

Model Managed Care Contract for Health Professionals and Clinical Providers of Mental Illness and Addiction Disorder Treatment and Prevention Services

(Adapted from the AMA Model Managed Care Contract)

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Introduction

Contracts between managed care organizations and health professionals and clinical providers are a critical part of the modern managed care system and crucial to the long-term professional and financial health of any clinical professional or entity. A network service agreement establishes the legal standards that will govern the service duties of network professionals as well as how they will be paid, their rights to dispute decisions of the contractor, and their ability to manage their patients' care in a professionally ethical fashion.

The contracting process is one that health care professionals oftentimes find complex and confusing. Furthermore, studies of managed care service contracts between managed care organizations and health professionals who furnish mental illness and addiction disorder prevention and treatment services have found that these contracts often heavily favor the managed care organization by allowing the MCO broad latitude over a network professional's service responsibilities, the rate of payment for covered benefits and extensive discretion over treatment decision-making.¹

As an aid to its members, the American Medical Association (AMA) has drafted a "model" provider agreement that gives physicians in both individual and group practice a tool that can be utilized in the managed care contracting process. The AMA's contract (accessible at <http://www.ama-assn.org/ama/pub/category/6578.html>) is designed to help physicians understand and negotiate the contracts they sign. At the same time, the model contract is designed as a general medical services template. As a result, specialty providers such as mental health and addiction

¹ See, for example: SAMHSA Issue Brief #9, *An Evaluation of Agreements Between Managed Care Organizations and Community-Based Mental Illness and Addiction Disorder Treatment and Prevention Providers* (May, 2000); *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts (3rd Edition): Special Report: Mental Illness and Addiction Disorders and Medicaid Managed Care*, GWU Center for Health Services Research & Policy, 2000.

disorder treatment professionals and clinical providers may find that the model does not address certain critical contracting issues which exist as a function of their specialty practices.

In order to address the need for a “customized” model contract designed for use by health professionals and clinics furnishing mental health and addiction disorder treatment and prevention services, the Substance Abuse and Mental Health Services Administration (SAMHSA), funded the George Washington University Center for Health Services Research and Policy (CHSRP) to adapt the AMA model contract for use in this specialty area. Working in collaboration with a number of professional organizations including the National Association of Social Workers, the American Psychological Association, the National Association of Alcohol & Drug Abuse Counselors, the American Psychiatric Association, and the University of Maryland’s Department of Behavioral and Community Health— CHSRP has adapted the AMA contract for use in the area of mental illness and addiction disorder network agreements.

CHSRP’s adaptations are highlighted in **bold** in the text of the AMA contract, with each change accompanied by an explanatory footnote. The adaptations address a number of issues that, through its previous research as well as consultation with professional organizations, CHSRP has identified as important to mental health and addiction disorder providers. These issues are as follows:

1. The definition of “emergency” in a mental illness and addiction disorder context;
2. The definitions of medical necessity;
3. Access to information about the full scope of coverage and network access available to enrollees under the master contract;
4. Prior authorization;
5. Interaction of MI/AD providers with the gatekeeping functions of the MCO;
6. Eligibility verification services;
7. Information disclosure;
8. Access to information regarding standards of treatment;
9. Involvement in the development of performance measurements and the adoption of clinical practice guidelines;
10. Panel sizes in the case of capitated provider agreements;
11. compliance with the federal Confidentiality of Alcohol and Drug Abuse Patient Records statute and state mental health record confidentiality statutes;
12. Notice periods for contract modification; and
13. Payment for treatment during the post-termination phase of a MCO/provider contract.

It is important to stress that a provider network agreement, no matter how generous to the provider, cannot add coverage beyond what is specified in the master contract between a group sponsor and a managed care organization. Similarly, where a master contract gives the MCO discretion to establish a tightly circumscribed and controlled network that enrollees can access only through centralized prior authorization, this is also an issue of basic master contract design and not one that the provider agreement can alter. Thus, many issues that are critical to the availability and quality of care are controlled by the master agreement, not the provider contract. At the same time, this model agreement does specify that the MCO must give the provider full access to the coverage and service terms of a master contract. This added provision has been recommended (a) so that the provider can understand the full scope of coverage to which enrollees are entitled; and (b) have a

means of measuring when a service that is denied as “uncovered” may in fact be one that the company is legally obligated to furnish.

Model Managed Care Contract for Health Professionals and Clinical Providers:
Mental Illness and Addiction Disorder Prevention and Treatment Services
(Adapted from the AMA Model Managed Care Contract)

(Suggested adaptations highlighted in **Bold**
with accompanying explanatory footnotes)

THIS AGREEMENT, made this ____ day of ____ 2001 and made effective on the ____ day of _____, 2001 (“Effective Date”) by and between [**name of physician or health professional**²] [**name of clinic or a medical group practice**]³ [a physician joint venture, such as a Network or IPA] _____ (“Contractor”), and _____ a [state of incorporation] Corporation (“Company”) (Contractor and Company jointly the “parties”).

Witnesseth:

WHEREAS, Company offers or directly administers one or more **mental illness and/or addiction disorder treatment**⁴ health benefit products or plans and wishes to arrange for the provision of medical services to enrollees of such products or plans.

WHEREAS, **Contractor**⁵ is capable of meeting the credentialing criteria of Company.

WHEREAS, Company desires to engage **Contractor** to deliver or arrange for the delivery of medical services to the Enrollees of its plans.

WHEREAS, **Contractor** is willing to deliver or arrange for the delivery of such services on the terms specified herein.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, and other good and valuable consideration, the parties hereby agree as follows:

² Certain terms used in the AMA model contract—such as “physician” or “medical provider”—may not be representative of the many types of health/medical professionals (e.g., psychologists, licensed clinical social workers, nurse practitioners, clinical nurse specialists, addiction disorder specialists, etc.) who provide behavioral health care services.

³ In the case of behavioral health care, the contracting entity may be licensed as a clinic, in which case the entity presumably would want the contract to run to the entity rather than to individual health professionals working for the entity.

⁴ A common term is “behavioral” health care. We recommend a descriptor that more accurately identifies the types of conditions to which the service coverage agreement relates.

⁵ The AMA model uses the term “Contractor.” We recommend the term “contractor” as the general catchall term to identify the health professional, clinic or entity entering into the agreement with the managed care organization. Persons using this model may wish to substitute their own name.

I. Definitions

- 1.1 **Claim.** A statement of services submitted to Company by **Contractor** following the provision of Covered Services to an Enrollee that shall include diagnosis or diagnoses and an itemization of services and treatment provided to Enrollee.
- 1.2 **Company Notice.** A communication by Company to **Contractor** informing Contractor of the terms of one particular Plan, modifications to the Plan, and any other information relevant to the provision of Covered Services pursuant to this Agreement.
- 1.3 **Company Compensation.** The Total Compensation less that portion designated by the Plan as a Copayment.
- 1.4 **Coordination of Benefits.** The determination of whether Covered Services provided to an Enrollee shall be paid for, either in whole or in part, under any other private or government health benefit plan or any other legal or contractual entitlement, including, but not limited to, a private group indemnification or insurance program.
- 1.5 **Copayment.** A charge that may be collected directly by a **Contractor or Contractor's** designee from an Enrollee in accordance with the Plan.
- 1.6 **Covered Services.** Health care services to be delivered by or through **Contractor** to Enrollees pursuant to this Agreement. A description of the medical services that are covered by the applicable products or plans is attached to this Agreement as Exhibit A.
- 1.7 **Emergency Condition.** A **physical, mental or addiction disorder-related**⁶ 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 patient's health in serious jeopardy; (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part.
- 1.8 **Enrollees.** Any individual(s) entitled to health care benefits under a Plan who presents an identification card that contains the following information:
- (i) the name of the Payor;

⁶ Clarifies that for purposes of prudent layperson protections, a medical emergency can involve a mental illness or addiction disorder. An alternative would be to use the following definition for mental health or addiction disorder related emergencies: "Mental illness or addiction disorder-related emergency shall mean the sudden onset of a mental health or substance abuse condition manifesting itself by acute symptoms and one or more of the following circumstances are present: (i) the patient is in imminent or potential danger of harming himself or others as a result of a condition included as a Covered Service; (ii) the patient shows symptoms (e.g., hallucinations, agitation, delusions, etc.) resulting in impairment in judgment, functioning and/or impulse control severe enough to endanger his or her own welfare or that of another person; or (iii) there is an immediate need for Covered Services as a result of or in conjunction with an event such as an overdose, detoxification or potential suicide.

- (ii) the Enrollee's name;
- (iii) the logo of the plan or product;
- (iv) contact information for pre-authorization, if necessary;
- (v) the billing address; and
- (vi) the applicable Plan.

1.9 Medically Necessary. Covered Services that are necessary and appropriate for the treatment or management of the patient's mental illness or addiction disorder, as defined in the most current version of the DSM. The term "**Medically Necessary**" with reference to a Covered Service, shall mean: (a) generally accepted by qualified professionals as necessary for the proper and efficient diagnosis, treatment and management of a mental illness or addiction disorder, (b) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency, and (b) no more intense a level of service than can safely be provided.⁷

1.10 Non-Covered Services. Health care services that **under the terms of the managed care organization's contract with a group sponsor, employee health plan, or other entity**⁸ are not Covered Services as defined herein.

1.11 Payor. The entity or organization directly responsible for the payment of Company Compensation to the **Contractor** under a Plan. With respect to a self-funded Plan covering the employees of one or more employers, the Payor shall be the employer(s) and/or any funding mechanism used by the employer(s) to pay Plan benefits. With respect to an insured Plan or Plan providing benefits through a health maintenance organization, the Payor shall be the insurance company or health maintenance organization, as the case may be. Under no conditions shall the parties interpret "Payor" to be, nor shall the negotiated rates herein described be accessible to, any party other than Company or an employer offering a self-funded, non-indemnity product that contracted with Company to administer such product.

1.12 Plan. An individual set of health service delivery and compensation procedures offered as a "managed care" product by Company, or administered by Company, on behalf of a **sponsor or other**⁹ Payor for the benefit of Enrollees, as it may be modified from time to time, and all the terms, conditions, limitations, exclusions, benefits, rights, and obligations thereof to which Company and Enrollees are subject. Nothing in this Agreement shall be construed to require physicians to participate in all of Company's Plans as a condition of participating in any individual plan or plans.

⁷ Eliminates as redundant the AMA model clause that the service not be primarily for the convenience of the treating professional, the patient or the family. A service that is clinically necessary is by definition not furnished primarily for non-medical or "convenience" purposes. Retains the concept of the safest and least intrusive service as consistent with community integration established under the Americans with Disabilities Act for persons with mental illness. Obviously changing the definition of medical necessity may in many cases be difficult unless the contractor possesses considerable market power in negotiations with the managed care organization.

⁸ Clarifies that in order to be excluded as a non-covered service the MCO would be expected to demonstrate that the service in question falls outside of its own "master agreement" with a group sponsor, employer, or other entity.

⁹ Includes the preferred terminology for group health plans purchased on either an insured or self insured basis by employers or other group purchasers such as Medicaid agencies, SCHIP agencies, or Medicare. Group purchasers typically are referred to as a "sponsors" of a health plan.

1.13 Qualified **health professional**.¹⁰ A **physician or other health professional who satisfies applicable conditions of licensure in the state in which health services are being purchased** who has agreed in writing, either through this Agreement or through another written instrument, to provide Covered Services to Enrollees and who has been credentialed pursuant to the rules and procedures of the Plan by the Company or a duly appointed and authorized agent to which such responsibility has been delegated.

1.14 Quality Management. The process designed to monitor and evaluate the quality and appropriateness of care, pursue opportunities to improve care, and resolve identified problems in the quality and delivery of care.

1.15 Total Compensation. The total amount payable by Payor and Enrollee for Covered Services furnished pursuant to this Agreement.

1.16 Utilization Review. The process by which Company, or a duly appointed and authorized entity (including Contractor) to which such responsibility has been delegated, determines on a prospective, concurrent, or retrospective basis the medical **necessity**¹¹ appropriateness of Covered Services furnished to Enrollees **on the basis of valid, relevant, and reliable clinical practice guidelines, all pertinent medical evidence from the enrollee's specific case, and the opinion of the treating professional.**

II. Delivery of Services

2.1 Covered Services. **Contractor** shall provide or, through its Qualified Physicians, arrange for the provision to Enrollees of those Covered Services that are identified in Exhibit A, attached hereto and made a part of this Agreement by this reference.¹²

2.2 Full Description. Exhibit A shall be comprised of separate schedules designated as Exhibit A1, A2, etc., which shall either identify separately the Covered Services relating to each Company Plan or provide a fixed location where the **Contractor** can conveniently find the complete list of covered services.

2.3 Full Disclosure. Where such schedule contemplates a global or capitated arrangement requiring Covered Services not normally provided by the Qualified Physicians of **Contractor** such Covered Services shall be designated in bold type on Exhibit A, and a note shall be displayed prominently stating that payment for these Covered Services shall be the **Contractor's** responsibility.

2.4 Administrative Responsibility. In the event Exhibit A is not attached or in the

¹⁰ Replaces the term "physician" with broader term "professional."

¹¹ Replaces the term "appropriateness" in order to maintain parallelism with the definition of "medical necessity".

¹² Prior to agreeing to a specific list of covered services, a contractor (particularly one with considerable bargaining power) may want to examine the master agreement between the managed care organization and the group sponsor or other purchasing entity in order to ascertain the full scope of the MCO's own treatment obligations. A contractor will want to know the full scope of coverage for any enrollee. In addition, the Contractor may be able to identify services such as case management, transportation, and other patient support services, that fall within the service duties of the MCO and that could be delegated to the contractor through this agreement.

event such exhibit contains descriptions of Covered Services that are so materially lacking in specificity that the purpose of this Agreement is defeated, Company shall pay **Contractor's** billed charge for each service performed for the benefit of Enrollee.

2.5 Medical Responsibility. All Covered Services shall be provided in accordance with generally accepted clinical standards, consistent with medical ethics governing the Qualified Physician.

2.6A Prior and Concurrent Authorization : Company shall prior to the effective date of this agreement provide Contractor with written guidelines related to prior and concurrent authorization including information on the specific services and procedures subject to prior or concurrent authorization, the manner and form in which requests must be submitted, applicable timelines under which the Company must make prior or concurrent authorization decisions, and the timing and manner in which Contractor and Enrollee will be notified. Where Company fails to meet the prior and concurrent authorization provisions in its own guidelines, federal or state law, or applicable terms under the Company's own contract with a group sponsor or other entity, the Contractor's claim for services shall be paid in full at the billed charge rate.¹³

2.6B Verification of Enrollment. Except in the case of emergency, **Contractor** shall use the mechanism, including identification card, on-line service or telephone, chosen by Company or its agent designated for such purpose, to confirm an Enrollee's eligibility prior to rendering any Covered Service, in order to guarantee payment. If Company does not provide verification services on a twenty-four hour a day, seven-day per week basis, **Contractor** shall be entitled to rely on the information printed on the Enrollee's identification card as conclusive evidence of such Enrollee's eligibility. In addition, Company and **Contractor** agree to the following:

2.6(a) Company or Payor shall be bound by Company's confirmation of eligibility and coverage for the requested services and shall not retroactively deny payment for Covered Services rendered to individuals the Plan has confirmed as eligible using Company's designated verification mechanism.

2.6(b) If **Contractor** , after following Company procedure to the extent reasonably possible, is unable to verify the eligibility of a patient who holds him or herself out to be an Enrollee, **Contractor** shall render necessary care and Company shall pay for such care if the patient is an Enrollee.

2.6(c) In the event of an emergency, at the first available opportunity, **Contractor** shall attempt to verify eligibility. In the event Contractor makes all good faith efforts to verify eligibility, and verification is not reasonably possible given time constraints caused by the Company's action or inaction, and patient is not an Enrollee, Contractor shall attempt to collect from patient the amount due, up to the usual and customary fee of the Qualified Physician providing the service. If, after two billing cycles, **Contractor** or Qualified Physician has not received full payment, Company will pay **Contractor** the Qualified Physician's usual and customary fee, minus that which the Qualified Physician or Contractor has already collected from the patient, not to exceed the amount provided for as Total Compensation herein.

¹³ *The issue of prior authorization is of particular importance. The failure of an MCO to comply with its own authorization guidelines or those specified under law should result in payment in full to the Contractor.*

2.6(d) “Round the clock” eligibility verification: MCO agrees to provide 24-hour/7-day per week eligibility verification services. ¹⁴

III. Compensation and Related Terms

3.1 Compensation. Contractor, or its designee, shall accept, from Company or Payor, as full payment for the provision of Covered Services, the Total Compensation identified in Exhibit B, attached hereto and made a part hereof by this reference.

3.2 Full Description. Exhibit B shall be comprised of separate schedules designated as B1, B2, etc., which shall identify separately the Total Compensation and related terms for each **sponsored Plan**.¹⁵

3.3 Full Disclosure. The Total Compensation set forth on the Exhibit B schedule(s) shall specify for each Payor and Plan, the manner of payment (such as fee-for-service, capitation, risk withholds, global payment, or bonus arrangement) for professional services rendered pursuant to the provision of Covered Services as set forth in the counterpart schedule of Exhibit A, and shall identify the portion of the Total Compensation that shall be the Company Compensation. Exhibit B shall also identify with specificity the additional business terms negotiated by the parties related to such Total Compensation. By way of example, and without limiting the requirements of this section, Exhibit B shall specify the following:

- 3.3(a) In the case of a capitation arrangement,
- i. the amount to be paid per Enrollee, per month;
 - ii. the date each month that the capitation payment is due;
 - iii. the manner by which Company will determine and communicate to Contractor who is an Enrollee assigned to Contractor at the beginning of each month;
 - iv. the precise terms of the stop-loss arrangement offered to Contractor by Company, or a recital indicating that Contractor shall obtain stop-loss protection through other arrangements;
 - v. the boundaries of the service area in which treatment of Enrollees shall be arranged by Contractor and outside of which treatment provided to Enrollees shall become the financial obligation of Company;
 - vi. the fee-for-service schedule to which the parties will revert in the event the number of Enrollees assigned to Contractor falls below a designated actuarial minimum, defeating the predictability of risk that both parties rely on in the arrangement;
 - vii. the **minimum** number¹⁶ of covered lives and the fee-for-service schedule upon which Contractor will be paid for those Covered Services provided to Enrollees not specifically made a part of the capitation arrangement on Exhibit A. In the case of a capitation arrangement, Contractor shall have the right to audit, at Contractor’s expense, the books and

¹⁴ MCOs should have a means of verifying eligibility at any time in order to ensure proper administration of the plan.

¹⁵ Slight modification in AMA language to conform to concept of “sponsored” plan.

¹⁶ Health professionals and clinics entering into capitation agreements in effect are accepting a considerable level of downstream financial risk. For this reason, the company should specify the minimum size of the network member’s capitation panel in order to guarantee a minimum monthly payment.

records of Company or a Payor for purposes of determining the accuracy of any capitation payment and for the purposes of determining the number of Enrollees assigned to Contractor.

viii. the description of reports and analyses to be supplied at least monthly by the Company to enable the Contractor to manage effectively the risk it assumes under capitation arrangements.

3.3(b) In the case of hospital services,

risk sharing on Non-Covered Services (i.e. risk pools for hospital services),

i. the amount allocated for Non-Covered Services including the figure used for measuring hospital inpatient days per one thousand (1,000) Enrollees assigned to Contractor and applicable hospital per diem or capitation payment;

ii. those services that will be charged against the hospital budget, such as hospital inpatient and outpatient care, ambulance service, home health services, durable medical equipment, and the capitation payment withhold, if any, of Contractor's contribution to the hospital budget;

iii. the monthly date upon which Company will submit to Contractor a report regarding current charges made against the hospital budget;

iv. the amount of the hospital budget surplus to which Contractor would be entitled in the event utilization of institutional services is favorable, and the degree and scope of risk to Contractor, if any, in the event utilization of institutional services is excessive.

3.3(c) In the case of a withhold or bonus,

i. the method by which the amount to be released or paid will be calculated and the date on which such calculation will be complete;

ii. the records or other information on which Company will rely to calculate the release of the withhold or the payment of the bonus;

iii. the date upon which Contractor will have access to such records or information relied on by Company in making such calculation for the purpose of verifying the accuracy thereof;

iv. the date upon which such payment or release, if any is finally due, shall be made.

3.3(d) In the case of a discounted fee for service arrangement, Exhibit B shall contain the following:

i. a comprehensive fee schedule that states clearly how much will be paid for each service to be rendered pursuant to the agreement or, as appropriate, sufficient information is provided to enable a fee for each service to be calculated accurately by each party;

ii. a statement that the fee schedule cannot be changed without the consent of Medical Service Entity;

iii. a provision stating the consequence for a Payor changing the terms of a fee schedule without consent of the Medical Service Entity, including the right to terminate the agreement and the right to recover billed charges.

3.4 Administrative Responsibility. In the event Exhibit B is not attached or contains descriptions of compensation and related terms that are so materially lacking in specificity that the purpose of this Agreement is defeated, then Exhibit B shall be considered null and void and Company shall pay Contractor the billed charge for each service. The Parties agree that the precise terms of Exhibit B, as opposed to the general description of the manner of payment, shall remain confidential between the parties and their respective attorneys.

3.5 Billing for Covered Services. Contractor shall submit a Claim to Company and, in the event payment is required under the terms of Exhibit B, Company shall pay Contractor for Covered Services rendered to Enrollees in accordance with the terms of this Agreement. Contractor shall arrange for all Claims for Covered Services to be submitted to Company within six (6) months after the date services were rendered. Contractor shall submit such claims electronically or on a HCFA-1500 billing form.

3.6 Coding for Bills Submitted. Company hereby agrees that claims submitted for services rendered by Contractor shall be presumed to be coded correctly. Company may rebut such presumption with evidence that a claim fails to satisfy the standards set forth on Exhibit C. Exhibit C shall include a detailed description of Company's coding standards and requirements, including, but not limited to, the rules on modifiers, multiple surgeries, evaluation and management, and bundling policies such as edits, including correct coding initiatives. Company shall not adjust the billing codes submitted by Contractor on a claim without first requesting additional documentation to satisfy the coding standards described on Exhibit C. Company or Payor must provide adequate notice if it wishes to adjust a code and must allow sufficient time for Contractor to submit additional documentation or explanation. Contractor shall have the right to appeal any adverse decision regarding the payment of claims based upon the level of coding with rights and duties as set forth in this Agreement. If Company reduces payment of a claim in contravention of this section, such party shall be obligated to reimburse Contractor for the full amount of billed charges for the claim.

3.7 Copayments to be Collected from Enrollees. When the Plan requires Enrollees to make Copayments, Contractor or one of its Qualified Physicians shall collect such Copayments from the Enrollee at the time of service. Company shall require Enrollees to make Copayments at the time of service and educate Enrollees about the amount of the Copayment and that making Copayment at the time of service is mandatory. [If Copayment is not remitted to Contractor in a timely fashion, Company agrees that Contractor may discontinue seeing patient, subject to its Qualified Physician's ethical duties, and that such action will not constitute a violation of Section 4.2 by Contractor.]¹⁷

3.8 Coordination of Benefits. When Enrollees are covered, either fully or partially, for services provided by a Qualified Physician under any contractual or legal entitlement other than this Agreement, including, but not limited to, a private group or indemnification pro-gram, Contractor shall be entitled to keep any sums it recovers from such primary source consistent with applicable federal and state law. **Except as indicated in the following sentence, the Company will pay Contractor the usual and customary fee at its normal rate for the covered service in question, less that which is obtained from any primary source.**¹⁸ If Exhibit B contemplates a fee-for-service compensation arrangement, the sum of such payments shall not exceed the Total Compensation set forth on Exhibit B; however, in the case of Medicare beneficiaries and where the Payor is the Secondary Payor, the sum of such payments shall not be less than one hundred percent (100%) of the Medicare allowed fee schedule.

3.8(a) If the **Company on behalf of the Enrollee's sponsor** is deemed "primary" in accordance with applicable industry coordination of benefits ("COB") standards, then **Company** shall pay Contractor in accordance with the terms of this Agreement with no delay, reduction, or offset.

¹⁷ This provision would not be permissible in the event that the enrollee is sponsored through

¹⁸ Modified to conform to the remainder of the contract, with payment to contractor used in lieu of payment to treating physician.

3.8(b) If the **Company on behalf of enrollee's sponsor** is deemed "secondary" in accordance with applicable industry COB standards, Company shall pay Contractor the difference between what Contractor received from the primary Sponsor and the amount Sponsor owes Contractor as Total Compensation under the terms of this Agreement.

3.8(c) **Company** shall be presumed to be the primary payer and shall make payments in accordance with this Agreement, unless the **Company** can document to the satisfaction of the Contractor that it is secondary under industry COB standards within 72 hours of receipt of a claim.

3.8(d) If **Company** pays a claim to Contractor in accordance with this Agreement, Contractor agrees to cooperate with the reasonable efforts of Sponsor to determine whether it is the primary or secondary Sponsor under industry COB standards.

3.8(e) If it is subsequently determined that **Company** should be considered secondary under industry COB standards, then Contractor will cooperate with that Sponsor's reasonable efforts to seek reimbursement from the responsible primary Sponsor.

3.8(f) If Exhibit B provides a fee-for-service schedule applicable to Enrollee's Plan, Contractor shall not retain funds in excess of the Total Compensation fee schedule listed on Exhibit B, unless applicable state law regarding COB requires or imposes a different requirement.

3.8(g) Secondary Sponsors shall not be relieved of their obligation to make full payment to Contractor in the event the primary Sponsor fails to pay Contractor properly submitted Claims within 90 days of submission.

3.9 Promptness of Payment. Each Sponsor shall remit to Contractor the Company Compensation within fourteen (14) days of receipt of an electronic Claim and thirty (30) days of receipt of a written Claim by Contractor, or such shorter time as set forth by law, that contains sufficient detail that Sponsor is able to reasonably determine the amount to be paid. In the case of Total Compensation described on Exhibit B that requires prepayment or lump sum payment for services, such as capitation, such Company Compensation shall be remitted by the fifteenth day of the month covered by such payments.

3.9(a) If additional information is needed by Sponsor to evaluate or validate any Claim for payment by Contractor, Sponsor shall request any additional information in writing within fifteen (15) days of receipt of the Claim. Sponsor shall affirm and pay all valid Claims within thirty (30) days of receipt of such additional information. Any undisputed portions of a Claim must be paid according to the time frame set forth in 3.9 while the remaining portion of the Claim is under review.

3.9(b) In the event that a Sponsor fails to make such payment in a timely fashion as specified herein, Sponsor shall be obligated for payment of such amounts plus interest accruing at the annualized rate of the Wall Street Journal prime rate of interest on the first day of the month on which such amounts were due plus three percent (3%) or such greater rate of interest as provided for under state law in the event of late payment. All payments to Contractor will be considered final unless adjustments are requested in writing by Contractor within ninety (90) days after receipt by Medical Service Entity of payment explanation from Sponsor.

3.10 Sole Source of Payment. Where Enrollee is enrolled in a Plan subject to state or federal legal requirements that prohibit a physician from billing patients for Covered Services in the event the Sponsor fails to make such payment, Contractor agrees to look solely to that Sponsor for payment of all Covered Services delivered during the term of the Agreement.

3.10(a) In such circumstances, Contractor shall make no charges or claims against Enrollees for Covered Services except for Copayments as authorized in the Plan covering Enrollee.

3.10(b) In such circumstances, Contractor expressly agrees that during the term of this Agreement it shall not charge, assess, or claim any fees for Covered Services rendered to Enrollees from such Enrollees under any circumstances, including, but not limited to, the event of Sponsor's bankruptcy, insolvency, or failure to pay the Qualified Physician providing services.

3.10(c) Notwithstanding the foregoing, Company shall cooperate in the processing of such claims against Sponsor to provide Contractor with its greatest chance to receive compensation for covered services provided, and this provision shall permit Contractor to collect payment not prohibited under state or federal law, including, but not limited to:

- i. Covered Services delivered to an individual who is not an Enrollee at the time services were provided;
- ii. services provided to an Enrollee that are not Covered Services, provided that Contractor advises the Enrollee in advance that the services may not be Covered Services; or
- iii. services provided to any Enrollee after this Agreement is terminated.

3.11 Subrogation. In the event an Enrollee is injured by the act or omission of a third party, the right to pursue subrogation and the receipt of payments shall be as follows:

3.11(a) If Exhibit B provides for a capitation payment for the Enrollee, Contractor shall retain the right of subrogation to recover reimbursement from third parties, such as automobile insurance companies, for all Covered Services for which it is at risk to provide in exchange for the capitation paid hereunder.

3.11(b) If Exhibit B provides for a fee-for-service arrangement for the Enrollee, Contractor shall permit Sponsor to pursue all its rights to recover reimbursement from third party Sponsors to the extent Sponsor is at risk for the cost of care.

3.11(c) Sponsor shall pay claims submitted by Contractor in accordance with this Agreement, notwithstanding Sponsor's pursuit of subrogation rights against potentially responsible third parties who caused an injury by their act or omissions in accordance with section 3.11(b).

3.11(d) Contractor shall abide by any final determination of legal responsibility for the Enrollee's injuries.

3.11(e) Upon receiving payment from the responsible party, Contractor will refund the amount of payment to Sponsor up to the amount paid by the Sponsor for the services involved. Contractor shall be entitled to keep any payments received from third parties in excess of the amount paid to it by Sponsor.

IV. Contractor's Obligation

4.1 Licensed/Good Standing. Contractor represents that it [and each of its **qualified health professionals**],¹⁹ is and shall remain licensed or registered to practice medicine and, if applicable, the legal entity is registered and in good standing with the state in which it is chartered and each state in which it is doing business.

4.2 Nondiscrimination. Contractor agrees that it, and each of its Qualified Physicians, shall not differentiate or discriminate in its provision of Covered Services to Enrollees because of race, color, ethnic origin, national origin, religion, sex, marital status, sexual orientation, income, disability, or age. Further, Contractor agrees that its Qualified Physicians shall render Covered Services to Enrollees in the same manner, in accordance with the same standards, and within the same time availability as such services are offered to patients not associated with Company or any Plan, consistent with medical ethics and applicable legal requirements for providing continuity of care. Section 4.2 is subject to state law, and the parties entitled to protection under Section 4.2 may be modified to be consistent with such law.

4.3 Standards. Covered Services provided by or arranged for by Contractor shall be delivered by professional personnel qualified by licensure, training, or experience to discharge their responsibilities and operate their facilities in a manner that complies with generally accepted standards in the industry.

4.4 Cooperation in Credentialing. Company and Contractor agree to cooperate in credentialing and re-credentialing Qualified Physicians in accordance with the process set forth on Exhibit D and consistent with Section 5.4 of this Agreement. Exhibit D shall identify with specificity the criteria for credentialing timelines and the rights and obligations of Company and the physicians during the credentialing process. By way of example, Exhibit D shall specify the following:

4.4(a) The criteria to be used by Company in its decision whether or not to credential or re-credential a health professional.

4.4(b) Identification of the internal process that Company will use in making credentialing decisions.

4.4(c) Identification of the individual or committee that has authority to decide whether to grant or remove credentials.

4.4(d) Identification of the individual or committee to whom the initial decision maker is accountable.

4.4(e) Identification of how and when **Contractor** will be notified of credentialing decisions, including a reasonable deadline by which Company must finalize credentialing decisions.

4.4(f) A requirement that an adverse decision state with specificity the reason for such decision.

¹⁹ Conforming change from "physician" to "health professional." Bracketed language necessary where the contractor is a clinic or other health care corporation.

4.4(g) A statement of the rights and duties of Contractor or a physician in an appeal of an adverse credentialing decision, including the following elements:

- (i) The deadline for filing an appeal;
- (ii) Whether the appeal will be in writing or a live hearing;
- (iii) What evidence the physician may introduce;
- (iv) The **Contractor's** right to review the material prepared by Company to support its adverse decision;
- (v) What individuals within the Company will review the appeal and have the final authority to make a decision and a statement of that person or committee's qualifications to make credentialing decisions;
- (vi) The deadline by which Company must make a final decision following the appeal procedure and communicate the decision to the physician; and
- (vii) Provisions for notice and corrective action prior to an adverse credentialing decision becoming final.

4.5 Authority. Contractor shall, and hereby does, represent and warrant that it has full legal power and authority to bind its Qualified Physicians to the provisions hereof. **Professional practice** groups/networks entering into this agreement on behalf of their **health professional** members must have this authorization from their individual member's agreement or evidence of an employment agreement.

4.6 Administrative Procedures. Contractor and each of its Qualified health professionals will comply with the policies and procedures established by Company or any of its Plans to the extent Contractor has received notice of same consistent with the terms of this Agreement. At the effective date hereof, the policies, rules, and procedures applicable to Contractor are contained in those manuals and other writings attached hereto on Exhibit D and incorporated by this reference. Contractor shall rely on these policies and procedures as the sole material policies and procedures of Company or its various Sponsors until such time as Contractor receives a Company Notice or is notified otherwise consistent with this Agreement. Neither Company nor a Sponsor may modify these policies and procedures in a manner that would have a material adverse effect on Contractor without Contractor's prior written consent.

4.7 Assistance in Grievance Procedure. Contractor agrees to have each of its Qualified **health professionals** keep available for Enrollees explanations of the grievance procedures and grievance encounter forms relating to Plan, which shall be supplied by Company. Contractor further agrees that it and its Qualified **health professionals** will abide by Company's and or Plan's process for resolving Enrollee grievances, which procedures are a part of Exhibit C, consistent with this Agreement. Contractor also agrees to require each of its Qualified Physicians to participate in helping resolve the grievances described in Section 5.6 hereof.

4.8 Use of Names for Marketing. Contractor and each of its Qualified **health professionals** shall permit Company to include the name, address, and telephone number of it or its Qualified Physicians in its list of Medical Services Entities distributed to Enrollees; provided, however, that such rights shall not extend to the listing of such Qualified Physicians or Contractor in any newspaper, radio, or television advertising without the prior written consent of Contractor.

4.9 Provision of Covered Services. In the event Exhibit B contemplates the provision of the full range of full medical services that may be offered by a medical group on a capitated basis to a

defined population of patients, Contractor agrees to provide or arrange for the provision of Covered Services on a 24 hour per day, 7 day per week, 365 day per year basis.

4.10 Noninterference with Medical Care. Nothing in this Agreement is intended to create (nor shall be construed or deemed to create) any right of Company or any Sponsor to intervene in any manner in the methods or means by which Contractor and its Qualified Physicians render health care services or provide health care supplies to Enrollees. Nothing herein shall be construed to require Contractor or Qualified Physicians to take any action inconsistent with professional judgment concerning the medical care and treatment to be rendered to Enrollees.

V. Company's Obligations

5.1A List of Sponsors. Company shall include as part of Exhibit C a list of each Sponsor and shall promptly update Exhibit C upon the addition or deletion of Sponsors. The parties acknowledge that the intent of Sections 1.11, 3.1, and this Section 5.1 is to provide a mechanism for assuring that "networks," "silent PPOs," and similar arrangements between entities similar to Company and Sponsors do not accede to this Agreement or avail themselves of the discounts and arrangements established by the Parties through this Agreement.

5.1B Disclosure: Company will disclose to Contractor all relevant service and coverage standards, service access and treatment timeline obligations, network capabilities and management standards, and other relevant standards applicable to the management of patient care that may be specified in the contract between the Company and any group sponsor or purchaser of services from the Company.²⁰

5.2 Deemed Notification. Company shall notify Contractor in writing of all policies, procedures, rules, regulations, schedules, in addition to those attached as Exhibit C, that Company considers material to the performance of this Agreement, as well as any amendments thereto. Contractor shall be deemed notified of such policies, procedures, rules, or regulations, or any amendment thereto, or any Company Notice ninety (90) days after receipt of written notice of same is delivered to Contractor consistent with the notice provisions of this Agreement. Neither Company nor a Sponsor may modify its policies and procedures in a manner that would have a material adverse effect on Contractor without Contractor's prior written consent.

5.3 Adverse UR/QM Decisions. Notwithstanding anything to the contrary contained in the policies, procedures, rules, or regulations of Company **and in accordance with applicable state and federal law**,²¹ Company shall grant Contractor or Qualified Physician a right and a mechanism to appeal any Utilization Review or Quality Management decision made by Company on behalf of a

²⁰ Contracts between managed care organizations and group sponsors often contain detailed coverage, access, network, and quality of care standards. These coverage rules and quality standards may or may not be disclosed by companies when they contract with their providers. This information can be crucial to a network provider as a means of understanding the scope of a patient's actual coverage, the actual range of services that are supposed to be made available to an enrollee, and the company's service timelines. The information is especially important in cases in which a health professional asserts the medical necessity of a service and the company denies the request on the grounds that the service falls outside the scope of the master contract.

²¹ This provision is intended to ensure that the company adheres to claims appeals procedures required under various state and federal laws and applicable to private insurance arrangements and public program requirements.

Sponsor. Such appeal shall be coordinated with any related appeal by the Enrollee filed at or prior to the time of the Contractor appeal.

5.3(a) Unless existing Company policies provide for a more liberal rule, and except for utilization review decisions related to emergency care, which shall be expedited, written notice of such appeal shall be given by either the Contractor or Qualified Physician to Company on behalf of Plan no more than ten (10) calendar days following the contested decision.

5.3(b) Company shall have five (5) calendar days after receipt of such notice to appoint a licensed physician in the same or similar specialty not employed by Company to hear the appeal, which shall be heard within ten (10) days. A decision will be communicated to the parties no later than five (5) days after the hearing.

5.3(c) In any such appeal, a prior authorization for treatment granted by Company shall be conclusive in determining whether payment for services should be made.

5.4 Administration. With respect to each Plan it offers or administers, Company shall promptly and diligently perform all necessary administrative, accounting, enrollment, and other functions including, but not limited to, eligibility determination, claims review, data collection and evaluation and, if applicable, maintenance of medical, ancillary, and hospital group risk pools.

5.4(a) With respect to each Plan, Company shall issue a Company Notice to Contractor identifying the manner in which rules, regulations, or policies relating to a particular Plan are at variance with the general rules, regulations, or policies of the Company upon which Contractor generally relies.

5.4(b) In the credentialing of qualified **health professionals**, Company agrees that neither it nor its agents to whom such duties have been delegated shall request that Qualified **health professionals** sign an information release broader than necessary to obtain the specific credentialing information sought, and Company shall limit such request to that which is reasonable and necessary to achieving valid credentialing purposes.

5.5 Payment by Parties other than Company. In the event Company contemplates that payment for services provided hereunder is to be made by a Sponsor other than Company, and in the event that such payment is not received by Contractor within the time and under the conditions set forth in Section 3.5, Company, within five (5) days of the receipt of written notice from Contractor, shall make a written demand to Sponsor on behalf of such Contractor for payment.

5.5(a) In the event a Sponsor fails to make payment within sixty (60) days after receipt of such notice, Company shall either: (i) make such payment on behalf of the Sponsor; (ii) initiate legal action to recover such payment on behalf of Contractor; or (iii) assign the right to initiate such action to Contractor.

5.5(b) In the event of an occurrence described in Section 5.5(a)(ii) or (iii) of this Section, Company shall tender to Contractor a copy of the agreement that governs the relationship between Company and Sponsor and upon which Contractor may rely in prosecuting such action and shall release Contractor, at Contractor's option, from any further obligation under this Agreement to provide services to Enrollees of Sponsor.

5.5(c) Company shall notify Sponsor of the provisions hereof and obligate Sponsor with respect to such provisions.

5.6 Grievances. Company shall establish and maintain systems to process and resolve a grievance by **Contractor or its qualified health professionals** toward Company or a Sponsor. Such process shall be set forth in the procedures which are a part of Exhibit C and any Company Notice amending such process. In connection with such grievances, to the extent that confidential patient information is discussed or made part of the record, or confidential patient records are submitted to Company, Company shall either abstract such information or shall remove the name of the patient such that none of the information or records would allow a third party to identify the patient involved. Notwithstanding anything in Company's policies, procedures, or rules to the contrary, the internal procedure for resolving such grievance will be conclusively presumed concluded in the event such grievance is not resolved to the parties' satisfaction within forty-five (45) days of the submission of such grievance and will allow either party resort to the dispute remedies of Article IX

5.7 Benefit Information. Company shall advise and counsel its Enrollees and Contractor on the type, scope, and duration of benefits and services to which Enrollees are entitled pursuant to the applicable agreement between Company or a Sponsor and Enrollees.

5.8 Cooperation on Care Review and Management. In the event that Contractor is responsible for utilization review and quality management activities, Company shall assist and cooperate with Contractor in the development and initial implementation of such activities that are necessary to carry out the terms of this Agreement. In the event that utilization review and quality management activities are the sole responsibility of Company, Company shall fully advise Contractor of the methods used and underlying information relied on to develop, implement, and manage or monitor utilization and quality on an ongoing basis, and shall develop a mechanism to allow Qualified Physicians to participate in the development of utilization review and quality management ongoing assessment and evaluation.

5.9 Practice and Treatment Guidelines; Quality Improvement Activities: In the selection or development of practice and treatment guidelines and quality performance measurement standards related to the diagnosis, treatment and management of mental illness and addiction disorders (including the development of prescription drug formularies and rules for prescribing), Company shall actively consult with qualified health professionals in its network.²²

5.9 Context of Company/Sponsor Obligations. To the extent Company is also a Sponsor under this Agreement, it shall perform and satisfy all duties and obligations of the Sponsor under this Agreement. To the extent Company is not a Sponsor under this Agreement, this Agreement shall be construed to require Company to use its best efforts to cause the Sponsor to perform and satisfy the Sponsor's duties and obligations under this Agreement.

5.10 Provision of Financial Information. Company shall provide to Contractor, no less frequently than quarterly, a balance sheet and income statement (collectively, "Financial Statements") accurately

²² Designed to encourage active participation by network professionals in the design of utilization management standards and treatment guidelines, as well as standards for measuring network performance.

depicting the financial condition of Company. Such Financial Statements shall be prepared in accordance with generally accepted accounting principles and shall be provided on an audited basis to the extent available. Contractor acknowledges the confidentiality of such Financial Statements and shall not: (a) use such Financial Statements for any purpose other than evaluating the financial condition of Company; or (b) disclose the Financial Statements, or any non-public information contained therein, to any third party, other than Contractor's attorneys or accountants, without the prior written consent of Company. The obligations of Contractor under the immediately preceding sentence shall survive termination of this Agreement.

VI. Records and Confidentiality

6.1 Confidential Medical Records. All medical records of Enrollees shall be maintained as confidential in accordance with applicable state and federal laws. All medical records shall belong to Contractor's Qualified Physicians consistent with the dictates of medical ethics. The release, disclosure, removal, or transfer of such records shall be governed by state and federal law and by the Contractor's established policies and procedures. Prior to the release of copies of any medical records to Company or other third parties, Company shall obtain from the subject Enrollee (or the Enrollee's legal representative) and present to Contractor an effective written consent or release that satisfies ethical constraints and applicable laws and is narrowly tailored to accomplish the sole purpose of such release, which the parties agree is to determine whether care was properly and efficiently rendered. The cost associated with copying medical records or any other records referred to in this Article VI shall be paid by Company. In handling all medical records, Company agrees to comply with all applicable state and federal laws and with any requirements or limitations described in the written consent or release. Company agrees it shall not release such information to other parties without written consent of the Enrollee and shall share such information internally only with the narrowest circle of Company's agents necessary to effectuate the specific purpose for which the MCO seeks the information. Company shall counsel such agents on their obligations to ensure such information remains confidential.

6.1A Compliance with federal laws. Company will comply with the federal Confidentiality of Alcohol and Drug Abuse Patient Records statute (42 U.S.C. § 290dd-2) and its implementing regulations (42 C.F.R. Part 2 ("42 C.F.R. Part 2")).

6.2 Records. All data and information obtained, created, or collected by Contractor relating to services provided to Enrollees that is not a part of the medical record shall be shared by Contractor with Company. Such information may be obtained by Company upon written request to Contractor without a requirement for obtaining the written release by Enrollee.

6.3 Access to Records. During normal business hours, each party shall have access to and the right to examine records of the other which relate to a Covered Services or payment provided for a Covered Service. However, any review of the medical record must be narrowly tailored to the specific purpose for which the Company seeks the information. Upon written request of Company or Contractor, such access shall be extended beyond normal business hours with respect to any records which are identified in such written request as the actual or potential subject of an investigation or litigation.

6.4 Other Confidential Information. Generally, the parties agree that the sole items of information subject to confidentiality under this Agreement are: (i) medical information relating to individual

Enrollees, so as to protect the patient's medical record as required by medical ethics and law; and (ii) the precise schedule of compensation to be paid to Contractor pursuant to Exhibit B. Otherwise, all other information, including the general manner by which Contractor is paid under this Agreement and the general terms and conditions of this Agreement, may be shared with non-parties in the reasonable and prudent judgment of the Parties to this Agreement or Qualified Physicians. In addition, the Parties agree that: Section 6.4 protects patient-physician communication, and clarifies that, except for a limited number of matters that are proprietary to both the MCO and physician or physician group/network, there are no inhibitions on free communication between the physician and the patient or any other parties.

6.4(a) Any financial or utilization information provided by Contractor to Company or a Sponsor (including the Compensation schedule(s) set forth in Exhibit B) shall be maintained in strict confidence by Company and each Sponsor and may not be disclosed by Company or Sponsor to any third party or used by Sponsor for any purpose, other than: (i) to satisfy mandatory governmental or regulatory reporting requirements; (ii) to compare cost, quality, and service among providers with whom Company has contracted; (iii) for premium setting purposes; (iv) for HEDIS reporting; or (v) to perform any of Company's obligations under this Agreement.

6.4(b) Notwithstanding the foregoing, Company shall be permitted to prepare and disclose to a third party a report of "Contractor Quality Data." For purposes of this subsection, Contractor Quality Data shall be limited to: (i) utilization data of all contracted Medical Services Entities in the aggregate; (ii) HEDIS data production and performance evaluation; (iii) Enrollee satisfaction data; (iv) overall compliance with NCQA or other comparable quality standards; and (v) Sponsor disenrollment data; provided, however, that Contractor Quality Data shall not include any information that identifies an individual Enrollee or an individual Qualified Physician or information that is privileged or confidential under applicable peer review or patient confidentiality laws.

6.4(c) At least thirty (30) days prior to providing Contractor Quality Data to a third party, the third party shall provide such Contractor Quality Data to Contractor so that Contractor may confirm the accuracy, completeness, or validity of the data and prepare a written response to such data to the extent Contractor deems appropriate.

6.4(d) To the extent Contractor believes that all or any portion of the Contractor Quality Data is inaccurate or incomplete, Contractor and Company shall negotiate in good faith to correct such inaccuracies or to make such data complete prior to its submission to the third party. If such inaccuracies or deficiencies are not corrected to the satisfaction of Contractor, Company shall submit, at the time the Contractor Quality Data is provided to the third party, any written response to such Contractor Quality Data prepared by Contractor.

VII. Insurance

7.1 Contractor Insurance. Contractor shall require each Qualified **Health Professional** to maintain, at all times, in limits and amounts standard in the community, a professional liability insurance policy and other insurance as shall be necessary to insure such Qualified **Health Professional** against any claim for damages arising directly or indirectly in connection with the performance or non-performance of any services furnished to Enrollees by such Qualified **Health Professional**. In the event that Contractor discovers that such insurance coverage is not maintained, Contractor shall immediately upon making such discovery ensure that such Qualified **Health Professional**

discontinues the delivery of Covered Services to Enrollees until such insurance is obtained. Evidence of such coverage shall be tendered to Company by Contractor upon Company's request.

VIII. Term and Termination

8.1 Term. This Agreement shall commence on the Effective Date and extend until terminated pursuant to this Article VIII.

8.2 Negotiation of Renewal of Exhibits A and B. Not later than ninety (90) days prior to each anniversary of the Effective Date hereof, a Party wishing to revise Exhibits A or B or any of the schedules affixed thereto shall serve notice in writing of such intention to the other Party, along with the new terms proposed. Within sixty (60) days thereafter, the Parties shall agree to a new Exhibit A and Exhibit B. In the event the Parties are unable to come to such agreement, either Party may notify the other within ten (10) days following the deadline for such agreement that it intends to terminate the Agreement entirely or with respect to one or more specific Plans reflected on a schedule. In such event, this Agreement (in the case of termination of all Plans) or the Agreement with respect to a particular Plan or Plans, shall be terminated sixty (60) days after such notice.

8.3 Termination for Cause. In the event either Party shall fail to keep, observe, or perform any covenant, term, or provision of this Agreement applicable to such Party, the other Party shall give the defaulting party notice that specifies the nature of such default. If the defaulting Party shall have failed to cure such default within thirty (30) days after the giving of such notice, the non-defaulting Party may terminate this Agreement upon five (5) days notice; provided, however, that it shall be grounds for immediate termination if Company should lose its license to underwrite or administer Plans; or if any Qualified Physician suffers a loss or suspension of medical license, a final unappealable loss of hospital medical staff privileges for reasons that would require reporting to the National Practitioner Data Bank pursuant to the requirements of the Health Care Quality Improvement Act of 1986, a conviction of a felony, or a loss of credentials for stated quality reasons under a Plan, and upon notice to Contractor, Contractor fails to immediately terminate such Qualified Physician from the provision of services to Enrollees.

8.4 Voluntary Termination. Either Party may terminate this Agreement or Contractor participation in any Plan with or without cause upon one hundred twenty (120) days written notice to the other Party specifying whether the termination relates to a specific Plan or to the Agreement generally. The terminating Party shall state the reason for such termination. In the event of a voluntary termination hereunder, neither party shall be foreclosed from participation in the dispute resolution procedures described in Article IX.

8.5 Termination for Failure to Satisfy Financial Obligations. This Agreement may be terminated in its entirety or with respect to a Sponsor by either party upon five (5) days written notice if either party, or in the case of termination by Contractor, a Sponsor is: (a) more than sixty (60) days behind its financial obligations to its creditors; (b) is declared insolvent; or (c) files in any court of competent jurisdiction: (i) a petition in bankruptcy; (ii) a petition for protection against creditors; or (iii) an assignment in favor of creditors or has such a petition filed against it that is not discharged within ninety (90) days.

8.6 Effect of Termination. This Agreement shall remain in full force and effect during the period between the date that notice of termination is given and the effective date of such termination. As of

the date of termination of this Agreement, and except as provided by Section 10.14, this Agreement shall be of no further force and effect, and each of the Parties shall be discharged from all rights, duties, and obligations under this Agreement, except that Company shall remain liable for Covered Services then being rendered by Qualified Physicians to Enrollees who retain eligibility under the applicable Plan or by operation of law until the episode of illness then being treated is completed and the obligation of Company to pay for Covered Services rendered pursuant to this Agreement is discharged.

Payment for such services shall be made pursuant to the fee schedule contained on Exhibit B or, if Exhibit B does not contain a fee schedule, at the usual and customary charge of the Qualified Physician performing the service.

8.9 Coverage of medically necessary services during post termination treatment period. In the event of termination, Company shall continue to compensate Contractor at the fee-for-service rate specified in Attachment B until the enrollee has successfully established a new professional/patient relationship with another member of Company's network.²³

IX. Dispute Resolution

9.1 Initial Mediation of Dispute. In the event of a dispute regarding this Agreement between the Parties to this Agreement, the following procedure shall be used to resolve the dispute prior to either party pursuing other remedies:

9.1(a) A meeting shall be held within seven (7) days of receipt by one Party of the disputing Party's written notice. All Parties shall be present or represented by individuals with full decision-making authority regarding the matters in dispute (the "Initial Meeting").

9.1(b) If, within thirty (30) days following the Initial Meeting, the Parties have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator mutually agreeable to the Parties and not regularly contracted or employed by either of the Parties ("Mediation"). Each Party shall bear its proportionate share of the costs of Mediation, including the mediator's fee.

9.1(c) The Parties agree to negotiate in good faith in the Initial Meeting and in Mediation.

9.1(d) If, after a period of sixty (60) days following commencement of Mediation, the Parties are unable to resolve the dispute, either Party may submit the dispute to binding arbitration in accordance with Section 9.2 upon ten (10) days prior written notice to the other Party.

9.2 Binding Arbitration. Unless one Party has previously filed suit in a court of competent jurisdiction regarding the same subject matter, either Party may submit any dispute arising out of this Agreement that is not resolved through Mediation to final and binding arbitration. Any such arbitration shall be held in the state where the services at issue in the dispute were or are to be performed and shall be conducted pursuant to either the rules of the American Arbitration Association or the American Health Lawyers Association Alternative Dispute Resolution Project. Each Party shall be responsible for its own costs and expenses related to the arbitration, including

²³ Ensures the right to continued post-termination payment in the event that a contract is terminated and the enrollee encounters difficulties in locating and establishing a new relationship with an in-network contractor.

attorneys' fees, and shall bear its proportionate share of the arbitrator's fees. The arbitrator shall be selected on the mutual agreement of both Parties and shall be an attorney and member of the National Academy of Arbitrators or the American Health Lawyers Association.

X. Additional Provisions as Required by State Law

State law may require specific language to be included in a medical services or "provider" agreement. State-specific requirements should be inserted here.

[RESERVED]

XI. Miscellaneous

10.1 Nature of Contractor. In the performance of the work, duties, and obligations of Contractor under this Agreement, it is mutually understood and agreed that Contractor and each of its Qualified Physicians are at all times acting and performing as independent contractors, practicing medicine, or providing for the delivery of medical services.

10.2 Additional Assurances. The provisions of this Agreement shall be self-operative and shall require no further agreement by the Parties except as may be specifically provided in this Agreement. However, at the request of either Party, the other Party shall execute such additional instruments and take such additional acts as may be reasonably requested in order to effectuate this Agreement.

10.3 Governing Law. This Agreement shall be governed by and construed in accordance with the applicable federal laws and regulations and the laws of the state in which the subject services are primarily performed by or through Contractor.

10.4 Assignment. This Agreement shall inure to the benefit of and be binding upon the Parties hereto and their respective legal representatives, successors, and assigns. Company may not assign this Agreement without Contractor's prior written consent, except that Company may assign this Agreement to an entity related to Company by ownership or control or to any successor organization without Contractor's prior written consent. Contractor may not assign this Agreement without Company's prior written consent, except that Contractor may assign this Agreement to an entity related to Contractor by ownership or control or to any successor organization without Company's prior written consent.

10.5 Waiver. No waiver by either Party of any breach or violation of any provision of this Agreement shall operate as, or be construed to be, a waiver of any subsequent breach of the same or any other provisions.

10.6 Force Majeure. Neither Party shall be liable for nor deemed to be in default for any delay or failure to perform under this Agreement deemed to result, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, failure of transportation, strikes or other work interruptions by either Party's employees, or any other cause beyond the reasonable control of either party.

10.7 Time is of the Essence. Time is of the essence in this Agreement. The Parties shall perform their obligations within the time specified.

10.8 Notices. Any notice, demand, or communication required, permitted, or desired to be given hereunder shall be deemed effectively given when personally delivered or sent by fax with a copy sent by overnight courier, addressed as follows:

If to Company:

If to Contractor:

or to such other address, and to the attention of such other person or officer as either Party may designate in writing.

10.9 Severability. In the event any portion of this Agreement is found to be void, illegal, or unenforceable, the validity or enforceability of any other portion shall not be affected.

10.10 Third-Party Rights. This Agreement is entered into by and between the Parties hereto and for their benefit. There is no intent by either Party to create or establish a third-party beneficiary status or rights in a third party to this Agreement, except for Enrollees or as such rights are expressly created and as set forth in this Agreement. Except for such parties, no such third party shall have any right to enforce or any right to enjoy any benefit created or established under this Agreement

10.11 Entire Agreement. This Agreement supersedes any prior agreements, promises, negotiation, or representations, either oral or written, relating to the subject matter of this Agreement.

10.12 Notification of Legal Matters. If any action is instituted against either Party relating to this Agreement or any services provided hereunder, or in the event such Party becomes aware of facts or circumstances which indicate a reasonable possibility of litigation with any Sponsor utilizing Contractor, any Enrollee, or any other third person or entity, relevant to the rights, obligations, responsibilities, or duties of the other Party under this Agreement, such Party shall provide timely notice to the other, and the other Party shall cooperate with the first Party in connection with the defense of any such action by furnishing such material or information as is in the possession and control of the other Party relevant to such action.

10.13 Amendment. This Agreement may not be modified without the express written approval of both parties.

10.14 Survival. Notwithstanding any provisions contained herein to the contrary, the obligations of the Parties under Articles III, VI, and IX shall survive termination of this Agreement.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed in their names by the undersigned officers, the same being duly authorized to do so.

CONTRACTOR

By: _____ Title: _____

COMPANY

By: _____ Title: _____