

PROVIDER SERVICES AGREEMENT

This Provider Services Agreement (“Agreement”) is made and entered into between Managed Care Health Plan, Inc. (“Plan”) and _____ (“Provider”), (together referred to as the “Parties”).

WHEREAS, Plan provides and arranges for the delivery and management of Covered Services to eligible Members;

WHEREAS, Provider desires to provide Covered Services to Members in Plan’s Products;

NOW, THEREFORE, in consideration of the mutual covenants and agreements set forth in this Agreement and other good and valuable consideration, the Parties hereto, intending to be legally bound, hereby agree as follows:

SECTION 1: DEFINITIONS

1.1 Clean Claim. A claim for payment for a Covered Service that has no defect or impropriety. A defect or impropriety includes, but is not limited to, lack of data fields required by Plan or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. The term shall not include a claim from a practitioner that is under investigation for fraud or abuse regarding that claim. The term shall be consistent with the Clean Claim definition set forth in applicable Federal or State laws and regulations.

1.2 Copayment. The portion of the reimbursement for Covered Services that a Member is obligated to pay as a fixed dollar amount before a Covered Service is provided under a particular Product. Provider must collect Copayment from a Member prior to the provision of Covered Services, unless the Member requires Emergency Services as defined under this Agreement.

1.3 Covered Services. The Medically Necessary health care services and supplies that are to be provided by Provider to Members for which a Member has coverage pursuant to the applicable Product.

1.4 Emergency Services. Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. Section 438.114(a) and 42 U.S.C. Section 1932(b)(2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition.

1.5 Medically Necessary. Medical services or hospital services which are determined by Plan to be: (a) rendered for the treatment or diagnosis of an injury or illness; (b) appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; (c) not furnished primarily for the convenience of the Member, the attending physician, or other provider of service; and (d) furnished in the most economically efficient manner which may be provided safely and effectively to the Member.

1.6 Member. An individual who, on the date of service, is eligible to receive Covered Services under a Product.

1.7 Payer. Payer means any entity which is financially responsible for the provision of Covered Services to Members, including but not limited to a self-funded employer, multiple employer trust or union trust, or governmental entity which maintains appropriate licensure, if applicable, and that has entered into an agreement with Plan for the provision of Covered Services to Members through a Product.

1.8 Product. Product means a health care benefits program or arrangement offered by a Payer which, pursuant to a written agreement with Plan utilizes participating providers to provide Covered Services to Members pursuant to the terms and conditions set forth in the corresponding Product Description, as defined below.

1.9 Product Addendum. Product Addendum means the written attachment to this Agreement which sets forth specific terms and conditions for the provision of Covered Services to Members enrolled in Products. To the extent that the requirements set forth in this Agreement conflict with the provisions in the Product Addendum, the terms of the Product Addendum shall control.

1.10 Product Description. Product Description means the written description located in the Provider Manual of any and all Products. Product Descriptions summarize the Covered Services to which Members may be entitled and for which participating providers may be reimbursed. Notwithstanding the forgoing, participating providers must verify Member eligibility and benefits to ensure proper reimbursement for the provision of Covered Services.

1.11 Provider Manual. Provider Manual means the rules, policies and procedures adopted by a Product to be followed by Provider in providing services and doing business with Plan and Payers under this Agreement. Provider Manual will be made available to Provider on Plan's website. Plan reserves the right to revise the Provider Manual in its discretion from time to time, with or without advance notice to Provider, including modifications to Plan procedures, documents or requirements, including those associated with utilization review, quality management and improvement, quality assurance, and credentialing, that have a substantial impact on the rights or responsibilities of Provider.

1.12 Quality Management Program. The functions, including but not limited to, credentialing, recredentialing and certification of Providers, site visits, review and audit of medical and other records, medical outcomes, peer review and Provider appeals and grievance procedures performed or required by Plan, or any other permitted person or entity, to review the quality of Covered Services rendered to Members. Provider shall be notified on a periodic basis by Plan of changes or additions to such Quality Management Program that are relevant to Provider and the terms of this Agreement.

1.13 Utilization Management Program. The functions including, but not limited to Preapproval, Referral and prospective, concurrent and retrospective review, case management and disease management performed or required by Plan or any other permitted person or entity, to review and determine whether medical services or supplies which have been or will be provided to Members are Covered Services under a Product and meet the criteria as Medically Necessary.

SECTION 2: PROVIDER OBLIGATIONS

2.1 Scope of Services. Provider agrees to provide Covered Services to Members who have selected, or are otherwise assigned to, Provider in accordance with the terms of this Agreement and the Plan's preauthorization and other Utilization Management Program polices as described in the Provider Manual, other than Emergency Services, which will be provided as needed. Provider shall participate in all of Plan's Products that Provider is qualified to provide services under provide such services in the same manner and with the same availability as services provided to other patients without regard to reimbursement and shall further provide these services in accordance with the clinical quality of care and performance standards which are professionally recognized as industry practice and/or otherwise adopted, accepted or established by the Plan.

2.2 Access to Services. Provider agrees to provide on a twenty-four (24) hours a day, seven (7) days a week basis Covered Services to Members. Provider shall be responsible for determining whether Members

are eligible for Covered Services on the basis of the most current Eligibility List issued for the month in which services are being furnished. Provider agrees that the average waiting time in Provider's office for an appointment scheduled by a Member shall be no greater than thirty (30) minutes. Provider shall make arrangements for coverage by a Covering Physician whenever Provider is unavailable. Provider may not utilize a non-participating physician as a Covering Physician without the express written approval of Plan's medical director. Provider shall be responsible for compensation payments to the Covering Physician and any non-participating physicians.

2.3 Emergency Services. Provider agrees to assist Members in obtaining Emergency Services, as necessary (including on-call after-hours telephone referral services) and/or assist the Plan to obtain, on behalf of a Member, crisis intervention services on a twenty-four (24) hours a day, seven (7) days a week basis.

2.4 Outreach Services. Provider agrees to conduct affirmative outreach any time that a Member misses a scheduled appointment, and will document such affirmative outreach attempts in the Member's medical record.

2.5 Excluded Services. This Agreement excludes services that Plan has elected to obtain under an arrangement between Plan and a national or regional vendor or provider or a capitated provider. Provider will not be reimbursed and will not bill Members for any such excluded services. If Plan notifies Provider that it no longer chooses to exclude a particular service from this Agreement, then that service will no longer be excluded.

2.6 Referral Services. Provider will refer Members to providers participating in the Plan network whenever Provider is unable to provide Medically Necessary services. Provider is responsible for the care delivered by providers to whom Provider refers Members. Provider shall arrange for Referral Services according to the procedures established by Plan as set forth in the Provider Manual. Evidence of Referrals made by Provider must be submitted to Plan's Utilization Management department via immediate facsimile transmission, via U.S. Mail, or other pre-approved methodology within three (3) days of the date of arrangement of Referral Services. Referrals made to non-contracting specialists for non-contracted services without authorization from Plan's Utilization Management department shall be prohibited except for in the case of Emergency Services. Further, Provider will evaluate the outcome of the Referral Services and coordinate the Member's further medical needs.

2.7 Provider's Practitioners. Provider shall ensure that any employed practitioner shall accept all Members. Provider shall notify Plan within ten (10) days of the addition of a new practitioner.

2.8 Pre-Authorization. The Plan's Utilization Management Programs include requirements for pre-authorization of certain services. Utilization Management Programs include concurrent, retrospective and prospective review of certain services and procedures to assure that care is delivered in the most appropriate setting and is Medically Necessary. Certain Covered Services may require prior approval from the Plan. The Covered Services subject to prior approval are more fully described in the Provider Manual and other Plan notices.

2.9 Professional Liability Insurance. Provider shall maintain general liability, professional liability, worker's compensation and other insurance to insure Provider, its employees, and its agents and contractors against claims, liabilities, damages or judgments arising directly or indirectly in connection with the performance or nonperformance of services under this Agreement. Provider shall ensure that professional liability insurance in an amount equal to the greater of the amount required by law, or the prevailing community standard is maintained for it, but in no event less than one Million Dollars (\$1,000,000) per occurrence and Three Million Dollars (\$3,000,000) in the aggregate. Provider agrees to provide Plan with written evidence, acceptable to Plan, of its insurance coverage within three (3) business days of such request

by Plan. Provider also agrees to notify, or to ensure that its insurance carriers notify Plan at least thirty (30) days prior to any proposed termination, cancellation or material modification of any policy for all or any portion of the coverage provided for above.

2.10 Utilization Management Requirements. Whether announced or unannounced, Provider agrees to cooperate with, participate in, and abide by internal or external quality assessment reviews, Member Appeal Procedures, Utilization Management Program procedures, and Quality Management Program procedures established by the Plan, and to follow practice guidelines as described in the Provider Manual and other Plan notices.

SECTION 3: BILLING AND COMPENSATION

3.1 Compensation. Plan or Payer shall compensate Provider for Covered Services provided to Members in accordance with the provisions and procedures set forth in the Product Addendum attached hereto and incorporated herein and in accordance with the Provider Manual and applicable law. Plan may, in its sole discretion, amend the Product Addendum. Provider shall participate in additional Products offered by Plan. Provider shall accept such compensation as payment in full for services rendered with the exception of any applicable copayments, coinsurance or deductible that may be due to Provider from Member. Notwithstanding any terms to the contrary, Plan shall compensate Provider for Covered Services in an amount equal to the lesser of billed charges and the amount set forth in the Product Addendum.

3.2 Claims Submission. Provider agrees to comply with all billing requirements as detailed in the Provider Manual. Where fee for service payment is required under applicable Product requirements, Provider shall submit to Plan Clean Claims in a format approved by Plan for Covered Services rendered to a Member within one hundred eighty (180) calendar days after such services are rendered. Where Plan is the secondary payer under Coordination of Benefits or where Provider billed another payer because Provider had a reasonable basis to believe that such other payer was the primary payer, such one hundred eighty (180) day period shall commence once the primary payer or other payer, as the case may be, has made payment on or has denied the claim. Plan shall not be under any obligation to pay Provider on any claim not timely submitted.

3.3 Payment. Unless the claim is disputed, Plan shall make payment on each of Provider's Clean Claims for Covered Services rendered to a Member, provided that Provider submits claims within the time required by applicable State or Federal law. Plan shall deny payment on any claims not submitted within the required time period. Claims payments to Provider shall be in accordance with the policies and procedures applicable to the Members' Product. Plan shall have the right to offset claim payments to Provider by any amount owed by Provider to Plan. Provider shall not be entitled to reimbursement if it is subsequently found that a Member's coverage under an applicable Product Agreement was terminated prior to the date of service, regardless of any authorizations that may have been issued. Plan may delegate claims payment to a third party. Payments for Covered Services under this Agreement are subject to the Payment Policies. Those Policies may change from time to time.

3.4 Medicaid Payments. For Medicaid Products, in the event the State Department of Health fails to provide or delays payment to Plan for the provision of Covered Services to Medicaid Members, Plan will suspend payment to Provider until such time as Plan receives payment from the Department. Plan will compensate Provider in a timely manner once payment is received from the Department. To the extent that the Department reduces any payments provided to Plan under the Medicaid program in any manner, Plan also will make corresponding reductions to any payments to Provider.

3.5 Penalties. Provider agrees that to the extent penalties, fines or sanctions are assessed against Plan by a regulatory agency with governing authority over the services provided under this Agreement, Provider shall

be responsible for the immediate payment of such penalties, fines or sanctions if they arise from Provider's failure to comply with Provider's obligations under this Agreement, including but not limited to, Provider's failure or refusal to respond to Plan's or a regulatory agency's request for medical records or credentialing information, the failure to provide other information required to be provided to Plan under this Agreement, or Provider's failure to comply with the terms of Plan's Provider Manual. In the event such payment is not made in a timely manner, Plan shall have the right to offset claims payments to Provider by the amount owed by Provider to Plan.

3.6 Hold Harmless. Provider agrees, and shall ensure its subcontractors agree, that in no event, including, but not limited to, nonpayment, insolvency, or breach of this Agreement, shall Provider or subcontractor bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against Members or persons other than Plan acting on behalf of Member for Covered Services provided pursuant to this Agreement. Provider shall look only to Plan for compensation for Covered Services. This provision shall not prohibit collection of Copayments, coinsurances or deductibles in accordance with the terms of the applicable Member's Product.

3.7 Coordination of Benefits. Certain claims for Covered Services are claims for which another payer may be primarily responsible under coordination of benefit rules. Provider may pursue those claims in accordance with the process set out in the Provider Manual. When a Member's coverage under a Product is secondary, payer will pay an amount no greater than that which, when added to amounts payable from other sources under applicable coordination of benefits rules, equals 100% of the reimbursement for Covered Services under this Agreement, but may be less as determined by the applicable Product.

SECTION 4: TERM AND TERMINATION

4.1 Term. The term of this Agreement shall be from the effective date of the Agreement and shall continue in effect unless and until it is terminated as provided herein.

4.2 Termination Without Cause. Either party may terminate this Agreement without cause upon ninety (90) days prior written notice to the other party. If this Agreement is terminated without cause, Provider shall continue to provide Covered Services for those Members requiring continuity of care for whom an alternative means of receiving necessary care was not arranged at the time of such termination. Provider shall continue to provide Covered Services to such Members so long as the Member retains eligibility under a Product, until the earlier of completion of such services or the assumption of treatment by another provider.

4.3 Termination for Cause. Plan may immediately terminate or suspend this Agreement, upon written notice to Provider stating the reason for such termination, in the event: (a) that in the judgment of Plan, any act or omission by Provider places persons receiving Covered Services in immediate danger of life, health, or safety; (b) of fraud by Provider related to the provision of Covered Services; (c) that criminal proceedings are initiated against Provider or any of its executive officers or board members; (d) that Provider initiates or consents to any judicial or non-judicial insolvency proceedings, including without limitation, any composition or assignment for the benefit of creditors; (e) that Provider is the subject of any involuntary insolvency proceedings that are not terminated within thirty (30) days of initiation; (f) that Plan's agreement with any of the Products for management of their respective program is terminated, suspended, or not renewed; (g) that Provider cannot or will not comply with any amendment to this Agreement; (h) that Provider is debarred from contracting with any agency, division, or other instrumentality of the State or any Federal agency; or (i) that any of Provider's practitioners lose their license or any other public agency approval to provide Covered Services under applicable statutes or regulations of the State or the Federal government.

SECTION 5: GENERAL PROVISIONS

5.1 Confidentiality. The Parties will comply with all applicable State and Federal laws and regulations regarding patient privacy and security requirements, including the privacy and security provisions set forth at 42 C.F.R. §403.812. The Parties will not disclose any information or knowledge concerning the other party's operations or procedures, which is hereby deemed confidential information, except as otherwise required by law. Each party also will keep the terms of this Agreement confidential except as required by applicable law. Notwithstanding the above, Plan may disclose this Agreement in accordance with applicable law, including to applicable regulatory authorities.

5.2 Indemnification. Provider will defend, hold harmless, and indemnify Plan and its directors, officers, members, agents, contractors, or employees from and against any and all claims, suits, liabilities, damages, judgments, costs, and expenses, which may be imposed upon, or suffered or incurred by, any of them as a result of claims by third parties or by employees of Provider and which arise out of, derive from, or pertain to any negligence and/ or actual or alleged acts or omissions by, or on the part of, the Provider or any of its directors, officer, agents, contractors, or employees.

5.3 Independent Contractor. The relationship between the Parties will solely be that of independent contractors engaged in the operation of their own respective businesses and neither party is authorized to or shall represent that it is authorized to make any agreement, representation or warranty, or to incur any liability on behalf of the other party except as may be specifically authorized in writing by the other party.

5.4 Assignment. This Agreement shall inure to the benefit of and be binding upon the Parties' successors and assigns. Neither party may assign this Agreement or any rights or obligations pursuant to this Agreement or subcontract any obligations under this Agreement to any other entity without the prior written approval of the other party; provided, however, that Plan may assign its rights or its duties and obligations to an Affiliate or successor in interest so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of Provider.

5.5 No Third-Party Beneficiary. This Agreement has been entered into solely for the benefit of Provider and Plan, and is not intended to create any legal, equitable, or beneficial interest in any third party or to vest in any third party any interest as to enforcement or performance.

5.6 Notices. All notices required under this Agreement will be in writing and sent by certified mail, return receipt requested, hand delivery, or overnight courier addressed as identified on the signature page.

5.7 Amendments. For amendments that are a material adverse change in the terms of this Agreement, Plan can amend this Agreement by providing ninety (90) days' advance written notice. The change will become effective at the end of the ninety (90) day notice period. If Provider objects to the material adverse change and notifies Plan of its intent to terminate within thirty (30) days of the date of the notice of amendment, the termination will be effective at the end of the ninety (90) day notice of the material adverse change or, if applicable, at the end of the shorter notice period required to comply with changes in applicable law. For amendments that are not materially adverse changes in the terms of this Agreement, Plan can amend this Agreement by providing thirty (30) days' advance written notice to Provider.

5.8 Waiver. The waiver of any breach or violation of any term or provision hereof will not constitute a waiver of any subsequent breach or violation of the same or any other term or provision.

5.9 Governing Law. This Agreement shall be governed in all respects by the laws of the State where Plan's primary office is located. In the event of a lawsuit, venue shall be proper only in the county where Plan's primary office is located.

5.10 Dispute Resolution. Disputes that might arise between the Parties regarding the performance or interpretation of the Agreement must first be resolved through the applicable internal dispute resolution process outlined in the Provider Manual. In the event the dispute is not resolved through that process, either party can request in writing that the Parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the Parties who have authority to settle the dispute. If the matter is not resolved within sixty (60) days of such a request, either party may initiate arbitration by providing written notice to the other. With respect to a payment or termination dispute, Provider must submit a request for arbitration within twelve (12) months of the date of the letter communicating the final decision under Plan's internal dispute resolution process. If arbitration is not requested within that twelve (12) month period, Plan's final decision under its internal dispute resolution process will be binding on Provider, and Provider shall not bill Plan, Payer or the Member for any payment denied because of the failure to timely submit a request for arbitration.

5.11 No Consolidation. Any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between the Parties. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

5.12 Entire Agreement. This Agreement and its Exhibits, embody the entire understanding of the Parties in relation to the subject matter hereof, supersedes any prior agreements among the Parties in relation to the subject matter hereof, and no other agreements, understandings, or representations, verbal or otherwise, relative to the subject matter hereof exists among the Parties at the time of execution of this Agreement.

[Signature Page to Follow]

Product Addendum

Provider agrees to participate in the Plan's Benefit Programs in accordance with the terms of the Provider Services Agreement and this Product Addendum. The Products available under this Product Addendum are listed below. Plan may amend this Product Addendum by adding new Products. Provider shall participate in additional Products offered by Plan. To the extent that the requirements set forth in this Addendum conflict with the provisions of the Agreement, the terms of this Addendum shall control.

I. General Provisions

- 1. Cooperation.** Provider shall cooperate with and shall require its individual participating providers to cooperate with Plan or its delegated entity for care management, utilization management, and quality assurance as outlined in the Provider Manual.
- 2. Treatment Plans.** Provider shall cooperate with and shall require its individual participating providers to cooperate with Plan's procedures for identifying, assessing, and establishing treatment plans for Members with complex or serious medical conditions. Such procedures are set forth in the Provider Manual.
- 3. Delegation.** In the event that Plan, pursuant to a separate agreement, delegates to Providers the responsibility for selection and/or credentialing of providers, Plan retains the right to approve, suspend or terminate any individual provider selected to be credentialed by the Provider. The Provider's credentialing process shall be subject to review and approval by Plan and Plan shall have the right to audit such process from time to time as Plan deems necessary and appropriate.
- 4. Termination.** This Product Addendum shall terminate on the earlier of: (a) the termination of the Participating Provider Agreement with Plan, (b) termination by Plan of the Provider or individual participating provider's participation under this Product Addendum immediately upon notice for reasons related to fraud, patient abuse, incompetency or loss of licensure as determined by Plan, or (c) the termination by Plan or Provider of the Provider's participation under this Product Addendum without cause upon not less than ninety (90) days prior written notice. Terminations pursuant to Subsection (c) hereunder shall not, in and of itself trigger termination of the Participating Provider Agreement or any other Product Addendum.

II. Compensation

Plan shall compensate Provider for the provision of Covered Services to Members in accordance with the Plan Maximum Allowable Fee Schedule, as subject to modification. Provider shall accept as payment in full for Covered Services the amount equal to the lesser of Provider's billed charges or the Maximum Allowable Fee in effect on the date of service, less any applicable co-payment, deductible, coinsurance or third party liability. Plan shall be responsible for payment for Covered Services provided pursuant to an insured Product. In the event that self-funded products are offered, payment for Covered Services shall be the responsibility of the employer or other Payer for which services are being provided and who has assumed responsibility for such payment on a self-funded basis.