PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT (the "Agreement"), effective as of , 20 (the "Effective Date"), is made and entered into by and among Zelis Network Solutions, LLC on behalf of itself and its subsidiaries and affiliates, including any and all entities under common ownership or control, with principal offices located at Two Concourse Parkway, Suite 300, Atlanta, GA 30328, (hereinafter referred to as "Network") and "Network Provider" as defined below:

Network Provider

Full Legal Name:		Date of Birth:		
Principal Business Address:		Email:		
City, State and Zip Code:		Tax ID No.:		
Phone No.:		NPI No.:		
Fax No.:		State License No:		Exp.
Office Manager:		DEA No.:		Exp.
Office Manager E-Mail:		Office No.:		

WHEREAS, Network develops and maintains a network of health care providers by entering into agreements with acute and ancillary health care providers, physicians and other health care professionals who have agreed to provide health care services to Participants covered by health services benefits programs or other types of programs, including workers' compensation programs as permitted by law, which are administered by Network's Customers in exchange for reimbursement at agreed upon rates; and

WHEREAS, Network also enters into agreements with various Customers as more particularly defined herein, pursuant to such agreements or other arrangements Customers gain access to Network Providers through Network; and

WHEREAS, Network Provider is a health care provider duly licensed, certified, accredited or otherwise duly authorized to practice health care in the state(s) indicated above and desires to provide or arrange to provide for Covered Services to Participants in a cost-effective manner consistent with quality medical care and in accordance with the terms of this Agreement and applicable law; and to participate in the Network Products offered to Network Provider by Network upon the terms set forth in this Agreement and any Exhibit(s) attached hereto; and

WHEREAS, Network seeks to establish a contractual relationship with Network Provider and Network Provider seeks to create and enter into a contractual relationship with Network in accordance with the terms of this Agreement because Network Provider wishes (a) to offer its health care services to Participants and in so doing maximize its opportunity to retain current patient volumes and maintain current market share, and (b) to grant Network's Customers access to reimbursement schedules that would otherwise be available to other payors, thereby enhancing competition among payors;

NOW, THEREFORE, for and in consideration of the foregoing, in exchange for the mutual promises herein, and for other good and valuable consideration the receipt and sufficiency of which are hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

A. DEFINITIONS

1. **Benefit Program** means a contract, policy, document, plan, or any other arrangement under which a Customer is obligated to provide benefits for Covered Services on behalf of Participants.

2. **Clean Claim** means (a) a properly completed paper billing form (whether a UB-04, CMS 1500, or other applicable form, and as such forms may be amended from time to time) for Covered Services provided to a Participant, or (b) an electronic transaction providing such information that complies with all applicable laws and regulations governing such transactions. Clean Claims shall not include those claims which require coordination of benefits, involve third party liability issues, or claims that are being reviewed for medical necessity.

3. **Coordination of Benefits** means the determination of which two or more Benefit Programs will pay health benefits for a Participant as a primary payor and which will pay as a secondary payor and/or as a tertiary payor.

4. **Covered Services** means health care services and supplies provided to a Participant who is eligible for reimbursement under the terms of the applicable Benefit Program or are payable by an individual.

5. **Customer(s)** means Network's clients, together with each of their respective affiliates, successors and assigns, who

seek access to Network Providers through Network. Customers may include Network's owners, subsidiaries, affiliates, payors, employers, employer groups, third party administrators, Taft Hartley Funds, insurance companies including those authorized to obtain health care services for work-related injuries and automobile accidents, limited liability plans, individuals, health savings accounts and those who may be directly or indirectly engaged by such Customers to obtain access to Network. Network shall maintain a list of its Customers, a copy of which shall be available to Network Provider upon reasonable request or shall be accessible to Network Provider on Network's password protected and secured website.

6. **Network Products** means the particular combination of Covered Services, provider network, and medical delivery system rules marketed under a specific product name including the specific network programs established pursuant to the Addenda hereto under which a Participant is eligible to received Covered Services through a Benefit Program.

7. **Participant** means an individual (a) who is entitled to benefits and who, on the date health care services are rendered, has satisfied the eligibility requirements under a Benefit Program, or (b) who receives health care services or is one that is responsible for payment for such health care services.

8. **Quality Assurance/Utilization Management** means the processes and rules established and used by a Customer or its designee, consistent with accepted standards and practices in the industry, to evaluate the quality, quantity, appropriateness and timeliness of health care services furnished to Participants, and to identify and resolve disputes regarding provision of health care services.

B. RIGHTS AND OBLIGATIONS OF NETWORK

1. **Limitations** Network does not determine benefits, eligibility or availability for Customers' Participants and does not exercise any discretion or control as to Customers' Benefit Program assets or with respect to policy, payment, interpretation, practices, or procedures. Customers are solely responsible for the design and implementation of all utilization review programs including all questions and decisions regarding eligibility, coverage, medical necessity, length of stay, referral approvals, and the like. Network is not a payor, administrator, insurer, underwriter, or guarantor of payment for or of Customers' Benefit Programs, and Network is not liable for any payment of services under this Agreement. Network Provider shall look solely to Customer as the party responsible for any payment hereunder and shall not seek reimbursement or any other recourse from Network for any such payment. Nothing in this Agreement shall be construed as interfering with the freedom of choice of eligible Participants.

2. **Provider Directory** Network shall maintain a provider directory for the purpose of advising Customers and Participants of Network Providers participating in the Network, which provider directory shall be accessible through Network's website. Network shall exercise best efforts to include Network Provider in such provider directory. Network Provider agrees that Network and/or Customers may use Network Provider's name, practice name, trade names, trademarks, service marks, symbols, addresses, telephone numbers, types of services provided by Network Provider and any other identifying information not only in such provider directory, but also in any other print or electronic media.

3. **Audit** Upon giving at least 48 hours advance notice, Network or a Customer shall have the right to conduct a site review and to review and copy Network Provider's records for purposes reasonably related to this Agreement including, but not limited to, Quality Assurance/Management. Such review shall not unreasonably interfere with Network Provider's business and shall be conducted during normal business hours by authorized individuals who have signed a confidentiality agreement. Each party shall bear its own costs of such review. Reports of such reviews shall be kept as internal documents and shall not be revealed to any outside source except (a) as may be required by law or (b) to Network or a Customer. To the extent applicable, all such reviews shall be conducted at the direction of medical review committees and/or peer review committees and shall therefore be subject to all applicable protections and immunities afforded under any applicable state and/or federal laws, rules or regulations.

C. RIGHTS AND OBLIGATIONS OF NETWORK PROVIDER

1. **Provision of Health Care Services** Network Provider shall be solely responsible for the provision of health care services, advice and treatment rendered, ordered, or authorized by Network Provider, its employees and/or agents, with respect to Participants. Such services shall be provided to Participants for all Customers in accordance with community standards, in the manner in which Network Provider renders services to other patients, and without discrimination based on sources of payment for services, gender, race, ethnicity, color, religion, marital status, sexual orientation, age, ancestry, national origin, mental or physical disability, or health status. Nothing contained in this Agreement shall interfere with nor in any way alter or affect (a) any physician, professional or hospital-patient relationship nor shall limit the level of care or performance of services by Network Provider nor (b) the obligation of Network Provider to exercise independent medical judgment in rendering healthcare services to Participants. Upon sixty (60) days' notice, Network Provider may decline to provide service pursuant to a contract to new patients covered by a Customer. The notice shall state the reason or reasons for this action. "New patients" means those patients who have not received services from the Network Provider in the immediately preceding three years. A patient shall not become a new patient solely by changing coverage from one Customer to another.

2. **Licensure and Certification**

a. At all times during the Term of this Agreement, Network Provider shall remain in compliance with Zelis' Minimum Credentialing Standards as set forth in Exhibit A, which is attached hereto and incorporated herein by reference. Network Provider shall respond timely to all requests for application and documentation as set forth therein.

b. Network Provider shall comply with all laws relating to furnishing health care services to Participants; shall maintain in effect and in good standing all licenses and

governmental approvals necessary for that purpose; and shall maintain compliance with all applicable credentialing criteria and requirements.

c. Network Provider shall maintain certification by the Center for Medicare and Medicaid Services (CMS), as well as accreditation by an appropriate recognized accrediting organization as applicable or as required by law. Copies of Network Provider's current certificates of accreditation shall be provided as requested in Exhibit A.

d. Network Provider shall notify Network in writing within thirty (30) days of any change in compliance with any of these requirements, or of any pending investigation, action, or sanction against it, any agent and/or any employee, which may materially affect Network Provider's ability to perform any obligation under this Agreement, or which would otherwise bear on a requirement of this Agreement.

3. **Quality Assurance** Network Provider shall participate in and cooperate fully with all reasonable Quality Assurance/ Management programs administered by Customers or their designees.

4. **Liability Insurance** Network Provider warrants to Network that it has, and shall maintain professional and comprehensive general liability insurance covering Network Provider against claims arising out of the services to be performed hereunder each in the minimum amounts required by law or, in the absence of statutory requirements, no less than $1,000,000 per occurrence and $3,000,000 in the annual aggregate. Proof of such coverage shall be made available to Network upon request. Network Provider shall notify Network in writing within thirty (30) days of cancellation, non-renewal, and/or any material change in such coverage. If the form of insurance described above is "claims made," appropriate tail coverage shall be purchased to insure against claims made after the expiration of such insurance relating to acts or omissions occurring during the term of this Agreement.

5. **Network Provider's Grievance Procedures** Network Provider shall maintain procedures for resolving grievances and shall cooperate with any grievance procedures or programs sponsored by Network, Customers, or their designees. Network Provider shall notify Network promptly upon knowledge of any dispute, complaint, or grievance relating to patient care or other disputes involving Network, its Customers, their designees, or Participants.

6. **Provider Demographics** Upon execution of this agreement and no less than monthly thereafter, Network Provider agrees to provide Network a listing of all applicable providers practicing under this contract with the content and format in compliance with Exhibit B. Network Provider agrees to notify Network within ten (10) business days of any changes to Exhibit B. Should any information supplied by Network Provider become materially inaccurate, Network Provider shall work with Network to immediately correct. It is understood by both parties that any changes in demographic information such as Tax Identification Number, practicing address, billing address or addition or deletion of providers does not alleviate Network Provider from their obligations under this Agreement.

D. COMPENSATION

1. **Compensation** The compensation to which Network Provider shall be entitled ("Contract Rate") shall be as set forth in Exhibit C, attached hereto, and incorporated herein by reference.

2. **Billing Customers** Network Provider shall submit claims to Customers on a properly completed UB-04, CMS 1500 or other acceptable standard billing form that provides the same information. Network Provider may not bill a Customer more than ninety (90) days after discharge or the date services are provided and expect to receive any payment.

3. **Payment by Customers**

a. Customers must make payment to Network Provider within thirty (30) business days (or less, if required by applicable state law) of Network's receipt of a Clean Claim in order to obtain the benefit of the Contract Rate, except as set forth in paragraph 6 of this Section D below. Upon request, Network Provider shall furnish to Customer and/or Network all information reasonably required to verify the health care services provided and the charges for such services. Customers' payments due under this Agreement shall be reduced by any and all applicable Benefit Program design deductibles, co-payments, and co-insurance amounts.

b. Network Provider acknowledges that (a) Network's arrangements with its Customers for access to the Contract Rate described in this Agreement may be deemed to be network "rental," "lease," or "sale" arrangements under some state or federal laws, and (b) some state or federal laws require specific disclosure of such arrangements. Accordingly, to the extent that the terms "rent," "lease," or "sale" apply to Network's Customer arrangements as contemplated under this Agreement, Network and Network Provider agree that Network and its affiliates may lease, sell, rent or otherwise grant access to Network Provider's Contract Rate to third parties, including other preferred provider organizations. Each Customer's entitlement to the Contract Rate under this Agreement is subject to such Customer's compliance with the applicable terms of this Agreement.

c. Nothing in this Agreement shall be construed as a waiver by any Customer of its right to review claims for medical necessity or appropriateness in accordance with the terms of its Benefit Program; and, in the event a conflict arises between the terms of this Agreement and the terms of a Benefit Program, the terms of the Benefit Program shall apply.

4. **Billing Participants** A Participant shall be billed only for co-payments, deductibles, co-insurance and non-Covered Services, as appropriate, in accordance with such Participant's Benefit Program(s). Co-insurance shall be calculated based upon Contract Rate. Participants shall not be billed for more than the difference between the Contract Rate and the sum of the amounts paid by the Customer(s) and any other payors. Network Provider shall not balance bill or attempt to collect compensation from Participants in connection with Covered Services, except as shall be permitted by law and by the Customer.

5. **Coordination of Benefits** Network Provider shall cooperate with Customers for purposes of coordinating benefits. When a Customer is the primary payor, Network Provider shall accept from Customer as payment in full for Covered Services the Contract Rate, less the appropriate deductibles, co-payments and co-insurance. When a Customer is the secondary payor, Network Provider shall accept from Customer as payment in full for Covered Services the difference between the Contract Rate, and the sum of the amount paid by the primary payor(s) together with the appropriate deductibles, co-payments and co-insurance amounts.

6. **Disputed Claims**

a. Network Provider shall notify Customer of any erroneous claim sent to a Customer within sixty (60) days of the date the claim was issued. If such claim was paid, then a refund is due the Customer and Participant, as applicable, from Network Provider. If the claim was not paid, no payment is expected by Network Provider from Customer or Participant.

b. Network Provider agrees to refund any overpayments made by Customers under this Agreement within thirty (30) days of discovery and immediately upon receipt of written request by Customer, unless disputed in accordance with section 6(c) below. In the event that Network Provider does not refund the overpayment within the above specified timeframe, Customer shall withhold the requested overpayment amount from the next payment due Network Provider.

c. Only the Network Provider may challenge a payment made by a Customer or Participant in accordance with the Contract Rate during the six (6) months following Network Provider's receipt of such payment. Thereafter, the payment shall be deemed final and no further payment will be expected from Customer or Participant.

d. In the event of a dispute between Network Provider and a Customer in relation to this Agreement, Network shall use its best efforts to facilitate resolution of the dispute. Network Provider shall cooperate with Network's efforts by providing access to records and personnel reasonably necessary to support resolution of the dispute.

E. TERM AND TERMINATION

1. **Term** This Agreement shall be effective for an initial term of one (1) year from the Effective Date indicated above. Thereafter, this Agreement shall automatically renew for successive one (1) year terms.

2. **Termination**

a. After expiration of the initial term, either party may terminate this Agreement without cause by giving the other party at least ninety (90) days' prior written notice. Termination shall be effective on the first day of the month following the notice period.

b. Either party may terminate this Agreement for cause due to a material breach, including loss of any license or registration required by law or regulation to be maintained by such party in order to operate or fulfill its obligations hereunder, by giving thirty (30) days advance written notice. The notice of termination for cause will not be effective if the breaching party cures the breach to the reasonable satisfaction of the other party within the thirty (30) day notice period.

c. Network shall have the right to terminate this Agreement immediately if it determines, in its reasonable discretion and based upon any official agency action, that the health or welfare of Participants is jeopardized by the continuation of the Agreement. Under such circumstances, Network shall provide written notice to Network Provider specifying the basis for termination. The above shall also apply for a pattern of miscoding, cost shifting, redundant inaccurate billing and other billing misconduct by Network Provider.

d. Either party may terminate this Agreement immediately in the event the other party becomes insolvent, is adjudicated as bankrupt, makes a general assignment for the benefit of creditors, has a receiver appointed for it, or comes under the control of a trustee in bankruptcy.

e. If this Agreement is terminated for any reason and if Network Provider is then providing services to Participants, then Network Provider shall continue to provide such services to those Participants as shall be required by applicable laws and at least until the completion of any episodes of care that may be underway on or as of such date of termination and Network Provider shall accept the then current Contract Rate as payment in full for such services.

3. **Effect of Termination** All obligations incurred prior to the date of termination shall survive termination.

F. MISCELLANEOUS

1. **Independent Contractors** Each party, including its officers, directors, employees and agents, acts as an independent contractor. Neither party has express or implied authority to assume or create any obligation on behalf of the other. Each party solely is responsible for its own acts or omissions to act (as well as those of its officers, directors, employees and agents) arising out of or in connection with obligations created under this Agreement, including Network Provider's rendering professional advice and/or treatment. This Agreement is not meant to preclude Network from entering into substantially similar arrangements with other health care providers.

2. **Indemnification** Each Party agrees to indemnify, defend and hold harmless the other party to the extent that party is assessed or incurs any Costs or Liabilities associated with any legal action brought against it by a third party, whether in settlement of any cause of action or threatened cause of action, which settlement either party approves which shall not be unreasonably withheld, or as a result of an order or judgment of a court of competent jurisdiction governing a cause of action, to the extent that such Costs or Liabilities do not result or arise from any negligent act or omission, intentional misconduct or material breach of this Agreement by the indemnifying Party, but arise from the other Party's,

intentional misconduct, or material breach of this Agreement. Material breach is defined as the failure of either party to this Agreement to meet any material covenant, agreement, or obligation provided for in this Agreement.

3. **HIPAA, Confidentiality, Non-Disclosure, Non-Solicitation, Remedies**

a. The parties shall comply with all applicable laws and regulations regarding maintenance and disclosure of Participants' medical records and other individually identifiable health information. In particular, all parties shall be in compliance with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended from time to time, the applicable provisions of the Health Information Technology for Economic and Clinical Health Act ("HITECH" Act), as amended from time to time, and all applicable rules and regulations promulgated thereunder. Information concerning each may be found at the following U.S. Department of Health & Human Services websites: www.cms.gov/HIPAAGenInfo/ and http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_home/1204.

b. Network Provider shall not disclose the Contract Rate and/or the compensation payable to Network Provider hereunder except as may be required in order to comply with this Agreement or to the extent required by applicable law. Network Provider understands and agrees that Network has the right to transfer, assign, disclose or otherwise allow the use of and/or access to the Contract Rate and/or the compensation payable to Network Provider hereunder to its Customers.

c. Network Provider shall keep strictly confidential any and all confidential information that may be given or disclosed to Network Provider by Network, or that may be learned directly or indirectly by Network Provider, including specifically, but without limitation, the names of Network's Customers, both individually and in the aggregate, and any list of Network's Customers, whether such list is accessed through the Network's password protected secured website, or a copy of which list is provided to Network Provider, or which list is otherwise obtained or created by Network Provider. In addition, Network Provider shall neither use such confidential information for its own benefit (other than internally in order to implement this Agreement) nor disclose such confidential information in any form or media to any other person, partnership, joint venture, corporation, network, firm or other entity (except as necessary in order to implement this Agreement) without the express prior written consent of Network. Network Provider understands and agrees that the disclosure or discovery of any confidential information does not confer upon Network Provider any license, interest or right of any kind or nature in or to the confidential information. The covenants and obligations under this paragraph shall remain in effect for a period of three (3) years from the date on which the confidential information is disclosed or discovered by Network Provider.

d. During the term of this Agreement and for a period of one (1) year from the expiration or termination of this Agreement for any reason, Network Provider agrees not to directly or indirectly, and neither through its directors, officers, employees, agents, representatives, independent contractors, brokers, advisors or otherwise: (a) solicit any Customer introduced to Network Provider by Network and with which Network Provider does not have a direct contractual relationship as of the Effective Date of this Agreement to use any other network or entity, or to form a direct relationship with any other network or entity, beside Network; and (b) divert or attempt to divert any of Network's Customers to other networks, entities or contractual relationships for the benefit of Network Provider or otherwise usurp Network's business opportunities.

e. Network Provider understands that Network will suffer irreparable harm in the event Network Provider fails to comply in any way with its obligations set forth in this Section F.3, and that monetary damages may be inadequate to compensate Network for any such breach. Accordingly, Network Provider agrees that Network shall have, in addition to any and all remedies available to it at law or at equity, and notwithstanding anything else to the contrary contained in this Agreement, the rights and entitlement to injunctive relief or other equitable relief to enforce the terms and covenants of this Section F.3.

4. **Notices** Any notice required to be given pursuant to this Agreement shall be in writing and delivered by hand, by certified mail/return receipt requested, or by overnight delivery, to the signatories, or their successors if any, at the addresses set forth above.

5. **Severability and Waiver** The waiver by either party of any breach of any provision of this Agreement shall not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder shall not operate as a waiver of such right. The finding by a court of competent jurisdiction that any provision herein is void shall not void any other valid provision of this Agreement and the remaining valid provision(s) shall remain in full force and effect unaffected by such severance, provided that the invalid provision is not material to the overall purpose and operation of this Agreement.

6. **Force Majeure** Neither party shall be liable for its failure to perform any of its obligations under this Agreement when performance is delayed or prevented by natural disaster, fire, war, terrorism, riots, strikes, governmental acts such as embargo, interruption in telephonic services, or any other cause which, by proper prudence, could not have been avoided.

7. **Entirety and Modification** This Agreement, together with Exhibits, constitutes the entire agreement between the parties with respect to the subject matter hereof, and as of the Effective Date, shall supersede any previous agreements or understandings, written or oral, between the parties. All modifications of the Agreement shall be in writing and signed by both parties. Provided however, that any language in this Agreement to the contrary notwithstanding, if there is an Exception Addendum, duly executed by all required authorities of Network, appended to this Agreement, to the extent that the terms and /or conditions of said Exception Addendum vary from the terms and/or conditions of this Agreement, then the terms and/or conditions of the Exception Addendum shall prevail. A material change to this Agreement shall be in writing to the provider with ninety (90) days notice before the effective

date of the change. The writing shall be conspicuously entitled 'notice of material change to contract.' If Network Provider objects in writing to the material change within fifteen (15) days and there is no resolution of the objection, either party may terminate the contract upon written notice of termination provided to the other party not later than sixty (60) days before the effective date of the material change. Non-material changes require notice at least fifteen (15) days prior to the effective date of the change. A material change may reasonably be expected to significantly increase Network Provider's administrative expenses, or adds a new product.

8. **Governing Law/Jurisdiction** This Agreement shall be interpreted and governed by the laws of the state of Georgia, without regard to any contrary choice or conflicts of law principles, and without regards to any construction in favor of either party by reason of the drafting and/or negotiation of this Agreement. The Parties agree that any enforcement action or proceeding arising out of or relating to this Agreement shall be brought in a state or federal court of competent jurisdiction located in Atlanta, Georgia.

9. **Dispute Resolution** Network and Network Provider agree to meet and confer in good faith to resolve any disputes arising under this Agreement through informal discussions between the parties. If the parties are unable to resolve the dispute through such discussions within ten (10) business days of the commencement of such negotiations, then either party may submit the dispute to arbitration in accordance with the rules of an appropriate arbitration program in Atlanta, Georgia, to the extent such rules are not inconsistent with this Agreement. All disputes arising out of or relating to this Agreement shall be determined by binding, non-appealable arbitration under the Commercial Arbitration Rules of the American Arbitration Association (AAA). The arbitration shall be conducted by a single arbitrator chosen by the parties, or, if the parties cannot agree upon a single arbitrator within thirty (30) days of a party giving notice to the other of a proposed choice for an arbitrator, then by a single arbitrator appointed by the Atlanta, Georgia AAA office, who shall be appointed immediately upon the failure of the parties to so agree. All arbitration matters shall be conducted and administered by the Atlanta, Georgia AAA office. The cost of any arbitration shall be borne equally by the Parties and each shall bear their respective attorney's and related fees, unless otherwise ordered by the arbitrator.

10. **Survival** In the event this Agreement is terminated for any reason, (a) all rights and obligations which by their terms survive termination and (b) any other provisions of this Agreement which must survive to give effect to their terms and (c) those rights and obligations which shall have accrued as a result of the operation of this Agreement, shall survive termination hereof.

11. **Medicare Requirements** If it is ultimately determined that this Agreement is a subcontract for services, the value of which is ten thousand dollars ($10,000) or more during a twelve (12) month period within the meaning of Section 952 of the Omnibus Reconciliation Act of 1980 (Pub. L. 96-499), and 42 C.F.R, Part 420, then, until the expiration of four (4) years after the furnishing of services, the parties shall make available, upon written request, to the Secretary of Health and Human Services or to the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement, and the books, documents and records of the parties that are necessary to evaluate the nature and extent of such costs.

12. **Compliance with Laws** The parties shall comply with all applicable laws, rules and regulations, including the federal anti-kickback statute (42 U.S.C. 1320a-7(b)) and the related safe harbor regulations; the Stark Law (42 U.S.C. Section 1395nn); and state and federal laws protecting the privacy and security of health care information. No part of any consideration paid hereunder is a prohibited payment for the recommending or arranging for the referral of business or the ordering of items or services, nor are the payments intended to induce illegal referrals of business. No payments will be made under this Agreement which would be prohibited under state or federal law.

13. **Contract Modifications for Prospective Legal Events** In the event of any legislative, judicial or regulatory change or determination, whether federal or state, which has or would have a significant adverse impact on either party hereto in connection with the performance of this Agreement, or in the event that performance by either party of any term, covenant, condition or provision of this Agreement should for any reason be in violation of any statute, regulation, or otherwise be deemed illegal, the affected party shall have the right to require that the other party renegotiate the terms of this Agreement, such renegotiated terms to become effective no later than thirty (30) days after receipt of written notice of such request for negotiation. If the parties fail to reach an agreement satisfactory to both parties within thirty (30) days of the request for renegotiation, the party requesting such renegotiation may terminate this Agreement upon thirty (30) days prior written notice to the other party or sooner if required by law.

14. **Counterparts** This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, and all of which together shall be deemed to be one and the same instrument with the same effect as if the signatures to each counterpart were upon the same instrument. A facsimile copy of the signature page will be deemed to be as effective as an original signature.

15. **Construction; Headings; Time** This Agreement has been the subject of negotiations and discussions between the parties so that any rule of construing ambiguities against the drafter shall have no force and effect. The headings of sections and paragraphs contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement. Time is of the essence of this Agreement.

16. **Binding Nature** The terms of this Agreement shall inure to the benefit of, and be binding upon, the respective permitted successors, assigns, affiliates, heirs, executors and personal representatives of the parties.

17. **Authority** Each party represents and warrants to the other that it has all the necessary right, power and authority to sign, bind, enter into and perform this Agreement for itself and for any other person or entity on whose behalf it has signed and entered into this Agreement.

18. **No Referral Requirement** Nothing in this Agreement shall be deemed to be an agreement requiring physicians or any Network Provider to refer any Participant to any other Network Provider.

19. **Assignment/Delegation/Change of Control**. Except as otherwise permitted herein, neither party shall have the right to assign, delegate, or otherwise transfer ("Transfer") any or all of its rights and/or obligations under this Agreement to any third party without the prior written consent of the other party hereto, which consent shall not be unreasonably withheld. The foregoing notwithstanding, either party shall have the unrestricted right to Transfer any or all of its rights and/or obligations under this Agreement to any parent, subsidiary, or other affiliate, or to any entity that is a successor-in-interest to such party's business. This Agreement shall be binding upon and shall inure to the benefit of the parties and their respective affiliates, successors, and assigns.

20. **Exception Addendum**. There IS X IS NOT _____ an Exception Addendum to this Agreement, and it consists of 3 page(s) in length.

IN WITNESS HEREOF, duly authorized representatives of the parties have executed this Agreement as of the day and year first above written.

NETWORK PROVIDER	**ZELIS NETWORK SOLUTIONS, LLC**
By: ______________________________	By: ______________________________
Print Name:________________________	Print Name: ________________________
Title:______________________________	Title: ______________________________
Date:______________________________	Date: ______________________________

EXHIBIT A

Zelis
NETWORK PROVIDER AGREEMENT
CERTIFICATE(S) OF ACCREDITATION

REQUIRED MINIMUM CREDENTIALS:

• Facilities

- Proof of current Medicare participation or, as permitted by Network in its discretion, Medicaid participation or other applicable certification(s) for specialties not affiliated with Medicare. May not be listed on CMS or GSA debarment lists;

- Proof of current state licensure;

- Proof of current Certification of Insurance, General and Professional Liability required.
- Minimum coverage: $1M per occurrence / $3M in the aggregate, or as required by state law;

- Proof of current accreditation from JCAHO or, as permitted by Network in its discretion, another recognized accrediting agency; and

- Disclosure of loss of license or other disciplinary actions, convictions, sanctions, terminations or contractual assignments of health care service obligations; and upon receipt of such disclosure, a determination by Network in its discretion that any such incidents are not disqualifying.

• **Practitioners**

- Proof of current Medicare participation or, as permitted by Network in its discretion, Medicaid participation or other applicable certification(s) for specialties not affiliated with Medicare. May not be listed on CMS or GSA debarment lists;

- Proof of current state licensure;

- Proof of current Certification of Insurance in amounts pursuant to applicable state law;
- Minimum coverage: $1M per occurrence / $3M in the aggregate, or as required by state law;

- Proof of active DEA number, as appropriate;

- In the event of any disclosure of loss of license or any other disciplinary actions, convictions, sanctions, terminations or contractual assignments of health care service obligations, a determination by Network in its discretion that any such incidents are not disqualifying; and

- Disclosure of loss of license or other disciplinary actions, convictions, sanctions, terminations or contractual assignments of health care service obligations; and upon receipt of such disclosure, a determination by Network in its discretion that any such incidents are not disqualifying.

EXHIBIT B

Zelis
NETWORK PROVIDER DEMOGRAPHICS

[Form will be provided by Network upon execution of this Agreement to be completed by Network Provider]

EXHIBIT C

Zelis

COMPENSATION AND PRODUCT ELECTION

Network Provider shall participate in the following products offered by Network:

	Network Type:	**Contract Rate:**
☒	Primary	The lesser of 100% of the Medicare rate or 40% of the Network Provider's billed charges. Initials: ________
☒	Supplemental	The lesser of 110% of the Medicare rate or 40% of the Network Provider's billed charges. Initials: ________
☒	Workers' Compensation	The lesser of 75% of the current state fee schedule or 40% of the Network Provider's billed charges. Initials: ________
☒	Auto	The lesser of 75% of the current state fee schedule or 40% of the Network Provider's billed charges. Initials: ________
☒	Medicare	The lesser of 85% of the Medicare rate or 40% of the Network Provider's billed charges. Initials: ________
☒	Medicaid	The lesser of 85% of the Medicaid rate or 40% of the Network Provider's billed charges. Initials: ________
☒	TriCare	The lesser of 85% of the current state fee schedule or 40% of the Network Provider's billed charges. Initials: ________

SUMMARY DISCLOSURE FORM

THIS FORM CONTAINS IMPORTANT INFORMATION. PLEASE READ IT CAREFULLY.

The purpose of this Summary Disclosure Form is to summarize the provisions of the Participating Provider Agreement (the "Agreement") between the person or entity named in Page 1 of this document (the "Network Provider") and Zelis Network Solutions, LLOC on behalf of itself and its subsidiaries and affiliates, including any and all entities under common ownership or control (collectively, the "Network").

The terms and conditions of the Agreement set forth the contractual rights of the parties. The information provided in this Summary Disclosure Form is a guide to the Agreement. Reading this Summary Disclosure Form is not a substitute for reading the entire Agreement. When the Network Provider signs the Agreement, it will be bound by its terms and conditions. The terms and conditions of the Agreement may be amended over time by the mutual agreement of the parties, or as otherwise provided in the Agreement. The Network Provider is encouraged to read carefully any proposed amendments sent to the Network Provider after execution of the Agreement. Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of any party.

1. Compensation. As stated in Exhibit C of the Agreement, the Network Provider will accept payment for its services on a fee-for-service basis.

2. Product/Network. Under the terms of the Agreement, customers of the Network will have access to the Network Provider's discounts. The Network Provider may obtain a list of such customers by calling 1-866-403-8772.

3. Term. As stated in Section E.1 of the Agreement, the initial term of the Agreement will end one year after date of execution. Thereafter, the Agreement will automatically renew for successive one-year periods.

4. Termination. As stated in Section E.2 of the Agreement.

(a) After expiration of the initial term, either party may terminate this Agreement without cause by giving the other party at least ninety (90) days' prior written notice. Termination shall be effective on the first day of the month following the notice period.

(b) Either party may terminate this Agreement for cause due to a material breach, including loss of any license or registration required by law or regulation to be maintained by such party in order to operate or fulfill its obligations hereunder, by giving thirty (30) days advance written notice. The notice of termination for cause will not be effective if the breaching party cures the breach to the reasonable satisfaction of the other party within the thirty (30) day notice period.

(c) Network shall have the right to terminate this Agreement immediately if it determines, in its reasonable discretion and based upon any official agency action, that the health or welfare of Participants is jeopardized by the continuation of the Agreement. Under such circumstances, Network shall provide written notice to Network Provider specifying the basis for termination. The above shall also apply for a pattern of miscoding, cost shifting, redundant inaccurate billing and other billing misconduct by Network Provider.

(d) Either party may terminate this Agreement immediately in the event the other party becomes insolvent, is adjudicated as bankrupt, makes a general assignment for the benefit of creditors, has a receiver appointed for it, or comes under the control of a trustee in bankruptcy.

(e) If this Agreement is terminated for any reason and if Network Provider is then providing services to Participants, then Network Provider shall continue to provide such services to those Participants as shall be required by applicable laws and at least until the completion of any episodes of care that may be underway on or as of such date of termination and Network Provider shall accept the then current Contract Rate as payment in full for such services.

5. Processing Payment. The Network Provider may obtain information regarding the entity responsible for processing payments to the Network Provider by calling 1-866-403-8772.

6. Categories of Coverage. The Network develops and maintains a network of health care providers by entering into agreements with acute and ancillary health care providers, physicians and other health care professionals who have agreed to provide health care services to Participants covered by health services benefits

programs or other types of programs administered by Network's Customers in exchange for reimbursement at agreed upon rates

7. Resolution of Disputes. The Network Provider may call 1-866-403-8772 in connection with any disputes concerning the interpretation or application of the terms and conditions of the Agreement. Any claim payment disputes will be handled in accordance with Section D.6 of the Agreement. Section F.9 of the Agreement further provides that any disputes between the Network and the Network Provider will be resolved through binding arbitration.

8 The Agreement contains the following attachments:

Exhibit A - Certificate(s) of Accreditation
Exhibit B - Network Provider Demographics
Exhibit C – Compensation and Product Election

9. More Information. The Network Provider may call 1-866-403-8772 to receive more information regarding items 1-8 of this Summary Disclosure Form.

EXCEPTION ADDENDUM TO THE PARTICIPATING PROVIDER AGREEMENT STATE OF NEW JERSEY

This Exception Addendum shall apply exclusively to providers in the State of New Jersey. To the extent of any conflict between the Participating Provider Agreement ("Agreement") and this Exception Addendum to Agreement ("Exception Addendum"), this Exception Addendum shall supersede, govern and control to the extent required by federal and/or state law and to the extent that Network and/or Network Provider are subject to such federal or state law.

1. As required by N.J.A.C. 11:24B-5.2(a)(1), the Agreement and amendments thereto are subject to prior approval of the Department of Banking and Insurance ("DOBI"), and may not be effectuated without such approval. Notwithstanding the preceding, the following types of amendments do not require prior approval of the Department of Banking and Insurance ("DOBI"):
   (i) Amendments that are of a clerical nature;
   (ii) Amendments that alter numbers, be they dollar amounts, enrollment amounts or the like, without altering methodologies from which the numbers were derived; and
   (iii) Amendments that involve the substitution of one set of variable text for another set of variable text, if both sets of variable text were previously approved by the DOBI for the provider agreement form.

   As required by N.J.A.C. 11:24-5.2 (a)(2), any provision of the Agreement that conflicts with applicable State or Federal laws are hereby amended to conform to such applicable State or Federal law.

   As required by N.J.A.C. 11:24-5.2 (a)(8), A Network Provider appealing a UM decision on behalf of a Participant, shall have the right to receive a written notice of the UM determination from the Payor by submitting a written appeal to the address provided on the Explanation of Benefits. The Network Provider must obtain the written consent of the Participant in order for the appeal to be reviewed in accordance with the Stage 1 and Stage 2 process as set forth at N.J.A.C. 11:24-8 and 11:24A-3.5, or whether failure to obtain consent of the covered person results in review of the appeal using a separate complaint or provider grievance process. In the event that an appeal instituted by a Network Provider on behalf of a Participant will be entertained as a member utilization management appeal without the Participant's consent, the provision shall explain that such appeals will not be eligible for the Independent Health Care Appeals Program, established pursuant to N.J.S.A. 26:2S-11, until the Participant's specific consent to the appeal is obtained. This provision shall not limit the right of the Network Provider to submit an appeal on behalf of the Participant in situations in which the Participant may be financially liable for the costs of the health care services.

   As required by N.J.A.C. 11:24-5.2 (a)(16), Network Providers shall have the right and obligation to communicate openly with all Participants regarding diagnostic tests and treatment options.

   As required by N.J.A.C. 11:24-5.2 (a)(17), Network Providers shall not be terminated or otherwise penalized because of complaints or appeals that Network Provider files for themselves, or on behalf of Participants, or otherwise acting as an advocate for Participants in seeking appropriate, medically necessary Covered Services.

2. As required by N.J.A.C. 11:22-1.2, Section A.2 of the Agreement shall be modified as follows: "**Clean claim**" means: (1) The claim is for a service or supply covered by the health benefits plan or dental plan; (2) The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person; (3) The person to whom the service or supply was provided was covered by the carrier's health benefits or dental plan on the date of service; (4) The carrier does not reasonably believe that the claim has been submitted fraudulently; and (5) The claim does not require special treatment. For the purposes of this subchapter, special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment.

3. As required by N.J.A.C. 11:22-3.4(C) Section D.2 of the Agreement shall be modified as follows: **Billing Customers** in the Agreement, Network Provider may not bill a Customer more than one hundred eighty (180) days after discharge or the date services are provided and expect to receive any payment.

4. As required by N.J.A.C. 11:24B-5.2(a)(19),

a. Claims shall be submitted and handled in accordance with the applicable state law, including any penalties that may result in the event that claims are not submitted timely. The standards for determining whether submission of a claim has been timely, and the process for providers to dispute the handling or payment of claims shall also follow New Jersey guidelines.

(i) Claims handling shall be consistent with applicable law.
(ii) Interest penalties for the late payment of claims shall be remitted to the Network Provider in accordance with the applicable law, and in no instance shall the provision obligate the Network Provider to request payment of the interest before the interest will be paid.

b. As required by N.J.S.A. 17B:27-44.2d (11), Section D.6.b of the Agreement shall be modified as follows: "thirty (30) days" shall be replaced with "forty-five (45) days".

c. As required by N.J.S.A. 17B:27-44.2d (12), Section D.6.c of the Agreement shall be modified as follows: "six (6) months" shall be replaced with "eighteen (18) months".

5. As required by N.J.A.C. 11:24B-5.3 (f), in the event this Agreement is terminated, Network Provider, if a physician, shall:

(i) Continue to provide health care services for up to four (4) months following the effective date of such termination in cases where it is medically necessary for the Participant to continue treatment with the Network Provider;
(ii) In the case of pregnancy of a Participant, through postpartum evaluation of the Participant, up to six (6) weeks after delivery;
(iii) In the case of post-operative care, up to six (6) months following the effective date of the termination;
(iv) In the case of oncological treatment, up to one (1) year following the effective date of the termination; or
(v) In the case of psychiatric treatment, up to one year following the effective date of termination.

6. As required by N.J.A.C. 11:24B-5.2 (a) (9), the Agreement is hereby governed by the laws of the State of New Jersey. Further, The Parties agree that any enforcement action or proceeding arising out of or relating to this New Jersey Addendum or the Agreement shall be brought in a state or federal court of competent jurisdiction located in the State of New Jersey.

7. As required by N.J.A.C. 11:24-5.3 (d) and (e), the Network Provider shall have the right to request a hearing following a notice that its status as a Network Provider with Network is being terminated, except that the Agreement may specify that the right to a hearing does not apply when the termination occurs on the date of renewal of the Agreement, or upon the Agreement's anniversary date, if no annual renewal date is specified, or termination is based on breach or alleged fraud, or because, in the opinion of the medical director, the Network Provider presents an imminent danger to one or more Participant, or the public health, safety or welfare and specifying the procedures for requesting a hearing from Network when a Network Provider is terminated from participation in the Network, which shall be consistent with the requirements of N.J.A.C. 11:24-3.6 or 11:24A-4.9, as appropriate.

8. As required by N.J.A.C. 11:24B-5.5(a) and (b), Network Providers and Customers shall:

(i) ensure Customers' Benefit Program provides 24-hour, seven-day per week emergency and urgent care Covered Services to its Participants, and Customer has procedures to assure proper utilization of such Covered Services; and
(ii) Providers shall acquire and maintain hospital admitting privileges.

9. As required by N.J.A.C. 11:24B-5.7 (a) the carrier, or payor as defined in the Agreement, is a third party beneficiary of the Agreement, with privity of contract, and a right to enforce the provisions of the Agreement in the event that Network fails to do so, except that such a provision is not required for provider agreements

between a carrier and Network (whose shareholders are composed solely of Provider, if Network is certified or seeking certification solely for the provision of the performance of Covered Services by its shareholders).

10. As required by N.J.A.C. 11:24B-5.4, in the event this Agreement is terminated, Network Provider, if a hospital, shall continue to abide by the terms of the Agreement for a period of at least four (4) months from the effective date of the termination with respect to at least those Participants enrolled with a carrier that is an HMO. The obligation shall apply to any health benefits plan underwritten by the HMO, regardless of the characterization of the health benefits plan (for example, regardless of whether the health benefits plan is for Medicaid, a point-of-service plan, or a closed panel plan).

11. As required by N.J.A.C. 11:24B-5.6, Section C.2(1) of the Agreement shall be modified by adding the following requirement: "Network Provider, if a hospital, shall refer to the instructions on the health care identification card of the Participant for: (a) admission authorization procedures, and (b) procedures for notifying carriers when a Participant presents at an emergency room."