended to directly identify certain clients within the PHS Network. The PHS+ rate applies to clients deemed by PHS to cover a substantial member directory of preferred customers. Additional client relationships that may access the PHS+ offering include:

3.5.5.1 Indigent-Care Populations: PHS offers access to the PHS Network for indigent care populations as a service to the community, which may include prison populations needing group health coverage. In such cases, Provider agrees to accept reimbursement for such Covered Persons at the stated Tier II rates. Further, all Covered Persons accessing the PHS Network under these programs will be properly identified while making an appointment or at presentation. Provider hereby agrees to make reasonable efforts, at Provider's sole discretion, to make accessible clinic times to accommodate such patients, and at such times as Provider deems appropriate. Following execution of the Agreement, should Provider decide to no longer treat such indigent care populations, Provider will notify PHS sixty (60) days prior to no longer treating these patients.

3.5.5.2 Medicare Health Plans: PHS offers access to Participating Providers that offer Covered Services to Covered Persons, which may include Medicare Advantage Plans or Medicare Private-Fee-For-Service Plans. Provider hereby agrees to accept the negotiated Tier II Rates for the "PHS+" program as payment for services rendered to these Covered Persons. Additionally, Provider hereby agrees to provide Medically Necessary Covered Services to all Covered Persons enrolled in such programs, as Provider's staff and facilities permit and in a manner that assures continuity of care. Provider shall accept Enrollee's as new patients on the same basis as Provider is accepting non-Enrollees as new patients without regard to type of benefit contract under which the Enrollee has coverage, the Enrollee's place of residence, race, religion, sex, ethnicity, national origin, age, sexual orientation, physical or mental services, genetic information or genetic history, English proficiency or reading skills, or

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the source of payment for the services rendered. Provider shall observe, protect, and promote the rights of the Enrollees as patients and to provide Enrollees treatment equal to that of other patients. Provider shall treat Enrollees with respect, dignity and consideration for their privacy. The provision of covered services shall be in a manner consistent with professionally recognized standards of health care. In addition to the preceding requirements, Provider must comply with the requirements of:

- a. Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 84;
- b. Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91;
- c. Rehabilitation Act of 1973;
- d. Americans With Disabilities Act;
- e. Other Applicable Law to recipients of federal funds;
- f. All Medicare laws, rules and regulations;
- g. All other Applicable Law, including but not limited to, the Health Insurance Portability and Accountability Act ("HIPAA") of 1996; and
- h. Genetic Information Nondiscrimination Act of 2008.

The following sections under §3.5.5 are in accordance with Title 42 of the Code of Federal Regulations, part 422:

3.5.5.2 (a) Provision of Services: Provider will take necessary and appropriate steps to arrange for the provision of Hospital Covered Services to Enrollees, if deemed appropriate, on a twenty-four (24) hours per day, seven (7) days per week, three-hundred sixty-five (365) days per year basis.

3.5.5.2 (a)(1) Medicare and Medicare Advantage Programs Including Utilization Management, Quality Assurance and Performance Improvement Projects: To the extent applicable to the Enrollee's plan for Covered Services, Provider shall cooperate with all reasonable utilization management, quality assurance, peer review, grievance, prior authorization, prior notification, on-site concurrent review, or other similar programs established by, or on behalf, of the Medicare health plan for Covered Services.

3.5.5.2 (a)(2) Submission and Accuracy of Encounter Data. Provider, when submitting claims to PHS's clients, shall provide all CMS required information relating to the Covered Services provided. To the best of the Provider's knowledge, information and belief, claims submitted by Provider shall be accurate, complete and truthful.

3.5.5.2 (a)(3) Hold Harmless. Provider agrees that in no event, including but not limited to non-payment by PHS client, including insolvency and/or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Enrollee or persons (other than PHS client) acting on their behalf for services provided pursuant to the Agreement. This provision does not prohibit the Provider from collecting cost sharing amounts or fees for non-Covered Services delivered on a fee-for-service basis to Enrollees, unless the Enrollee is a Dual Eligible Enrollee, where the Enrollee will not be responsible for any cost sharing for Medicare part A and B services. Collection of cost sharing amounts will be deemed as waived by Provider, or when the state is responsible for paying those amounts, remuneration will be sought by Provider through the state. These provisions supersede any oral or written contract agreement now existing or hereafter entered into between the Provider and Enrollees or person acting on their behalf insofar as such

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contrary agreement relates to liability for payment for, or continuation of covered services provided under the terms and conditions of these clauses. Provider agrees that neither CMS nor any Covered Person will be held liable for any debts of the Medicare health plan or for any services for which the Medicare health plan is liable. The provisions of this section shall survive the termination of the Agreement.

3.5.5.2 (b) Participation Criteria. Provider must meet the following criteria:

1. Maintain state required licensure and insurance levels of malpractice, general and professional liability and Medicare certification;
2. Have in place a quality assurance program that conforms with local and nationally recognized quality of care standards. Such standards shall include appropriate physician review standards. This plan shall be made available for PHS client's review upon request, and shall be adapted if necessary to meet CMS guidelines; and

3.5.5.2 (c) Appeal and Grievance Procedures. Provider shall cooperate with and participate in all aspects of PHS client's Enrollee Appeal and Grievance procedures, including the expedited appeals procedures. Such cooperation shall include gathering, providing copies, and forwarding information related to the appeal to PHS client, as necessary, within three (3) days of PHS client's request for information.

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

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

3.5.5.2 (f) Excluded Individuals. Provider shall not employ or contract with any individual who has been excluded from participation in Medicare under Sections 1128 or 1128A of the Social Security Act.

3.5.5.2 (g) Federal Requirements. The parties agree that the Secretary of the Department of Health and Human Services (DHHS), the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts,

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medical records, patient care documentation, and other records of PHS client and/or Provider, related entity, contractor, subcontractor, or transferee that pertains to any aspects of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the Agreement or as the Secretary of DHHS may deem necessary to enforce the Agreement.

The parties further agree to make available their premises, physical facilities and equipment, records relating to Medicare Enrollees and any additional relevant information that CMS may require.

DHHS, the Comptroller General, or their designees right to inspect, evaluate, and audit records shall extend through ten (10) years from the final date of the contract period or completion of the audit, whichever is later, unless:

1. CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies PHS client and/or Provider at least thirty (30) days before the normal disposition date;
2. there has been a termination, dispute, or fraud or similar fault by PHS client or Provider, in which case the retention may be extended to ten (10) years from the date of any resulting final resolution of termination, dispute, or fraud or similar fault; or
3. CMS determines there is a reasonable possibility of fraud, in which case it may inspect, evaluate, and audit PHS client and/or Provider at any time.

3.5.5.2 (h) Federal Funds. The parties acknowledge that under its contract with CMS, PHS client is receiving federal funds. As such, monies paid by PHS client to Provider for Covered Services rendered to Enrollees are federal funds, and Provider is subject to Applicable Law related to entities receiving such funds.

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

3.5.5.2 (j) Delegated Administrative Functions. PHS shall delegate those administrative functions outlined in an attachment to the Agreement (only where applicable). Initial delegation and delegation renewal will be subject to review, on an ongoing basis, and approval of Provider's performance of delegated administrative functions and compliance by Provider of all Plan and regulatory guidelines. PHS retains the right to approve, suspend, or terminate delegated functions. Failure of Provider to perform delegated administrative functions in compliance with PHS's policies and procedures shall result in revocation of delegation for one or all of the administrative functions that have been delegated. Provider acknowledges and agrees that its agreements with subcontractors are subject to review and approval by PHS, Payors, CMS, and other applicable state or regulatory agencies. Any services or other activity performed by related entity, contractor, subcontractor, or first-tier or downstream entity of the Provider, in accordance with the Agreement, are consistent and comply with contractual obligations.

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

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

3.7 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 and all documents that reasonably may be required to enable Payor to bill and/or collect payments from any third parties or to assign payments to Payor, consistent with Applicable Law, regarding patient confidentiality.

3.8 Provider Authorization. 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.

3.9 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 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:

- (a) provider credentialing;
- (b) billing; and
- (c) Covered Person and Provider grievances.

Provider agrees to comply with the determination of PHS or Payor regarding all such matters during the term of the Agreement. Provider agrees not to discriminate in the provision of health care services against Covered Persons due to the source of payment, or any other impermissible ground under Applicable Law.

3.10 Provider Manual: Provider acknowledges that PHS represents clients that cover a variety of Payor models (primarily third party administrators, self-insured Employers, and insurance companies). Consequently, no single manual can detail the specific policy descriptions associated with all PHS clients. However, the information necessary to begin Provider's participation in the PHS Network, specifically regarding accessing and working with PHS clients, will be supplied in the *Provider Manual* and a copy is supplied to the Provider after execution of the Agreement. In some instances PHS clients have developed specific protocols to be used with their patients. Such protocols will be supplied, in most cases, at 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 the Provider's ability to treat Covered Persons using commonly accepted standards of practice.

3.10.1 Provider Manual Updates: Provider understands and acknowledges that the *Provider Manual* is an ongoing extension of the Agreement and is to be considered part of the terms and

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conditions of this Booklet. Further, the *Provider Manual* will be updated periodically to advise Provider of changes to programs offered by PHS and to advise Provider of any alterations or additions to the specific products offered by PHS.

3.11 Records. Provider agrees to 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 will be retained by Provider for at least five (5) years, or such other period required by Applicable Law, from the date the service was provided or termination of the Agreement, whichever occurs first. Provider agrees that PHS and Payor have the right to review records regarding to services provided to Covered Persons, upon reasonable notice, during regular business hours. Provider further agrees to obtain any necessary releases from Covered Persons with respect to PHS and Payor review of their records. PHS, Payor, and Provider agree that each Covered Person's medical records will be treated as confidential and will be retained so as to comply with all Applicable Law, including compliance with all Health Insurance Portability and Accountability Act (HIPAA) provisions, and regulations regarding the confidentiality and retention of patient records. Notwithstanding termination of the Agreement or termination of Provider's participation in any Payor Program for any reason, the access to records set forth in this Section 3.11 shall survive the termination of the Agreement and any Payor Program.

4.0 PROVIDER FEES AND COMPENSATION: This section concerns the processing of claims and the reimbursements the Provider can expect.

4.1 Provider Fees and Compensation. Provider shall 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 shall not be responsible for Provider's compensation, up to and including any state penalties accrued during payment resolutions.

4.2 No Recourse Against Covered Persons. Provider hereby acknowledges and agrees that payment for Covered Services will come from Payors participating with PHS to utilize the PHS Network for the various product offerings detailed in this Booklet. With this understanding, Provider hereby agrees that under no circumstance, including but not limited to nonpayment, a Payor's insolvency, or breach of this 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.

5.0 INSURANCE AND NOTICE OF CLAIMS: The following details the risk relationship of the Agreement, and how insurance and claims notification must occur during the term of the Agreement.

5.1 Provider's Professional Liability Insurance. Provider agrees to maintain, at Provider's sole cost and expense, professional liability insurance coverage from an insurer acceptable to PHS, insuring Provider and his/her employees for damages related to the provision of, or failure to provide, services to Covered Persons. Such coverage shall be in the form and amounts in no event less than \$1 million per incident and \$3 million in the aggregate, or in such amounts and types as is mutually acceptable to PHS, or in such amount and type as is required by Applicable Law. Provider agrees to provide PHS with at least thirty (30) days notice prior to the effective date of any adverse changes in the amounts of coverage or other policy terms, and suspension or cancellation of such coverage. Provider agrees that any associated health professional with whom he/she contracts will maintain the professional liability coverage required by PHS for that class of provider.

5.2 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 which 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.

6.0 TERM AND TERMINATION: This section details what is expected prior to the termination of our relationship.

6.1 Term and Renewal. The Agreement shall commence on the Effective Date and its initial term shall continue in effect until the next December 31. Thereafter, the Agreement and all Payor Programs then

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in effect shall 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 §6.4 of this Booklet), either Provider or PHS may, without cause, terminate the Agreement at any time upon no less than ninety (90) days prior notice, which notice shall be effective on the ninetieth (90th) day after notice is given. Subject to Provider's obligations to continue to provide services according to section 6.4 of this Booklet, termination of the Agreement shall terminate Provider's participation in all Payor Programs.

6.2 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 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.

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

6.4 Continuation of Services and Continuity of Care. Nothing in this Booklet shall be construed as authorizing or permitting Provider to abandon any Covered Person or other patient. Upon termination of the Agreement or Provider's participation in a Payor Program, Provider shall, at PHS's option, remain obligated to furnish Covered Services to any Covered Person under Provider's care who, at the time of termination, is a registered bed patient at an institutional Participating Provider or covering provider until such Covered Person's discharge, in accordance with the terms and conditions of this Booklet and the Agreement (including the compensation terms). In addition, Provider further acknowledges and agrees that PHS must honor its commitments to offer Covered Services through the term of the Payor Program. Therefore, at PHS's option, if the Agreement or Provider's participation in a Payor Program is terminated for any reason, Provider shall remain obligated to furnish Covered Services to any Covered Person for at six (6) months from the effective date of termination or until the renewal or termination dates of the applicable Payor Programs, whichever occurs first, in accordance with the terms and conditions of this Booklet and the Agreement (including the compensation terms) and as required by the applicable Payor Program. This section 6.4 shall survive the termination of the Agreement regardless of the cause giving rise to termination.

7.0 AMENDMENTS: Business relationships require change; thus, as the relationship established by the Agreement and the terms in this Booklet progress, PHS will communicate those changes to Provider.

7.1 Amendments. The Agreement may be amended only in writing by either party. However, PHS reserves the right as detailed in Section 3.10.1 above, to amend and alter the 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 shall be effective for product offerings and Provider thirty (30) days following receipt.

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8.0 GENERAL PROVISIONS: These are the "odds and ends" that both parties must state and understand:

- 8.1 Assignment.** The Agreement, being intended to secure the personal services of Provider, shall not in any manner be assigned, delegated, or transferred by Provider without the prior written consent of PHS. 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. For each Payor Program, 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 the Payor.
- 8.2 Notices.** Any notice pertaining to the Agreement and as set forth in this Booklet shall be in writing and sent by certified mail, return receipt requested, postage prepaid, to the recipient at the address designated on the signature page of the Agreement, and shall be deemed given when deposited with the United States Postal Service for delivery in the manner stated above.
- 8.3 Non-Exclusive Agreement.** Nothing in the Agreement shall 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.
- 8.4 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 purposes of effecting the provisions of the Agreement. Neither the parties, nor any of their respective officers, directors, or employees, shall be construed to be the agent, employee, or representative of the other. PHS, Payor, and Provider are not authorized to speak on behalf of the other party or parties for any purpose whatsoever without the prior written consent of the other party or parties. Nothing in the Agreement or Booklet is intended to create any right of PHS or Payor to intervene in any manner in the methods or means by which Provider renders professional services to Covered Persons.
- 8.5 Entire Agreement.** The Agreement and its amendments (as specified in section 7.1 above) 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 this Agreement.
- 8.6 Interpretation.** In the event of a conflict between the language of the Agreement or terms in the Booklet and any Payor Program, PHS reserves the right to resolve such differences regarding the terms applicable to that Payor Program. Provider hereby agrees to work with and accept such determination of PHS in such cases.
- 8.7 Arbitration.** Any controversy or claim between the parties arising out of or relating to the Agreement shall be settled in accordance with the Commercial Arbitration Rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Notwithstanding any dispute arising under the Agreement, each party shall continue to perform its obligations hereunder pending the decision of the arbitrator. This paragraph shall survive any termination of the Agreement.
- 8.8 National Provider ID Number.** Provider hereby agrees to supply an NPI number with the Agreement.

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8.9 Provider Annual Subscription Fee: Provider hereby agrees to an annual subscription fee to cover miscellaneous costs, for example, those costs associated with credentialing (where allowed by Applicable Law) and making Provider accessible to clients via website and directory production. Provider hereby agrees to submit to PHS with the Agreement **\$WAIVED** per physician, or ancillary provider and to remit invoices for such provided annually in subsequent years. If Provider fails to include the **\$WAIVED** fee with the signed Agreement, then PHS will invoice the provider within thirty (30) days of the executed contract, which will be due upon receipt.

8.9.1 Specials, Coupons, and Promotions: PHS reserves the right to offer special incentive savings on annual subscription fees charged to Providers, based upon locality, need, specialty and development efforts of PHS. Such special incentives may include discounting the annual subscription fee for one or all years, or waiving the subscription fee altogether. Such decisions are solely at the discretion of PHS, and by executing the Agreement, Provider acknowledges and accepts PHS's right to modify these rates without due prejudice.

8.9.2 Provider Rights: Provider may contact PHS representatives to request modification to the annual subscription fee prior to the execution of the Agreement. PHS reserves the right to modify or change subscription fees once the Agreement has been executed.

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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 in 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.

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Directory Listing
(Complete only for "Group Practices" or "Ancillary Organizations")

Group(s) Name(s):	Specialty(ies)	Physical Address/Phone	Billing Address/Phone	County	Group NPI#	TIN#
(List all Groups to be included under this Provider Participation Agreement)						
Provider Name(s):	Specialty(ies)	Physical Address/Phone	Billing Address/Phone	County	Individual NPI#	TIN#
(List all Providers to be included under this Provider Participation Agreement)						

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SCHEDULE OF ATTACHMENTS

Attachment 1.0: Delegation (where applicable and agreed upon)

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ATTACHMENT 1.0
Delegation Agreements (If Applicable)

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