PROVIDER AGREEMENT

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PROVIDER AGREEMENT

This Provider Agreement ("Agreement") is made and entered into as of _____, 20__ (“Effective Date”) by and between Carrier Health Management, LLC, a Delaware limited liability company, on behalf of itself and its Affiliates (hereinafter “Company”) and _____ (hereinafter "Provider").

WHEREAS, Company offers, issues and administers Full Risk Plans and Plans for Plan Sponsors that provide access to health care services to Members; and

WHEREAS, Company contracts with certain health care providers and facilities to provide access to such health care services to Members; and

WHEREAS, Provider provides health care services to patients within the scope of Provider’s licensure or accreditation; and

WHEREAS, Company and Provider mutually desire to enter into an arrangement whereby Provider will become a Participating Provider and render health care services to Members; and

WHEREAS, in return for the provision of health care services by Provider, Company will pay Provider’s claims for Covered Services under the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein, the sufficiency of which is hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

Commented [RK1]: The Parties

Commented [RK2]: Recitals

Commented [RK3]: Meeting of the minds to the following..

1.0 DEFINITIONS

Commented [RK4]: Definitions

When used in this Agreement, all capitalized terms shall have the following meanings:

1.1 AAA. Defined in Section 8.3 of this Agreement.

1.2 Affiliate. Any corporation, partnership or other legal entity (including any Plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company.

1.3 Agreement. Defined in first paragraph of this Agreement.

1.4 Clean Claim. Unless otherwise required by law or regulation, a claim which (a) is submitted within the proper timeframe as set forth in this Agreement and (b) has (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-9, HCPCS) as

required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-92 or CMS-1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier ("NPI"), date(s) of service, complete and accurate breakdown of services), and (c) does not involve coordination of benefits, and (d) has no defect or error (including any new procedures with no CPT code, experimental procedures or other circumstances not contemplated at the time of execution of this Agreement) that prevents timely adjudication.

The clean claim clause has elements of both content and procedures (timeliness, referral, preauth, absence of COB.

1.5 Coinsurance. The percentage of the lesser of: (a) the rates established under this Agreement; or (b) Provider's usual, customary and reasonable billed charges, which a Member is required to pay for Covered Services under a Plan.

The lesser of billed charges or the negotiated rate is a key element providers should understand with respect to setting their fees.

1.6 Company. Defined in first paragraph of this Agreement.

1.7 Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information," as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999.

1.8 Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Provider.

1.9 Covered Services. Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan.

1.10 Covering Provider. A Participating Provider designated by Provider to provide Covered Services to Members when Provider is unavailable (e.g. out of the office or on vacation).

Allows locum tenens, but providers should check policies and procedures to be sure.

1.11 Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid.

1.12 Effective Date. Defined in first paragraph of this Agreement.

1.13 Emergency Services. Those services necessary to treat a 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, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious

dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

1.14 Full Risk Plan. A Plan where Company is the underwriter, in full, of the Plan (i.e. fully-insured Plans).

Full risk or fully insured means that the plan has been paid a premium and is the underwriter of the risk vs. acting as an ASO or TPA for the customer.

1.15 Government Programs. Defined in Section 2.4.3 of this Agreement.

1.16 Information. Defined in Section 5.3.2 of this Agreement.

1.17 Initial Term. Defined in Section 6.1 of this Agreement.

1.18 License. Defined in Section 3.2 of this Agreement.

1.19 Material Change. Any change in Policies that could reasonably be expected, in Company's determination, to have a material adverse impact on (i) Provider's reimbursement for Provider Services or (ii) Provider administration of Provider's practice.

Commented [RK5]: The payer unilaterally dictates what's a material change in the contract.

1.20 Member. An individual covered by or enrolled in a Plan.

1.21 Participating Provider. Any physician, hospital, hospital-based physician, skilled nursing facility, or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current valid contract with Company to provide Covered Services to Members, and, where applicable, has been credentialed by Company or its designee consistent with Company's credentialing policies. Certain categories of Participating Providers may be referred to herein more specifically as, e.g., "Participating Physicians" or "Participating Hospitals."

Note practitioner is not effective under contract until credentialed.

1.22 Party. Company or Provider, as applicable.

1.23 Plan. A Member's health care benefits as set forth in the Member's Summary Plan Description, Certificate of Coverage or other applicable coverage document.

Note the reference to the contract between the insurer and the patient, purchased by the employer.

1.24 Plan Sponsor. An employer, insurer, third party administrator, labor union, organization or other person or entity which has contracted with Company to offer, issue and/or administer a Plan that is not a Full Risk Plan and has agreed to be responsible for funding benefit payments for Covered Services provided to Members under the terms of a Plan.

Commented [RK6]: Reference to "ASO" business where the contract acts as a rental PPO agreement.

1.25 Policies. The policies and procedures promulgated by Company which relate to this Agreement, including, but not limited to: (a) quality improvement/management; (b) utilization management, including, but not limited to, precertification of elective admissions and procedures, concurrent review of services and referral processes or protocols; (c) pre-admission testing guidelines; (d) claims payment review; (e) member

grievances; (f) Provider credentialing; (g) electronic submission of claims and other data required by Company; and (h) any applicable Participation Criteria as set forth in the **Participation Criteria Schedules** attached hereto and made a part hereof. Policies also include those policies and procedures set forth in the Company's manuals, Health Care Professional Toolkit or their successors (as modified from time to time); Clinical Policy Bulletins made available via Company's internet web site; and other policies and procedures, whether made available via a password-protected web site for Participating Providers (when available), by letter, newsletter, electronic mail or other media.

Commented [RK7]: Policies and procedures are dynamic, and therefore referred to by reference and not hard-coded in the contract. Makes it the responsibility of the Provider to ensure their up to date.

1.26 Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement whether furnished prior to or after the Effective Date. Proprietary Information includes but is not limited to, with respect to Company, the development of a pricing structure, (whether written or oral) all financial information, rate schedules and financial terms which relate to Provider and which are furnished or disclosed to Provider by Company. Notwithstanding the foregoing, the following shall not constitute Proprietary Information:

Note what's proprietary, even possibly to the patient regarding the Plan's fee schedule, but definitely to competitors of the plan. COB provides payers with what you agreed to, but you are not allowed to share what the plan pays you.

(a) information which was known to a receiving Party (a "Recipient") prior to receipt from the other Party (a "Disclosing Party") (as evidenced by the written records of a Recipient);
(b) information which was previously available to the public prior to a Recipient's receipt thereof from a Disclosing Party;
(c) information which subsequently became available to the public through no fault or omission on the part of a Recipient, including without limitation, the Recipient's officers, directors, trustees, employees, agents, contractors and other representatives;
(d) information which is furnished to a Recipient by a third party which a Recipient confirms, after due inquiry, has no confidentiality obligation, directly or indirectly, to a Disclosing Party; or
(e) information which is approved in writing in advance for disclosure or other use by a Disclosing Party.

1.27 Provider. Defined in first paragraph of this Agreement.

1.28 Provider Services. Defined in Section 2.1 of this Agreement.

1.29 Records. Defined in Section 5.3.2 of this Agreement.

1.30 Rules. Defined in Section 8.3 of this Agreement.

1.31 Specialty Program. A Company established program for a targeted group of Members with certain types of illnesses, conditions, cost or risk factors (e.g., organ transplants, women's health, other disease management programs, etc).

1.32 Specialty Program Providers. Those hospitals, physicians and other providers that have been identified or designated by Company to provide transplant services and other Covered Services associated with a Specialty Program.

2.0 PROVIDER SERVICES AND OBLIGATIONS

Commented [RK8]: Provider Obligations Section

2.1 Provision of Services.

Provider shall provide to Members those services which are within the scope of Provider's license and certification to practice ("Provider Services"). Provider shall also, as applicable, arrange and coordinate the overall provision of Covered Services to Members under the terms and conditions of the Member's applicable Plan. Provider shall provide or arrange for the provision of Covered Services, including, without limitation, urgently needed services or Emergency Services, regardless of whether Provider has previously seen or treated the Member. Provider may not provide any Covered Services to Members unless and until Provider has been fully credentialed and approved by the applicable peer review committee.

Commented [RK9]: Credentialing requirement. Applicable review committee is designated by whether or not credentialing is or is not delegated.

2.2 Non-Discrimination.

2.2.1 Equitable Treatment of Members. Provider agrees to provide Provider Services to Members with the same degree of care and skill as customarily provided to Provider's patients who are not Members, according to generally accepted standards of Provider practice. Provider and Company agree that Members and non-Members should be treated equitably; to that end Provider agrees not to discriminate against Members on the basis of race, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, color, national origin, place of residence, health status, source of payment for services, cost or extent of Provider Services required, or any other grounds prohibited by law or this Agreement.

2.2.2 Affirmative Action. Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Provider, Provider, on behalf of itself and any subcontractors, agrees to comply with the following, as amended from time to time: Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164, the Americans with Disabilities Act of 1990, Federal laws, rules and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (Section 1128B(b) of the Social Security Act), and any similar laws, regulations or other legal mandates

applicable to recipients of federal funds and/or transactions under or otherwise subject to any government contract of Company.

2.3 Referral by Primary Care Physician.

Except for Emergency Services, if a referral is required by the Member's Plan, Provider shall provide Provider Services to Members only upon prior referral of such patients by a Primary Care Physician to Provider on prescribed forms or by electronic means as instructed by Company. Except for Emergency Services, payment for retroactive referrals shall be subject to adjustment or denial by Company in accordance with Policies. Provider shall render services to Members only at Participating Hospitals or other Participating Providers, or those inpatient, extended care, and ancillary service facilities which have otherwise been approved in advance by Company. Provider agrees promptly to submit a report on the treatment of each Member to the referring Primary Care Physician, if such Member was referred to the Provider by a Primary Care Physician in accordance with the Member's Plan.

Note reference to procedure needed, if not met could result in denial.

2.4 Provider Representations.

2.4.1 General Representations. Provider represents, warrants and covenants, as applicable, that: (a) it has, and shall maintain throughout the term of this Agreement all appropriate license(s) and certification(s) or other authorization(s) mandated by governmental regulatory agencies, including without limitation DEA certification (unless such certification is not a criterion of participation for Provider under the **Participation Criteria Schedule**), and an unrestricted license to practice medicine in the state(s) in which Provider maintains offices and provides Provider Services to Members; (b) it is, and will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder, including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, self-referral, false claims and prohibition of kickbacks; (c) Provider has and shall maintain throughout the term of this Agreement unrestricted hospital privileges at a Participating Hospital (unless the maintenance of such privileges is not a criterion of participation for Provider under the **Participation Criteria Schedule**; and (d) this Agreement has been executed by its duly authorized representative; and (e) executing this Agreement and performing its obligations hereunder shall not cause Provider to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

Note allusions to Federal laws like Stark, Antikickback, CMP etc.

The specific Participation Criteria is a critical section to examine and presents the part of the document that is most negotiable.

2.4.2 Qualified Personnel. Provider also represents that Provider has established an ongoing quality assurance/assessment program which includes, but is not limited to, credentialing of employees and subcontractors. Provider shall supply to Company the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications, Federal agency certifications and/or registrations upon request. Provider further represents that all

personnel employed by, associated or contracted with Provider who treat Members: (a) are and shall remain throughout the term of this Agreement appropriately licensed and/or certified and supervised (when and as required by state law), and qualified by education, training and experience to perform their professional duties; and (b) shall act within the scope of their licensure or certification, as the case may be. Company may audit Provider's compliance with this section upon prior written notice.

2.4.3 Government Program Representations. Company has or may seek a contract to serve Medicare and Medicaid beneficiaries ("Government Programs"). To the extent Company participates in such Government Programs, Provider agrees, on behalf of itself and any subcontractors of Provider acting on behalf of Provider, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Provider acknowledges and agrees that all provisions of this Agreement shall apply equally to any employees, independent contractors and subcontractors of Provider who provide or may provide Covered Services to Members of Government Programs, and Provider represents and warrants that Provider shall take all steps necessary to cause such employees, independent contractors and subcontractors to comply with the Agreement and all applicable laws, rules and regulations and perform all requirements applicable to Government Programs. With respect to Members of Government Programs, Provider acknowledges that compensation under this Agreement for such Members constitutes receipt of Federal funds. Provider agrees that all services and other activities performed by Provider under this Agreement will be consistent and comply with Company's obligations under its contract(s) with the Centers for Medicare and Medicaid Services ("CMS"), and any applicable state regulatory agency, to offer Medicare/Medicaid Plans. Provider further agrees to allow CMS, any applicable state regulatory agency, and Company to monitor Physician's performance under this Agreement on an ongoing basis in accordance with Medicare/Medicaid laws, rules and regulations. Provider acknowledges and agrees that Company may only delegate its activities and responsibilities under its contract(s) with CMS and any applicable regulatory agency, to offer Medicare/Medicaid Plans in a manner consistent with Medicare/Medicaid laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Provider, the activity or responsibility may be revoked if CMS or Company determine that Provider has not performed satisfactorily.

This refers to Medicare Advantage or PFFS Medicare Replacement products. Brings Federal anti-kickback, Stark and Civil Money Penalties statute (the "CMP") generally prohibits compensation to physicians to induce them to reduce or limit services to Medicare or Medicaid beneficiaries

2.5 Provider's Insurance.

During the term of this Agreement, Provider agrees to procure and maintain such policies of general and professional liability and other insurance at minimum levels required from time to time by Company, but in no event less than: (a) professional liability insurance at a minimum level of $200,000 per claim/$600,000 annual aggregate and (b) comprehensive general liability insurance at a minimum level of $1,000,000 per claim/$3,000,000 annual aggregate. Such insurance coverage shall cover the acts and omissions of Provider as well as those of Provider's agents and employees. Provider agrees to deliver memorandum

Ensure you know how the plan's requirements determine if you need additional coverage.

copies of such policies to Company upon request. Provider agrees to make best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies.

2.6 Product Participation.

Provider agrees to participate in the Plans and other health benefit products listed on the **Product Participation Schedule** attached hereto and made a part hereof. Company reserves the right to introduce and designate Provider's participation in new Plans, Specialty Programs and products during the term of this Agreement and will provide Provider with written notice of such new Plans, Specialty Programs and products and the associated compensation.

Nothing herein shall require that Company identify, designate or include Provider as a preferred participant in any specific Plan, Specialty Program or product; provided, however, Provider shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Plan, Specialty Program or product in which Provider has agreed to participate hereunder.

Commented [RK10]: Allows payer to add business lines. Providers must be careful to ensure only business lines worthy of discounted rates should be included in the contract.

Company may sell, lease, transfer or otherwise convey to payers (other than Plan Sponsors) which do not compete with Company's product offerings (e.g., workers' compensation or automobile insurers) in the geographic area where Provider provides Covered Services, the benefits of this Agreement, including, without limitation, the **Services and Compensation Schedule** attached hereto, under terms and conditions which will be communicated to Provider in each such case. For those programs and products which are not health benefit products (e.g., worker's compensation or auto insurance), Provider shall have thirty (30) days from receipt of the aforementioned notice from Company to notify Company in writing if Provider elects not to participate in such products(s).

Commented [RK11]: OPT Out Provision – this puts the responsibility on the Provider to not allow a line of business to become part of the contract. Ideally the lines of business you don't want ever made applicable to the contract will be omitted in the body of the contract or excluded by amendment, to avoid the hassle of having to notify the payer each time an impermissible line of business is added to the payers product line.

2.7 Consents to Release Medical Information.

Provider covenants that it will obtain from Members to whom Provider Services are provided, any necessary consents or authorizations to the release of Information and Records to Company, Plan Sponsors, their agents and representatives in accordance with any applicable Federal or state law or regulation or this Agreement.

2.8 Encounter Data.

For those services for which Provider is compensated on a capitated basis, if any, Provider agrees to provide Company with encounter data by type of Provider Service rendered to Members in the form and manner as specified by Company. There shall be no restrictions on Company's use of such encounter data. Furthermore, Company is under no obligation to return such encounter data to Provider.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.

Company or Plan Sponsors shall provide Members with a means to identify themselves to Provider (e.g., identification cards), explanation of Provider payments, a general description of products (e.g., Quick Reference Card), a listing of Participating Providers, and timely notification of Material Changes in this information. Company shall provide Provider with a means to check eligibility. Company shall include Provider in the Participating Provider directory or directories for the Plans, Specialty Programs and products in which Provider is a Participating Provider, including when Provider is designated as preferred participant, and shall make said directories available to Members. Company reserves the right to determine the content of Provider directories.

Commented [RK12]: Payer agrees to ensure patients are aware of the benefits of going to a preferred provider and that preferred providers are identified through a provider directory.

3.2 Company Representations.

Company represents and warrants that: (a) it, where applicable, is licensed to offer, issue and administer Plans in the service areas covered by this Agreement by the applicable regulatory authority ("License"); (b) it will not lose such License involuntarily during the course of this Agreement; (c) it is, and will remain throughout the term of this Agreement, substantially in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder; including without limitation, any applicable prompt payment statutes and regulations or capital reserve requirements; provided however, that for the purposes of (b) and (c), Provider will have no basis for termination to the extent that such action does not impact the obligations of Company under this Agreement; (d) this Agreement has been executed by its duly authorized representative; and (e) executing this Agreement and performing its obligations hereunder shall not cause Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

3.3 Company's Insurance.

Company at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance (or maintain a self-insurance program) as shall be necessary to insure Company and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Company under this Agreement and the administration of Plans.

4.0 CLAIMS SUBMISSIONS, COMPENSATION AND MEMBER BILLING

4.1 Claim Submission and Payment.

4.1.1 Provider Obligation to Submit Claims. Provider agrees to submit Clean Claims for non-capitated services to Company for Provider Services rendered to Members. To the extent that Provider submits claim and/or risk adjustment data related to a Member enrolled in a Government Program, Provider certifies that any such data is accurate,

Note the reference to what paperwork you should have for getting assignment from the patient to the payer and be directly compensated.

complete and truthful. Provider represents that, where necessary, it has obtained signed assignments of benefits authorizing payment for Provider Services to be made directly to Provider. To the extent Provider is capable of submitting claims electronically, Provider and Company will cooperate as necessary to facilitate submission in such manner. If Provider submits a claim electronically, Provider shall not submit a claim to Company in paper form unless Company fails to pay or otherwise respond to electronic claims submission in accordance with the time frames required under this Agreement or applicable law or regulation. Provider agrees that Company, or the applicable Plan Sponsor, will not be obligated to make payments for billings received more than one hundred and twenty (120) days from (a) the date of service or, (b) the date of receipt of the primary payer's explanation of benefits when Company is the secondary payer. This requirement will be waived in the event Provider provides notice to Company, along with appropriate evidence, of other extraordinary circumstances outside the control of Provider that resulted in the delayed submission. In addition, unless Provider notifies Company of any payment disputes within one hundred eighty (180) days, or such longer time as required by applicable state law or regulation, of receipt of payment from Company, such payment will be considered full and final payment for the related claims. If Provider does not bill Company or Plan Sponsors, or disputes any payment, timely as provided in this Section 4.1.1, Provider's claim for payment will be deemed waived and Provider will not seek payment from Plan Sponsors, Company or Members. Provider shall pay on a timely basis all employees, independent contractors and subcontractors who render Covered Services to Members of Company's Medicare/Medicaid Plans for which Provider is financially responsible pursuant to this Agreement.

Commented [RK13]: Timely filing clause.

Commented [RK14]: Timely appeal clause.

Provider agrees to permit rebundling to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and make other adjustments for inappropriate billing or coding (e.g., duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). To the extent Provider is billing on a CMS 1500, as of the Effective Date, in performing rebundling and making adjustments for inappropriate billing or coding, Company utilizes a commercial software package (as modified by Company for all Participating Providers in the ordinary course of Company's business) which commercial software package relies upon Medicare/Medicaid and other industry standards in the development of its rebundling logic.

Note that these to references can play havoc with your accounting and posting of payments from EOBs.

4.1.2 Company Obligation to Pay Covered Services. Company agrees to: (a) pay Provider for Covered Services rendered to Members of Full Risk Plans, and (b) notify Plan Sponsors to forward payment to Company for payment to Provider for Covered Services rendered to a Plan Sponsor's Members. Such payment shall be made as follows: (a) for capitated services Provider shall be paid according to the rates set forth in the **Services and Compensation Schedule** attached hereto and made a part hereof;

(b) for non-capitated services: the lesser of (i) Provider's actual billed charges; (ii) the rates set forth in the **Services and Compensation Schedule**; or (iii) the fee schedule then in effect as applicable to such Member's Plans, within forty-five (45) days (or such shorter time as required by applicable law or regulation) of actual receipt by Company of a Clean Claim. While Company may pay claims on behalf of Plan Sponsors, Provider and Company acknowledge that Company has no legal responsibility for the payment of such claims for Covered Services rendered to a Plan Sponsor's Members; provided, however, that Company agrees to reasonably assist Provider as appropriate in collecting any such payments. Company may, from time to time, notify Provider of overpayments to Provider, and Provider agrees to cooperate with Company to secure the return of any such overpayment or payment made in error (e.g., a duplicate payment or payment for services rendered by Provider to a patient who was not a Member) within a reasonable period of time. In the event Company is unable to secure the return of any such payment within such reasonable time, Company reserves the right to offset such payment against any other monies due to Provider under this Agreement provided Company has delivered to Provider at least ten (10) days prior written notice and Provider has otherwise failed to return such payment to Company. To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a case-based rate methodology, Provider acknowledges the financial risks to Provider of this arrangement and has made an independent analysis of the adequacy of this arrangement. Provider, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Provider was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement. Furthermore, to the extent that the compensation under certain Plans is in the form of capitation payments or a case-based methodology and Provider utilizes the services of a Covering Provider, Provider agrees to hold Company, Affiliates, Sponsors, Members and Payers harmless against any and all claims by such Covering Provider related to or arising out of payment for Covered Services rendered to Members. Provider understands that if Company makes payment to such Covering Provider under the circumstances described above, Company may offset future capitation or case-rate payments by the amount paid to such Covering Provider. Notwithstanding anything in this Agreement to the contrary, during such time as Provider is a member of a Group, Provider agrees to seek compensation solely from Group for those Covered Services provided to Members and for which Group is compensated by Company on behalf of Provider, and Provider shall in no event bill Company, its Affiliates, Payers or Members for any such Covered Services (except for the collection of Copayments, Coinsurance, Deductibles in accordance with Section 4.3).

Commented [RK15]: Timely payment clause and reference to incorporated payment schedule.

Commented [RK16]: A form of remedy for over payment. This can cause accounting nightmares but can rarely if ever removed from contracts.

Commented [RK17]: The no balance billing clause.

4.1.3 Utilization Management. Company utilizes systems of utilization review/quality improvement/peer review to promote adherence to accepted medical treatment

standards and to encourage Participating Providers to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Provider agrees, consistent with sound medical judgment:

(a) To participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) and decisions with respect to all Members.

(b) To comply with Company's pre-certification and utilization management requirements for all elective admissions and other Covered Services.

(c) To regularly interact and cooperate with Company's nurse case managers.

(d) To utilize Participating Providers to the fullest extent possible, consistent with sound medical judgment.

(e) To abide by all Company's credentialing criteria and procedures, including site visits and medical chart reviews, and to submit to these processes biannually, annually, or otherwise, when applicable.

(f) To obtain advance authorization from Company prior to any non-emergency admission, and in cases where a Member requires an emergency hospital admission, to notify Company, both in accordance with Company's rules, policies and procedures then in effect.

(g) To cooperate with Member's Primary Care Physician, if applicable, including timely scheduling of appointments and appropriate communication after patient evaluation and treatment.

For those Members who require services under a Specialty Program, Provider agrees to work with Company in transferring the Member's care to a Specialty Program Provider.

4.2 Coordination of Benefits.

Except as otherwise required under applicable Federal, state law or regulation or a Plan, (a) when Company and Provider agree that Company or a Plan Sponsor, as the case may be, is the primary payer under applicable coordination of benefit principles, Company or such Plan Sponsor agrees to pay in accordance with this Agreement, and (b) when Company or a Plan Sponsor is secondary under said principles, and payment from the primary payer is less than the compensation payable under this Agreement without coordination of benefits, then Company or Plan Sponsor will pay Provider the amount of the difference between the amount paid by the primary payer and the compensation payable under this Agreement, absent other sources of payment; provided, however, that if payment from this primary payer is greater than or equal to the compensation payable under this Agreement

without coordination of benefits, neither Company, Plan Sponsor nor the applicable Member (in accordance with Section 4.3.2 below) shall have any obligation to Provider. Notwithstanding anything to the contrary in this section, in no event shall Provider collect more than Medicare allows if Medicare is the primary payer. Medicaid is never the primary payer.

4.3 Member Billing.

4.3.1 Permitted Billing of Members. Provider may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or Deductibles not collected at the time that Covered Services are rendered; (b) a Plan Sponsor becomes insolvent or otherwise fails to pay Provider in accordance with applicable Federal law or regulation (e.g., ERISA) provided that Provider has first exhausted all reasonable efforts to obtain payment from the Plan Sponsor, however, this Section 4.3.1 (b) is not applicable to Medicaid Members; and (c) services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Provider acknowledges that Company's denial or adjustment of payment to Provider based on Company's performance of utilization management as described in Section 4.1.3 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise under this Section 4.3. Provider may bill or charge individuals who were not Members at the time that services were rendered.

Commented [RK18]: Restatement of no balance billing, plus statement of billing rights and procedures for non-covered services.

4.3.2 Holding Members Harmless. Provider hereby agrees that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other res controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles or other supplemental charges made in accordance with the terms of the applicable Plan. Provider further agrees that this Section 4.3.2: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

To protect Members, Provider agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 4.3.

Commented [RK19]: The no balance billing or hold harmless provision.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies.

Provider agrees to accept and comply with Policies of which Provider knows or reasonably should have known (e.g., Clinical Policy Bulletins or other Policies made available to Participating Providers). Company may at any time modify Policies. Company will provide ninety (90) days prior notice by letter, newsletter, electronic mail or other media, of Material Changes. Failure by Provider to object in writing to any Material Change within thirty (30) days following receipt thereof constitutes Provider's acceptance of such Material Change. In the event that Provider reasonably believes that a Material Change is likely to have a material adverse financial impact upon Provider's practice, Provider agrees to notify Company, specifying the specific bases demonstrating a likely material adverse financial impact, and the Parties will negotiate in good faith an appropriate amendment, if any, to this Agreement. Provider agrees that noncompliance with any requirements of this Section 5.1 or any Policies will relieve Company or Plan Sponsors and Members from any financial liability for the applicable portion of the Provider Services.

Commented [RK20]: An opt out provision for new policies and procedures.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Provider agrees to provide notice to Company, and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition, of: (a) any litigation brought against Provider or any of its employees or affiliated providers which is related to the provision of health care services and could have a material impact on the Provider Services provided to Members; (b) comply with any Company requirements regarding reporting of self-referrals, loss of licensure or accreditation, and claims by governmental agencies or individual regarding fraud, abuse, self-referral, false claims, or kickbacks; and (c) any material change in services provided by Provider or licensure status related to such services. Provider agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by or against Provider described in this Section 5.2.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Provider agrees (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive manner and in accordance with customary medical practice, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws; (c) to maintain such Information and Records for the longer of six (6) years after the last date Provider Services were provided to Member, or the period required by applicable law. This Section 5.3.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Provider agrees that (a) Company (including Company's authorized designee) and Plan Sponsors shall have access to all data and information obtained, created or collected by Provider related to Members and necessary for payment of claims, including without limitation Confidential Information ("Information"); (b) Company (including Company's authorized designee), Plan Sponsors and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access to all books, records and other papers (including, but not limited to, contracts, medical and financial records and physician incentive plan information) and information relating to this Agreement and to those services rendered by Provider to Members ("Records"); (c) consistent with the consents and authorizations required by Section 2.7 hereof, Company or its agents or designees shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to medical records for assessing the quality of care or investigating Member grievances or complaints; and (e) Members shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Provider agrees to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by any applicable law or regulatory authority. This Section 5.3.2 shall survive the termination of this Agreement, regardless of the cause of termination.

5.3.3 Government Requirements Regarding Records for Medicare Members. In addition to the requirements of Sections 5.3.1 and 5.3.2, with respect to Medicare Plans, Provider agrees to maintain Information and Records (as those terms are defined in Section 5.3) for the longer of: (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date the U.S. Department of Health and Human Services ("HHS"), the U.S. Comptroller General, or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. Provider further agrees that, with respect to Medicare Plans, Company and Federal, state and local government authorities having jurisdiction, or their designees, upon request, shall have access to all Information and Records, and that this right of inspection, evaluation and audit of Information and Records shall continue for the longer of (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date HHS, the U.S. Comptroller General, or their designee complete an audit, or (iii) the period required by applicable laws, rules or regulations. This Section 5.3.3 shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Quality, Accreditation and Review Activities.
Provider agrees to cooperate with any Company quality activities or review of Company or a Plan conducted by the National Committee for Quality Assurance (NCQA) or a Federal or state agency with authority over Company and/or the Plan, as applicable.

5.5 Proprietary Information.

5.5.1 Rights and Responsibilities. Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the same. Each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this Agreement to any third party without the other Party's consent, except (i) to governmental authorities having jurisdiction, (ii) in the case of Company's disclosure to Members, Plan Sponsors, consultants or vendors under contract with Company, and (iii) in the case of Provider's disclosure to Members for the purposes of advising Members of potential treatment options and costs. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party hereto, return any Proprietary Information upon termination of this Agreement for whatever reason. Notwithstanding the foregoing, Provider is encouraged to discuss Company's provider payment methodology with their patients, including descriptions of the methodology under which the Provider is paid. In addition, Provider through its staff may freely communicate with patients about their treatment options, regardless of benefit coverage limitations. This Section 5.5.1 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

6.0 TERM AND TERMINATION

6.1 Term.
This Agreement shall be effective for an initial term ("Initial Term") of _____ (__) year(s) from the Effective Date, and thereafter shall automatically renew for additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0.

Commented [RK21]: The "evergreen" clause.

6.2 Termination without Cause.
This Agreement may be terminated as of the anniversary date of the Effective Date, by either Party with at least ninety (90) days prior written notice to the other Party prior to such anniversary date of the Effective Date; provided, however, that no termination of this Agreement pursuant to this Section 6.2 shall be effective during the Initial Term hereof.

6.3 Termination for Breach.

This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within sixty (60) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such sixty (60) day period, any termination pursuant to this Section 6.3 will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such sixty (60) day period. Notwithstanding the foregoing, the effective date of such termination may be extended pursuant to Section 6.6 herein.

6.4 Immediate Termination or Suspension.

Any of the following events shall result in the immediate termination or suspension of this Agreement by Company, upon notice to Provider, at Company's discretion at any time: (a) the suspension, withdrawal, expiration, revocation or non-renewal of any Federal, state or local license, certificate or other legal credential authorizing Provider to perform Provider Services; (b) a suspension or revocation of Provider's DEA certification or other right to prescribe controlled substances (unless such certification is not a criterion of participation for Provider under the **Participation Criteria Schedule**); (c) Provider's indictment, arrest or conviction of a felony or for any criminal charge related to or in any way impairing Provider's performance of Provider Services; (d) the loss or material limitation of Provider's insurance under Section 2.5 of this Agreement; (e) a determination by Company that Provider's continued participation in provider networks could result in harm to Members; (f) the debarment or suspension of Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (g) the listing of Provider in the HIPDB; (h) change of control of Provider's practice to an entity not acceptable to Company; (i) any false statement or material omission in the participation application and/or confidential information forms and all other requested information, as determined by Company in its sole discretion; or (j) any adverse action with respect to Provider's hospital staff privileges, if Provider is required to maintain such privileges under the **Participation Criteria Schedule**. To protect the interests of patients, including Members, Provider will provide immediate notice to Company of any of the aforesaid events, including notification of impending bankruptcy.

6.5 Obligations Following Termination.

Following the effective date of any expiration or termination of this Agreement or any Plan, Provider and Company will cooperate as provided in this Section 6.5. This Section 6.5 shall survive the termination of this Agreement, regardless of the cause of termination.

6.5.1 Upon Termination. Upon expiration or termination of this Agreement for any reason, other than termination by Company in accordance with Section 6.4 above, Provider agrees to provide Provider Services at Company's discretion to: (a) any Member who is inpatient as of the effective date of termination until such Member's discharge or

Company's orderly transition of such Member's care to another provider; and (b) any Member, upon request of such Member or the applicable Plan Sponsor, for one (1) calendar year. The terms of this Agreement, including the **Services and Compensation Schedule** shall apply to such services.

Commented [RK22]: Member or their Employer may choose to use Provider and still obtain contracted for services.

6.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of Company, and as to Members of HMOs that become insolvent or cease operations, then in addition to other obligations set forth in this section, Provider shall continue to provide Provider Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined as inpatients on the date of insolvency or other cessation of operations until medically appropriate discharge. This provision shall be construed to be for the benefit of Members. No modification of this provision shall be effective without the prior written approval of the applicable regulatory agencies.

6.5.3 Obligation to Cooperate. Upon notice of expiration or termination of this Agreement or of a Plan, Provider shall cooperate with Company and comply with Policies, if any, in the transfer of Members to other providers.

6.6 Obligations During Dispute Resolution Proceedings.
In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 6.3 and the dispute is required to be resolved or is submitted for resolution under Article 8.0 below, the termination of this Agreement shall be stayed and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status.
The relationship between Company and Provider, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Company and Provider will each be solely liable for its own activities and those of its agents and employees, and neither Company nor Provider will be liable in any way for the activities of the other Party or the other Party's agents or employees arising out of or in connection with: (a) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (b) any negligent act or omission or other misconduct; (c) the failure to comply with any applicable laws, rules or regulations; or (d) any accident, injury or damage. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and that Policies do not dictate or control Provider's clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless the Company from any and all claims, liabilities and third party causes of action arising out of the Provider's provision of

Note that although you must follow all their rules and obligations for payment, they in essence absolve themselves of liability with respect to the right clinical course of care.

care to Members. Company agrees to indemnify and hold harmless the Provider from any and all claims, liabilities and third party causes of action arising out of the Company's administration of Plans. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

Commented [RK23]: Mutual or reciprocal indemnification clause in the event of a suit by a third party.

7.2 Use of Name.
Provider consents to the use of Provider's name and other identifying and descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media. Provider may use Company's names, logos, trademarks or service marks in marketing materials or otherwise, upon receipt of Company's prior written consent, which shall not be unreasonably withheld.

7.3 Interference with Contractual Relations.
Provider shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, Plan Sponsors or other entities currently under contract with Company to cancel, or not renew said contracts; (b) impeding or otherwise interfering with negotiations which Company is conducting for the provision of health benefits or Plans; or (c) using or disclosing to any third party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this Section 7.3 is intended or shall be deemed to restrict (i) any communication between Provider and a Member determined by Provider to be necessary or appropriate for the diagnosis and care of the Member and otherwise in accordance with Section 5.5.1; or (ii) notification of participation status with other HMOs or insurers. This section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement.

This is a gag clause on communication with the employer or ultimate stakeholder. This clause can be problematic when trying to ensure the fairness of the contract by enlisting the help of the ultimate customer.

8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.
Provider agrees to (a) cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicare appeals and expedited appeals procedures), (b) provide Company with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees.

8.2 Provider Dispute Resolution.
Company shall provide an internal mechanism whereby Provider may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider shall exhaust this internal mechanism prior to instituting any arbitration or other permitted legal proceeding. Discussions and negotiations held pursuant to this Section 8.2 shall be treated as inadmissible compromise and settlement negotiations for purposes of applicable rules of evidence.

8.3 Arbitration.

Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration administered by the American Arbitration Association ("AAA") and conducted by a sole arbitrator in accordance with the AAA's Commercial Arbitration Rules ("Rules"). The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the arbitrator may be entered by any court having jurisdiction thereof. Except as may be required by law or to the extent necessary in connection with a judicial challenge, or enforcement of an award, neither a party nor the arbitrator may disclose the existence, content, record or results of an arbitration. Fourteen (14) calendar days before the hearing, the parties will exchange and provide to the arbitrator (a) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (b) premarked copies of all exhibits they intend to use at the hearing. Depositions for discovery purposes shall not be permitted. The arbitrator may award only monetary damages in accordance with this Agreement.

Commented [RK24]: The means of remedy vs. mediation or suite in a court of competent jurisdiction.

8.4 Arbitration Solely Between Parties; No Consolidation or Class Action.

Company and Provider agree that any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between them. 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.

9.0 MISCELLANEOUS

9.1 Amendments.

This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed by both Parties, except as expressly provided herein. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement upon written notice, by letter, newsletter, electronic mail or other media, to Provider to comply with applicable law or regulation, or any order or directive of any governmental agency.

Commented [RK25]: Spells out how the contract can be amended, changed by either party.

9.2 Waiver.

The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Provider waives any claims or cause of action for fraud in the inducement or execution related hereto.

9.3 Governing Law.
This Agreement shall be governed in all respects by the laws of the State of Oregon.

9.4 Liability.
Notwithstanding Section 9.3, either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

9.5 Severability.
Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither Party shall assert or claim that this Agreement or any provision hereof is void or voidable if such Party performs under this Agreement without prompt and timely written objection.

9.6 Successors; Assignment.
This Agreement relates solely to the provision of Provider Services by Provider and does not apply to any other organization which succeeds to Provider assets, by merger, acquisition or otherwise, or is an affiliate of Provider. Neither Party may assign its rights or delegate its duties and obligations under this Agreement without the prior written consent of the other Party, which consent may not be unreasonably withheld; provided, however, that Company may assign its rights or delegate 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.

Commented [RK26]: Non-reciprocal assignment rights.

9.7 Headings.
The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

9.8 Notices.
Except for any notice required under Article 6, Term and Termination, or if otherwise specified, notices required pursuant to the terms and provisions hereof may be effective if sent by letter, electronic mail or other generally accepted media. With respect to notices required under Article 6, notice shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the following addresses (which may be changed by giving notice in conformity with this Section 9.8). Provider shall notify Company of any changes in the information provided by Provider below.

Keep the payer up to date on where to send notices, this ensures your opt-in and opt-out rights are protected with receipt of proposed updates or changes to the agreement.

To Provider at:

and to Company at:

Carrier
Regional Network Contracting
12345 Insurer Way
Anywhere, USA XXXXXX

9.9 Remedies.
Notwithstanding Sections 8.3 and 9.3, the Parties agree that each has the right to seek any and all remedies at law or equity in the event of breach or threatened breach of Section(s) 5.5, 6.6 and 7.3.

9.10 Force Majeure.
If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental order, directive, ruling or request) then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof. This Section 9.10 shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

9.11 Non-Exclusivity.

This Agreement is not exclusive, and nothing herein shall preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Provider.

9.12 Survival.

In addition to those provisions which by their terms survive expiration or termination of this Agreement (e.g. 4.3.2 and 5.3.1), Sections 5.5, 6.5 and 7.3 shall survive expiration or termination of this Agreement, regardless of the cause giving rise thereto.

9.13 Entire Agreement.

This Agreement (including any attached schedules) constitutes the complete and sole contract between the Parties regarding the subject hereof and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included herein and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. There are no oral agreements between the Parties. Provider represents that it has not relied on any data, financial analysis, reports, notes, proposals, conclusions or projections, whether made orally or in writing, made by Company or any of its representatives, agents, employees or advisors, in connection with negotiation, acceptance, execution or delivery of the Agreement by Provider.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

PROVIDER	**COMPANY**
By:_____	By:_____
Printed Name:_____	Printed Name:_____
Title:_____	Title:_____

FEDERAL TAX I.D. NUMBER:_____

PHYSICAL THERAPY/OCCUPATIONAL THERAPY
PARTICIPATION CRITERIA SCHEDULE

Commented [RK27]: Special exhibit applicable to provider party. This needs to be examined carefully and also presents the best opportunity to strike or add language.

I. BUSINESS CRITERIA

A. Applicability

1. These criteria shall apply to each Facility applicant for participation and each Facility participating in Plans, and shall be enforced at the sole discretion of Company[1].

2. Each applicant for participation as a Facility must have documentation that it has met the criteria stated below for at least six (6) months prior to application.

Is this reasonable? Is it even enforced?

3. Each participating Facility must continue to meet the following criteria for the duration of participation in the Plans.

B. General

1. Facility must have all appropriate license(s) and certification(s) mandated by governmental regulatory agencies, including, without limitation, any certificate of operation and certificate of occupancy.

2. Each provider at Facility who is a Therapist ("Provider") providing services to Members must be a graduate of an accredited school of therapy appropriate to the specialty and licensed by the state licensing board in the state in which Provider practices.

3. Facility must have documented emergency procedures, including procedures addressing treatment, transportation and disaster evacuation plans to provide for the safety of Members. Additionally, Facility must have functional generators to provide emergency power service in the event of a power failure.

Not things typical for outpatient PT clinics.

4. Facility must have an agreement with a Participating Hospital in place for the immediate transfer of patients.

5. When applicable to Facility, as determined by Company in its sole discretion, Facility's equipment must have current certifications indicating proper maintenance, calibration and compliance with any and all applicable standards, including OSHA standards and federal, state and local laws and regulations.

6. Facility shall provide or arrange for the provision of all technical and professional

[1] "Company" is defined in the opening paragraph of the Agreement.

components of the Services listed on the Services Schedule to the Agreement, including hand therapy and pediatric services.

7. All providers providing services at Facility must be Participating Providers. Facility shall notify company in writing within ten (10) business days of its acquiring knowledge of any addition or change in status of providers who provider services at Facility.

This is often difficult for small practices to have as part of their systems and procedures.

C. Facility Standards

1. Each Facility must:

   a. Be clean, presentable, and have a professional appearance;

   b. Be handicapped accessible to all patients, including but not limited to its entrance, parking and bathroom facilities;

   c. Have appropriate equipment immediately available for the treatment of medical emergencies;

   d. Have a waiting room able to accommodate at least five patients and a sufficient number of changing rooms to allow for patient privacy;

   e. Occupy at least 1,500 square feet dedicated to physical therapy and rehabilitation services;

   f. Not be located within, or directly adjacent to, a physician's office;

   g. Facility must complete a **Location Schedule**, attached hereto, identifying the address and physical location(s) of the above referenced Facility.

These types of references all seem overly intrusive with respect to the operations of your business.

2. Any exceptions to the above must be approved in advance by the Company Quality Improvement Committee.

D. Facility Requirements

1. Facility must possess equipment adequate for the provision and administration of all therapy treatments. This includes modality treatments, resistive exercises, and objective strength testing of trunk and/or lower extremities.

2. The Provider to assistant staffing ratio must not exceed 1:2;

3. Participating providers must be willing to contract separately with Company for home care services;

4. Monthly utilization data must be forwarded to Company in a format and time frame as required by Company.

This sentence is ambiguous. It suggests that you will be willing to be supplier of home health services under a separate contract. It should be reworded to simply exclude home health PT from the scope of services in this agreement.

E. Availability of Services

1. Hours of Operation -- Facility shall be available for all Facility Services from 8 a.m. to 5 p.m., Monday through Friday, or as may be modified from time to time at the sole discretion of Company. In addition, Facility shall be available from 5 p.m. to 8 p.m., a minimum of two evenings a week, and from 8 a.m. to 12 noon on Saturday mornings or as may be modified from time to time at the sole discretion of Company.

The payer can't guarantee patients on evenings and Saturdays. To comply is to let them dictate your operations.

2. Facility must be able to initiate treatment within 24 hours of contact by the referring physician or Member. Facility must return treatment reports to referring physicians in a timely fashion.

This is possibly unreasonable, given fluctuating demand.

F. Insurance

Facility shall maintain professional liability insurance at minimum levels required from time to time by Company, but in no event less than $200,000 per claim and $600,000 in the annual aggregate, except in cases where this level of insurance exceeds that required by applicable state law, in which instance Facility shall maintain the maximum level of professional liability insurance required by law. In addition, Facility shall maintain comprehensive general liability insurance at minimum levels required from time to time by Company, but in no event less than $1,000,000 per claim and $3,000,000 in the annual aggregate. Facility's insurance shall cover the acts and omissions of its participating provider as well as Facility's agents and employees. Memorandum copies of such policies shall be delivered to Company upon request. Facility must notify Company at least 30 days in advance of the cancellation, limitation or material change of said policies.

G. Subcontractors

Facility must obtain Company's approval prior to using any subcontractor to provide Facility Services to Members and all such subcontractors must be Participating Providers. Facility shall provide Company with a list of all subcontractors in existence on the Effective Date which Facility intends to use to provide Facility Services to Members. In the event Facility subcontracts for the provision of Facility Services:

1. Facility assumes full and complete responsibility for compensating subcontractor;

2. Facility guarantees that subcontractor will abide by the provisions set forth in the Agreement; and

3. Facility will provide Company with a Designation of Payment Schedule from all subcontractors, which will indemnify and hold harmless Company and its Members for payment of all compensation owed subcontractor under subcontractor's arrangement with Facility.

H. Philosophy

1. Facility must be supportive of the philosophy and concept of managed care and Company. A Facility shall not differentiate or discriminate in the treatment of, or in the access to treatment of, patients on the basis of their status as Members, or other grounds identified in the Agreement.

2. Facility shall have the right and is encouraged to discuss with its patients pertinent details regarding the diagnosis of the patient's condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment.

3. Facility's obligations under the Agreement not to disclose Proprietary Information do not apply to any disclosures to a patient determined by Facility to be necessary or appropriate for the diagnosis and care of a patient, except to the extent such disclosure would otherwise violate Facility's legal or ethical obligations.

4. Facility is encouraged to discuss Company's provider reimbursement methodology with Facility's patients who are Members, subject only to Facility's general contractual and ethical obligations not to make false or misleading statements. Accordingly, Proprietary Information does not include descriptions of the methodology under which Facility is reimbursed, although such Proprietary Information does include the specific rates paid by Company due to their competitively sensitive nature.

II. PROFESSIONAL CRITERIA

A. Accreditations and Licensures

1. Facility must be Medicare certified.

You may wish to ensure that a CARF or other form of accreditation is not required. Simple Medicare numbers for outpatient billing, and DME billing numbers are what is likely needed.

III. Professional Competence and Conduct

A. Professional Standing

1. Facility shall provide immediate notice to Company of any adverse action relating to Facility's, or any of Facility's participating providers', where applicable: (i) hospital staff privileges, where applicable; or (ii) DEA or state narcotics numbers, where applicable; or (iii) participation in Medicare, Medicaid, or other governmental programs, where applicable; or (iv) state licensure, certification, accreditation or other authorization required by law or the Agreement to provide the Facility Services. Facility shall inform the applicable Company peer review committee in writing of any previous adverse actions with respect to any of the above. For the purpose of this section, "adverse action" includes, but is not limited to, any of the following or their substantial equivalents (regardless of any subsequent action or expungement of the record): denial; exclusion; fine; monitoring; probation; suspension; letter of concern, guidance, censure, or reprimand; debarment; expiration without renewal; subjected to disciplinary action; or other similar action or limitation; restriction; counseling; medical or psychological evaluation; loss, in whole or in part; staff privileges reduced, withheld, suspended, voluntarily surrendered, resigned, revoked or subject to any special provisions; termination or refused participation; revocation; administrative letter; non-renewal; voluntary or involuntary surrender of licensure or status to avoid, or in anticipation of, any of the adverse actions listed regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry; and initiation of investigations, inquiries or other proceedings that could lead to any of the actions listed, regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry. Any such adverse actions may be grounds for action, including without limitation, denial or termination of Facility or other sanctions imposed pursuant to Company's credentialing/quality improvement programs.

2. Facility shall provide immediate notice to Company of any circumstance that limits Facility's ability to provide the Facility Services.

Perhaps the most comprehensive credentialing issue clause I've ever read.