VISTA HEALTH SYSTEM, LLC

PRIMARY CARE PROFESSIONAL PROVIDER

PARTICIPATION AGREEMENT

FOR

_____

Dated: _____

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PRIMARY CARE PROFESSIONAL PROVIDER
PARTICIPATION AGREEMENT

THIS PARTICIPATION AGREEMENT (this "Agreement") is made and entered into on this _____day of _____, by and between

VISTA HEALTH SYSTEM, LLC, a New Jersey limited liability company with offices located at 95 Summit Avenue, Summit, New Jersey 07901 ("IPA")

and

_____
("Professional Provider"), a Professional Provider with offices located at:

_____

_____

RECITALS

A. IPA is an independent practice association that arranges for the provision of health care services by its network of participating Professional Providers, and that intends to offer such services to insurance companies, health maintenance organizations, preferred Professional Provider organizations, employee welfare benefit plans and other purchasers and administrators of health care services in the State of New Jersey.

B. Professional is a Professional Provider duly licensed and qualified to practice medicine or advance practice nursing in the State of New Jersey. Professional desires to participate in IPA's network of Professional Providers, and Professional Provider desires to be included in the roster of professionals with whom IPA offers to arrange for the provision of health care services.

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, the parties agree as follows:

ARTICLE I
DEFINITIONS

1.1 "Coinsurance," "Copayment," or "Deductible" refer to those charges for Professional Provider services that should be collected directly by Participating Professional Providers from Enrollees in addition to the amounts due from a Plan (or its designee) for Covered Services.

1.2 "Covered Services" means those health care services and supplies that an Enrollee is entitled to receive under a Plan's benefit program as described and defined in the Plan Documents.

1.3 "Enrollee" means a person enrolled in a Plan's benefit program (including an enrolled dependent) who is entitled to receive Covered Services.

1.4 "Non-Covered Services" means those health care services that are not benefits under the applicable Plan Documents.

1.5 "Participating Hospital" means a hospital that has entered into an agreement with a Plan or IPA to provide certain Covered Services to Enrollees.

1.6 "Participating Professional Provider " means a Participating Physician, Advance Practice Nurse, Physician Assistant or other licensed health professional who has entered into an agreement with IPA to participate in IPA's network of participating Professional Providers.

1.7 "Participating Provider" means a Participating Physician, Advance Practice Nurse or Physician Assistant, Participating Hospital, or other licensed health facility or licensed health professional that has entered into an agreement with a Plan or IPA to provide Covered Services to Enrollees.

1.8 "Plan" means any insurance company, health maintenance organization, preferred provider organization, employee welfare benefit plan or other purchaser or administrator of health care services with which IPA has entered into an agreement or otherwise made arrangements for the provision of health care services by IPA's network of Participating Professional Providers.

1.9 "Plan Documents" means the agreements and other documents governing the provision of health care services to Enrollees and the payment for such services, including, without limitation, individual participation agreements, subscriber agreements, group contracts, coverage schedules and exhibits, and provider manuals.

ARTICLE II
IPA NETWORK PARTICIPATION

2.1 Participating Professional Provider. Upon execution and delivery of this Agreement by Professional Provider and an authorized officer of IPA, Professional Provider will be identified as a Participating Professional Provider, and Professional Provider will be eligible for the benefits and subject to the obligations of membership in IPA's network of Participating Professional Providers.

2.2 Participation Fees. Professional Provider shall pay to IPA such participation fees as may be assessed by IPA against Participating Professional Providers under this Agreement. The participation fees include an initial participation fee, which is ordinarily assessed upon Professional Provider's application for participation, and an annual participation fee. The participation fees are subject to change.

2.3 Exclusivity. Except as otherwise approved by the IPA, during the term of this Agreement Professional Provider may not participate in any health care Professional Provider network sponsored or managed by, or otherwise affiliated with, any independent practice association or similar entity other than IPA or its designated affiliates, whether as a member,

shareholder, director, officer, employee or independent contractor of such independent practice association or other entity.

ARTICLE III
PLAN PARTICIPATION

3.1 Eligibility for Plan Participation. As a Participating Professional Provider, Professional Provider may participate under the health care benefit plans and programs for which IPA arranges for the provision of health care services, subject to the requirements for participation, and subject to negotiation and approval of the applicable contracts in accordance with Section 3.2 below.

3.2 Contract Negotiation and Approval.

(a) IPA may select, from time to time, in its sole discretion, purchasers or administrators of health care services from which IPA will solicit contracts or other agreements. IPA may determine, on a case-by-case basis, the methodologies it may utilize to negotiate and to seek Professional Provider's approval of proposed contracts and other agreements with the selected purchasers and administrators.

(b) Professional Provider shall comply with the determinations made by IPA under Section 3.2(a) above, and if Professional Provider expressly approves a contract or other agreement, or, if under the methodology utilized by IPA, Professional Provider is deemed to approve a contract or other agreement as a result of Professional Provider's failure to disapprove of the contract or other agreement on a timely basis, then Professional Provider will abide by and be bound legally by the contract or other agreement.

(c) Professional Provider acknowledges that IPA may delegate some or all of its rights and responsibilities under this Section 3.2 to entities affiliated with IPA, including, without limitation, independent entities affiliated with IPA for contracting purposes.

3.3 Services. Professional Provider agrees to provide to Enrollees, who have selected or who have been assigned to Professional Provider, the full range of health care services that Professional Provider regularly offers to Professional Provider's other patients.

3.4 Plan Documents. Professional Provider agrees to abide and be bound by all of the applicable terms and conditions of the Plan Documents relating to the contracts and other agreements under which Professional Provider is bound in accordance with Section 3.2 above. If any of the terms or conditions of the Plan Documents conflict with the terms or conditions of this Agreement, the terms and conditions of the Plan Documents will govern, but only to the extent necessary to overcome the conflict.

3.5 Covering Professional Provider. If Professional Provider is, for any reason, from time to time unable to provide Covered Services when and as needed, Professional Provider may secure the services of a qualified covering Professional Provider to provide such services subject to the terms and conditions of the Plan Documents.

3.6 Professional Provider Standards. Professional Provider shall determine the method, details, and means of performing Covered Services, subject to applicable national and local Professional Provider standards for the provision of such care. Professional Provider acknowledges and agrees that neither IPA nor any of its officers, directors, employees or agents is responsible in any way to Professional Provider or any other person or entity for any acts or omissions of Professional Provider or Professional Provider's employees or agents in connection with the provision of health care services.

3.7 Admissions and Referrals.

(a) Professional Provider shall admit Enrollees for Covered Services only to Participating Hospitals and other Professional Providers described or otherwise identified by the Plan unless otherwise required or permitted under the Plan Documents.

(b) Professional Provider shall comply with the referral procedures adopted from time to time by a Plan or IPA when referring an Enrollee to any individual or institutional health care Professional Provider. Professional Provider shall use best efforts, consistent with applicable medical standards, to refer Enrollees only to Participating Professional Providers unless otherwise required or permitted under the applicable Plan Documents.

3.8 Professional Provider Roster. Professional Provider authorizes IPA, its designee, and each of the health care benefit plans and programs with which Professional Provider participates under this Agreement, to use Professional Provider's name, address, telephone number, type of practice and willingness to accept new patients in the roster of Professional Provider participants and marketing materials used by IPA, its designee or the Plans. The roster of Professional Provider participants may be inspected by and is intended to be used by IPA, Enrollees and the Plans, as well as prospective patients, prospective members of IPA, and other persons and entities that may be evaluating IPA or its network of participating Professional Providers.

ARTICLE IV
REPRESENTATIONS

4.1 Representations by IPA. IPA hereby warrants and represents that it is a New Jersey limited liability company in good standing with the New Jersey Secretary of State.

4.2 Representations by Professional Provider. Professional Provider hereby warrants and represents that Professional Provider is a Professional Provider duly licensed to practice medicine or advanced practice nursing in the State of New Jersey, and is in good standing with the New Jersey State Board of Medical Examiners or New Jersey Board of Nursing. Professional Provider further warrants and represents that all information Professional Provider provides to IPA concerning Professional Provider's credentials will be true and complete, and will not omit any material information, when provided to IPA, and that Professional Provider will promptly notify IPA of any change in such information.

ARTICLE V
COMPENSATION

5.1 Compensation Formula. A Plan or, as specified under IPA's agreement with the Plan, IPA (or its designee) shall pay Professional Provider for Covered Services the amounts set forth in the fee schedule or calculated with the compensation formula adopted under the contract or other agreement approved or deemed approved by Professional Provider in accordance with Section 3.2 above, subject to any withholds or reasonable deductions IPA (or its designee) determines, in its sole discretion, are necessary for antitrust compliance or to compensate IPA (or its designee) for its services to the Plan or to its Participating Professional Providers.

5.2 Restrictions on Enrollee Billing. Professional Provider shall look only to the applicable Plan or, as specified under IPA's agreement with the Plan, to IPA (or its designee) for compensation for Covered Services, and at no time will Professional Provider "balance bill" or otherwise seek compensation from an Enrollee, except for applicable Coinsurance, Copayments and Deductibles. Professional Provider shall hold each Enrollee harmless from and against all amounts owed by a Plan or IPA (or its designee), except for applicable Coinsurance, Copayments and Deductibles.

5.3 Coinsurance; Copayments; Deductibles. Professional Provider shall bill Enrollees, and use reasonable efforts to collect from Enrollees, the Coinsurance, Copayments and Deductibles described under the Plan Documents. Professional Provider also may bill and collect fees and other charges from Enrollees for Non-Covered Services, as long as Professional Provider notifies the Enrollees, prior to providing the Non-Covered Services, that the services are not covered under the applicable Plan Documents.

5.4 Limits on IPA's Liability. Professional Provider acknowledges and agrees that, (a) the Plans and their designees are responsible for determining the extent of coverage under the health care benefit plans or programs issued, sponsored or administered by the Plans; (b) IPA is not liable or in any way responsible for any decisions to make or to deny the payment of claims submitted by Professional Provider; (c) IPA is neither an insurer, underwriter nor guarantor of the payment or performance by any Plan or any health care benefit program issued or administered by the Plan; and (d) IPA is not, under any circumstances, obligated to make any payment due Professional Provider for the provision of Covered Services beyond the amount, if any, that IPA may receive from the applicable Plan directly for and on behalf of Professional Provider.

ARTICLE VI
PRACTICE STANDARDS

6.1 Board Certification. Professional Provider shall obtain and maintain such board certification or board eligibility in Professional Provider's areas of practice as required by IPA from time to time, and as may be required by the health care benefit plans and programs in which Professional Provider participates.

6.2 Performance and Availability. Professional Provider shall devote the time, attention and energy necessary for the competent and effective performance of Professional

Provider's duties under this Agreement. Professional Provider shall be available to provide Covered Services, or Professional Provider shall provide appropriate coverage for such services, twenty-four hours per day, seven days per week, three hundred sixty-five days per year.

6.3 Personnel, Equipment and Supplies. Professional Provider shall supply all necessary office space, personnel, equipment, instruments and supplies required to perform Covered Services as are usual and customary for a medical practice in Professional Provider's areas of practice and as otherwise may be necessary to conform to applicable medical standards.

6.4 Insurance.

(a) Workers' Compensation Insurance. Professional Provider shall maintain, at Professional Provider's sole cost and expense, workers' compensation insurance for Professional Provider's employees and agents in accordance with the laws of the State of New Jersey as the same may from time to time be amended.

(b) Malpractice Insurance. Professional Provider shall maintain, at Professional Provider's sole cost and expense, Professional Provider malpractice liability insurance covering acts or omissions of Professional Provider and Professional Provider's employees or agents during the term of this Agreement. Such insurance must be issued by a licensed insurance company admitted to do business in the State of New Jersey, and it must provide coverage limits that are no less than $1,000,000 per claim and $3,000,000 in the annual aggregate, unless otherwise permitted by IPA, or otherwise mandated by applicable federal or state law. Professional Provider shall purchase such extended reporting endorsements, so called "tail" insurance, or prior acts insurance, as may be necessary to provide insurance coverage, with the same or greater limits of liability as required above, for a period of not less than five years following the effective termination date of any Professional Provider malpractice insurance maintained during the term of this Agreement.

(c) Comprehensive Insurance. Professional Provider shall provide, at Professional Provider's sole cost and expense, unless otherwise permitted by the IPA, insurance covering each of Professional Provider's places of business, insuring Professional Provider against claims of loss, liability or damage committed or arising out of an alleged condition of the premises, or the furniture, fixtures, appliances or equipment located therein, together with standard liability protection against any loss, liability or damage resulting from Professional Provider's, or any of Professional Provider's employee's or agent's, operation of a motor vehicle for business purposes. All such insurance must provide coverage limits that are no less than $100,000 per claim and $300,000 in the annual aggregate, unless otherwise mandated by applicable federal or state law.

(d) Proof of Insurance. Professional Provider shall provide IPA with a minimum of thirty days' prior written notice of any suspension, termination, expiration without renewal or amendment of any of the policies of insurance required under this Article VI. Professional Provider shall from time to time, promptly upon the reasonable request of IPA, furnish to IPA written evidence that the policies of insurance required under this Section 6.4 are valid and in full force and effect.

6.5 Laws and Ethical Standards. Professional Provider shall comply with all applicable federal, state and local statutes, rules and regulations, including, without limitation, the regulations of the New Jersey State Board of Medical Examiners. Professional Provider shall comply with the applicable ethical standards and guidelines of the American Medical Association, the Medical Society of New Jersey, the American Osteopathic Association and the New Jersey Association of Osteopathic Professional Providers and Surgeons. Nothing in this Agreement should be construed to require Professional Provider to violate any such statutes, ordinances, rules, regulations or ethical standards.

6.6 Hospital Privileges. During the term of this Agreement, Professional Provider must be a member in good standing of the medical staff of at least one Participating Hospital for each health care benefit plan or program with which Professional Provider participates if applicable to their clinical practice or is required to participate under this Agreement, with such clinical and admitting privileges as necessary for Professional Provider to perform fully within Professional Provider areas of practice.

6.7 Continuing Education. During the term of this Agreement, Professional Provider shall maintain Professional Provider's competence and skills commensurate with applicable Professional Provider standards, and as required by law, by attending and participating in accredited continuing medical education courses.

6.8 Certificate of Formation; Operating Agreement; Rules. Professional Provider shall abide, and is bound, by IPA's Certificate of Formation and Operating Agreement, and the rules, regulations and procedures of IPA, as amended by IPA from time to time, directly or through IPA's designee.

6.9 NCQA; HEDIS Guidelines; URAC. Professional Provider shall comply with the standards and requirements established by each of the health care benefit plans and programs with which Professional Provider participates under this Agreement, and the standards, requirements and recommendations of the applicable accrediting agencies, including, without limitation, the National Committee for Quality Assurance ("NCQA") and URAC (American Accreditation HealthCare Commission, Inc.), and the Health Plan Employer Data and Information Set ("HEDIS") guidelines. Such compliance includes, without limitation, the timely collection, organization and delivery of data and other information requested or otherwise required by the accrediting agencies, IPA or the Plans.

6.10 Cooperation with IPA's Compliance Efforts. Professional Provider shall cooperate with IPA and its designees in a manner and to the extent necessary for IPA and its designees to comply with applicable federal, state and local laws, ordinances, rules and regulations, and the rules, policies and procedures of the Plans, each as amended from time to time.

(a) Without limiting Professional Provider's obligations under this Section 6.10, and subject to Section 7.2 below, Professional Provider shall maintain and provide to IPA, its designees, the Plans and all federal and state regulatory agencies and authorities with jurisdiction over IPA, Professional Provider, or the provision of health care services or reimbursement therefore, such records, data and other information as may be required, from time

to time, for compliance applicable federal, state and local laws, ordinances, rules and regulations, and the rules, policies and procedures of the Plans. Professional Provider shall maintain and provide such records, data and other information for a period of at least seven years from and after the termination of this Agreement or its expiration without renewal, or for such longer period as may be required by law or the Plan Documents.

(b) Without limiting Professional Provider's obligations under this Section 6.10, and subject to Section 7.2 below, Professional Provider shall permit IPA and its authorized representatives, its designees and the Plans to access and to inspect, upon request and at all reasonable times, the office space and other facilities utilized by Professional Provider, and the records, data and other information maintained by Professional Provider relating to the provision of health care services, including, without limitation, records, data and other information concerning the fees charged by Professional Provider, and payments received from Enrollees and from others on behalf of the Enrollees.

(c) Without limiting Professional Provider's obligations under this Section 6.10, and subject to Section 7.2 below, Professional Provider shall permit each federal or state regulatory agency or authority with jurisdiction over IPA, Professional Provider, or the provision of health care services or the reimbursement therefore, to access and to inspect, upon demand, the office space and other facilities utilized by Profession, and the records, data and other information maintained by Professional Provider relating to the provision of health care services, including, without limitation the New Jersey Department of Banking and Insurance, the New Jersey Department of Health and Senior Services, the United States Department of Health and Human Services, and the Comptroller General of the United States.

6.11 No Discrimination. Professional Provider shall not differentiate or discriminate in Professional Provider's provision of Covered Services to Enrollees because of race, color, national origin, ancestry, religion, age, gender, marital status, sexual orientation, health status, disability, place of residences or source or payment. Professional Provider shall provide Covered Services to Enrollees in the same manner, in accordance with the same standards, and within the same time availability as offered to all other patients of Professional Provider, consistent with applicable medical, ethical and legal standards and requirements.

6.12 Cooperation with Medical Directors. Professional Provider understands that Plans may place certain obligations upon IPA and its designees regarding the quality of care received by Enrollees, and that Plans in certain instances will have the right to oversee and review the quality of care administered to Enrollees. Professional Provider shall cooperate with the medical directors of the Plans and of IPA in respect to their review of the quality of care administered to Enrollees.

6.13 Pharmaceutical Formularies. Professional Provider shall comply, unless medical necessity dictates otherwise, with the pharmaceutical formularies adopted by IPA, its designees, and the health care benefit plans and programs in which Professional Provider participates under this Agreement.

6.14 Notice and Disclosure.

(a) Non-Compliance. Professional Provider shall notify IPA and its designees immediately, in writing, should Professional Provider be in violation of Section 4.2, Section 6.1, Section 6.4 or Section 6.6 of this Agreement, or should Professional Provider be in violation of any other provision of this Agreement, which violation may materially affect Professional Provider's ability to perform under this Agreement.

(b) Malpractice Actions. If and when required by IPA or any health care benefit plan or program with which Professional Provider participates under this Agreement, Professional Provider shall promptly advise IPA, its designees and, if required, the Plans of each settlement or judgment concerning a malpractice claim or action to which Professional Provider is bound, unless such disclosure is otherwise prohibited by court order.

(c) DEA and CDS Registrations. Professional Provider shall notify IPA, its designees and, if required, the Plans immediately, in writing, should Professional Provider's Drug Enforcement Agency Number or New Jersey controlled dangerous substance registration be revoked, suspended or restricted.

(d) IPA's Notice to Plans. IPA or its designee may, in accordance with the Plan Documents, or as otherwise required by law or deemed necessary or desirable by IPA or its designees, disclose to the Plans or to any federal or state regulatory agency or authority, any notice provided by Professional Provider to IPA or its designee in accordance with this Section 6.14.

6.15 Consent to Obtain Information. Professional Provider grants IPA and its designees permission to gain access to any and all information, records, summaries of records, reports, files or data relating to Professional Provider's qualifications, or the quality of care rendered by Professional Provider, from any hospital, government or private agency or association, including, without limitation, the National Practitioner Data Bank, the New Jersey State Board of Medical Examiners or New Jersey State Board of Nursing. Professional Provider shall provide IPA and its designees with any authorizations, consents or releases that may be required from Professional Provider to obtain the information described above. In addition, Professional Provider authorizes IPA and its designees to disclose such information to the Plans and to further authorize representatives of Plans, for and on behalf of Professional Provider, to obtain such information directly. Professional Provider hereby releases IPA, its designees, and their respective employees and agents from any and all liabilities and expenses that may be incurred by Professional Provider, its employees or agents relating to any action taken pursuant to this Section 6.15.

6.16 Credentialing.

(a) Compliance. Professional Provider shall comply with all aspects of IPA's and its designees credentialing and recredentialing policies and procedures, and the credentialing and recredentialing policies and procedures of each health care benefit plan or program with which Professional Provider participates under this Agreement.

(b) Disclosure of Credentialing Information. Professional Provider hereby authorizes IPA and its designee to release, in good faith and for the legitimate business purposes, any and all information, records, summaries of records and statistical reports specific to Professional Provider (including, but not limited to, utilization profiles pertinent to Professional Provider's practice and use of Covered Services, records of Professional Provider's qualifications and credentialing information) to Plans and to prospective purchasers or administrators of health care services without receiving Professional Provider's prior written consent. Professional Provider further authorizes each Plan to release such information to IPA without receiving Professional Provider's prior written consent to such a release. Professional Provider hereby releases IPA, and its employees and agents, from any and all liabilities and expenses that may be incurred by Professional Provider, its employees or agents relating to any action taken pursuant to this Section 6.16.

ARTICLE VII
MEDICAL RECORDS

7.1 Medical Record Retention. Professional Provider shall maintain with respect to each Enrollee a standard medical record in such form, containing such information, and preserved for such period of time, as required by federal and state law. To the extent permitted by law, in accordance with procedures required by law, and upon receipt of at least three business days' prior written notice from IPA, Professional Provider shall permit IPA, it designees and the Plans to inspect and to make copies of such medical records, and, upon request, Professional Provider shall provide copies of such medical records to IPA, its designees and the Plans.

7.2 Privacy and Security of Health Information. Professional Provider shall maintain the confidentiality of all medical records and all other information created or received by Professional Provider that may be deemed "protected health information" under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Professional Provider shall comply with the Standards for Privacy of Individually Identifiable Health Information and the Security Standards for the Protection of Electronic Protected Health Information, if and to the full extent that such regulations promulgated under HIPAA apply to Professional Provider. Professional Provider acknowledges that IPA, together with Professional Provider, and each of the other Participating Professional Providers, constitutes an "organized health care arrangement" as defined under HIPAA.

ARTICLE VIII
TERM AND TERMINATION

8.1 Term. This Agreement is effective as of the date first written above and it will be effective for a period of twelve months thereafter. Upon the expiration of its initial term, and each renewal term thereafter, this Agreement automatically renews for a successive period of twelve months, on the same terms and conditions contained herein, unless sooner terminated pursuant to the terms of this Agreement.

8.2 Immediate Termination. Notwithstanding any other provision of this Agreement, IPA may terminate this Agreement immediately in the event that IPA determines, in its sole and

absolute discretion, that Professional Provider is in breach of, or has otherwise failed to comply with, any of the terms or conditions of this Agreement.

8.3 Termination without Cause. This Agreement may be terminated by Professional Provider at any time, without cause, by the giving of ninety (90) days' prior written notice to IPA. This Agreement may be terminated by IPA at any time, without cause, by the giving of ninety (90) days' prior written notice to Professional Provider.

8.4 Termination of Agreement with Plan. IPA or, if applicable, its designee may terminate its contract or other agreement with a Plan at any time, with or without advance notice to Professional Provider, and without terminating or otherwise amending this Agreement. Professional Provider may terminate Professional Provider's contract or other agreement with a Plan if and only if, (a) such termination is expressly permitted under that contract or other agreement, or IPA otherwise approves of the termination, (b) such termination does not violate any term or condition of this Agreement or the Plan Documents (including, without limitation, IPA's agreement with the Plan), and (c) Professional Provider notifies IPA reasonably in advance of taking any action to terminate Professional Provider's contract or other agreement with the Plan.

8.5 Responsibility for Enrollees Subsequent to Termination. Professional Provider shall continue to provide Covered Services to each Enrollee who is under Professional Provider's care on the effective termination date of this Agreement until the services being rendered to the Enrollee by Professional Provider are completed or up to one hundred twenty days, whichever occurs later (consistent with existing medical, ethical and legal standards and requirements), unless IPA or a Plan makes reasonable and medically appropriate provision for the assumption of such services by another health care Professional Provider. Professional Provider is entitled to compensation for the Covered Services provided to an Enrollee pursuant to this Section 8.5 (prior to and following the effective termination date of this Agreement) in accordance with terms and conditions of this Agreement as if this Agreement was in full force and effect.

8.6 Termination of Professional Provider by a Plan. Notwithstanding any other provision of this Agreement, in the event that a Plan notifies IPA (or its designee), that the Plan wishes to remove Professional Provider from the Plan's roster of participating Professional Providers or Professional Providers, IPA may terminate Professional Provider's participation in the health care benefit plans or programs issued or administered by the Plan or from IPA entirely, in IPA's sole and absolute discretion.

8.7 Professional Provider's Rights upon Termination. Professional Provider may appeal IPA's decision to terminate Professional Provider, subject to and accordance with the rules, regulations, policies and procedures of IPA then governing termination of this Agreement.

ARTICLE IX
MISCELLANEOUS PROVISIONS

9.1 Organized Delivery System Addendum. The terms and conditions of this Agreement are subject to and limited by the contract terms and conditions set forth in the Organized Delivery System Addendum attached to this Agreement, which terms and condition

are incorporated into and made part of this Agreement by this reference. If any of the terms or conditions of this Agreement conflict with the terms or conditions of the Organized Delivery System Addendum, the terms and conditions of the addendum will govern to the extent necessary to overcome the conflict.

9.2 Attorney-in-Fact. If Professional Provider fails to execute and to deliver on a timely basis any document required by a Plan with which Professional Provider participates or is deemed to participate under this Agreement, Professional Provider hereby designates IPA as Professional Provider's Attorney-in-Fact, authorized to execute and to deliver said document for and on behalf of Professional Provider.

9.3 Amendment. This Agreement may be amended by IPA (or its designee) to comply with any agreement entered into between IPA and a Plan, or to comply with any applicable federal, state or local law, ordinance, rule or regulation.

9.4 Internal Grievances; Arbitration. Subject to the provisions of Section 9.4(a), below, any controversy, dispute or claim arising out of, in connection with, or related to the interpretation, performance or breach of this Agreement will be resolved by final and binding arbitration ("Arbitration") in accordance with Section 9.4(b) below.

(a) IPA (or its designee) shall establish and maintain a system to provide for the presentation and resolution of complaints and grievances brought by Professional Provider concerning IPA. These procedures, described in IPA's policies and procedures, as amended from time to time, must be exhausted by Professional Provider before Professional Provider may submit any controversy or dispute to Arbitration.

(b) Subject to the provisions of Section 9.4(a), if a controversy, dispute or claim arises out of, in connection with, or related to the interpretation, performance or breach of this Agreement, and such matter is not one that is resolved in accordance with the procedures set forth under Section 9.4(a) above or the parties cannot otherwise informally resolve the dispute after they have made a good faith effort to do so, then either party may demand that the dispute be settled by Arbitration in accordance with the rules and procedures of the American Health Lawyers Association Alternative Dispute Resolution Service ("AHLA-ADRS"). The parties shall select a single, neutral arbitrator under the procedures established by AHLA-ADRS. The arbitration will be held in Union County, New Jersey.

(c) The arbitrator shall have the power to grant all legal and equitable remedies provided by New Jersey or federal law, except for punitive or exemplary damages. The decision of the arbitrator will be final and unreviewable for any error of law or legal reasoning of any kind. Judgment upon any award rendered by the arbitrator may be entered in any court having jurisdiction thereof and the award may be judicially enforced. In the discretion of the arbitrator, the prevailing party in any Arbitration hereunder may be awarded reasonable attorney's fees, expert and non-expert witness costs and expenses incurred directly or indirectly with said Arbitration, including but not limited to, the fees and expenses of the arbitrators and any other expenses of the Arbitration.

9.5 Independent Contractor. At all times relevant and pursuant to the terms and conditions of this Agreement, Professional Provider, IPA and the Plans are and should be construed to be independent contractors. Nothing in this Agreement is intended to be or should be construed to create a partnership, joint venture or employer-employee relationship between or among Professional Provider, IPA and the Plans, or between any of them.

9.6 Confidentiality. The parties understand and agree that terms and conditions of this Agreement, and that neither party may disclose any of the terms and conditions except if and to the extent necessary to perform under this Agreement or to comply with applicable law.

9.7 Proprietary Information. Professional Provider shall maintain the confidentiality of all trade secrets and other proprietary information belonging to IPA or its designees. Professional Provider may not disclose or use any such information for Professional Provider's own benefit or gain, or the benefit or gain of any other person or entity, either during the term of this Agreement or at any time after the date of termination of this Agreement or its expiration with renewal. For purposes of this Agreement, such information includes, but is not limited to, (a) all Plan Documents, including agreements between IPA (or its designee) and the information contained therein regarding IPA (or its designee) or the Plans, (b) the agreements and other arrangements between IPA and other Professional Providers, hospitals or other institutions, and (c) all manuals, policies, forms, records, files (other than patient medical files) and lists of IPA.

9.8 Non-Solicitation of Enrollees.

(a) During the term of this Agreement and for a period of two years immediately following the expiration or termination of this Agreement, Professional Provider may not, on his or her own behalf or on behalf of any other person or entity, directly or indirectly solicit, recruit, entice, persuade or induce, or attempt to solicit, recruit, entice, persuade or induce, any Plan to sever, modify or let expire its relationship with IPA (or its designee), or any Enrollee to disenroll from a health care benefit plan or program issued or administered by a Plan. This Section 9.8 is not intended, and it should not be construed, (i) to limit communications between Professional Provider and any Enrollee about the Enrollee's diagnostic testing or treatment options regardless of whether such options are Covered Services, (ii) to prohibit Professional Provider from continuing to participate in any underlying agreement with any Plan after termination of this Agreement, or (iii) to prohibit Professional Provider, at any time, from soliciting, negotiating or entering into an agreement with any Plan for the provision of services to enrollees of the Plan.

(b) A breach of this Section 9.8 during the term of this Agreement is grounds for immediate termination of this Agreement. A breach of this Section 9.8 during the term of this Agreement or during the two-year period immediately following the expiration or termination of this Agreement will entitle IPA (or its designee) to seek injunctive relief or, if applicable, damages from Professional Provider in an amount equal to compensation lost to IPA (or its designee) as a result of the breach.

ARTICLE X
GENERAL PROVISIONS

10.1 Notices. All notices, requests, demands and other communications hereunder must be in writing and will be deemed given when delivered, if delivered in person, or three days after being mailed by certified or registered mail, postage prepaid, return receipt requested, or one day after being sent by an overnight courier such as Federal Express, to the parties, their successors in interest or their assignees at the following addresses, or at such other addresses as the parties may designate by written notice in the manner aforesaid.

If to IPA: Vista Health System, LLC
95 Summit Avenue
Summit, New Jersey 07901

Attn: Deborah Rodgers
Executive Director

If to Professional Provider: Addressed to Profession at the address set forth in the introduction to this Agreement.

10.2 Severability. If any provision of this Agreement is held by a court of competent jurisdiction or applicable federal or state law and their implementing regulations to be invalid, void or unenforceable, the remaining provisions will nevertheless continue in full force and effect.

10.3 Attorney's Fees. IPA and Professional Provider agree that the prevailing party in any legal dispute among the parties hereto is entitled to payment of the prevailing party's attorney's fees by the other party.

10.4 Governing Law. This Agreement is governed by and should be construed in accordance with the laws of the State of New Jersey.

10.5 Assignment; Benefit. Professional Provider may not assign this Agreement or any of Professional Provider's rights or obligations under this Agreement without receiving the prior written consent of IPA. Any purported assignment in violation of this Section 10.5 will be void *ab initio*, and of no force and effect. IPA may, in its sole and absolute discretion, assign this Agreement or any of its rights or obligations under this Agreement upon its delivery of at least thirty days' advance written notice to Professional Provider. This Agreement is binding upon and inures to the benefit of the parties to this Agreement and their respective heirs, legal representatives, successors and permitted assigns.

10.6 Waiver. The waiver of any provision, or of the breach of any provision, of this Agreement must be set forth specifically in writing and signed by the waiving party. Any such waiver will not operate as or be deemed to be a waiver of any prior or future breach of such provision or of any other provision.

10.7 Headings. The subject headings of the articles and sections of this Agreement are included for purposes of convenience only, and are not intended to and should not be construed to affect the construction or interpretation of any of its provisions.

10.8 Third Party Beneficiaries. Nothing in this Agreement, expressed or implied, is intended or should be construed to confer upon any person, firm or corporation other than the parties hereto and each Plan, and their respective successors and permitted assigns, any remedy or claim under or by reason of this Agreement or any term, covenant or condition hereof, as third party beneficiaries or otherwise, and all of the terms, covenants and conditions hereof are for the sole and exclusive benefit of the parties hereto and their successors and permitted assigns.

10.9 Entire Agreement. This Agreement supersedes any and all agreements, either written or oral, between the parties hereto with respect to the subject matter contained herein. Each party to this Agreement acknowledges that no representations, inducements, promises or agreements, oral or otherwise, have been made by either party, or anyone acting on behalf of either party, which are not embodied herein, and that no other agreement, statement or promise not contained in this Agreement will be valid or binding. Except as otherwise provided herein, any effective modification must be in writing signed by the party to be charged.

10.10 Survival. This Article X and the following Articles and Sections of this Agreement survive the expiration or termination of this Agreement: Article I; Sections 3.4, 3.6, 5.2, 5.4, and 6.10; Article VII; Sections 8.5, 8.6, 8.7, 9.1, 9.5, 9.6, 9.7 and 9.8.

Executed at Summit, New Jersey, on the date and year first written above.

PROFESSIONAL PROVIDER:

_____

Signature

_____

Print Name

IPA:

By:_____

Signature

John F. Vigorita, MD

President and Chairman

ORGANIZED DELIVERY SYSTEM ADDENDUM
TO
PRIMARY CARE PROFESSIONAL PROVIDER
PARTICIPATION AGREEMENT

The following terms and conditions are required under the Organized Delivery System regulations adopted by the New Jersey Department of Health and Senior Services ("DHSS"), as recorded in N.J.A.C. §§ 8:38B-5.2 through 8:38B-5.9. These terms and condition are incorporated into the Primary Care Professional Provider Participation Agreement (the "Participation Agreement") to which this addendum is attached under Section 9.1 of the Participation Agreement.

Unless otherwise defined under this addendum, the capitalized terms and phrases set forth below have the meanings assigned to them under the Participation Agreement. If any of the terms or conditions of this addendum conflict with the terms or conditions of the Participation Agreement, the terms and conditions of this addendum will govern to the extent necessary to overcome the conflict.

1. Amendments. Except as otherwise provided below in this Section 1, amendments to the Participation Agreement are subject to prior approval of DHSS, and may not be effectuated without such approval.

(a) The following types of amendments to the Participation Agreement do not require prior approval of DHSS:

(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 DHSS for the Participation Agreement form.

(b) Any sections of the Participation that conflict with federal or state law are effectively amended to conform with the requirements of the federal or state law.

(c) IPA must provide Professional Provider with at least thirty calendar days' advance notice of an amendment to the Participation Agreement unless more immediate amendments are required by state or federal law, in which case no advance notice is required.

[N.J.A.C. § 8:38-5.2(a)1-3]

2. Compensation. The compensation methodology for each health care benefit plan or program in which Professional Provider participates under the Participation Agreement will be

specified under contracts or other agreements with the applicable Plans approved under Section 3.2 of the Participation Agreement.

(a) The compensation methodology adopted under any Plan Documents may not provide financial incentives to Professional Provider for the withholding of Covered Services that are medically necessary. This restriction does not, however, prohibit or limit the use of capitated payment arrangements.

(b) To the extent that some portion of Professional Provider's compensation is tied to the occurrence of a pre-determined event, or the non-occurrence of a pre-determined event, the compensation methodology must clearly specify the event, and in such cases, Professional Provider is entitled to receive a periodic accounting of any funds held by IPA in respect to the compensation, if any, which accounting will be provided be no less frequently than annually.

(c) Professional Provider may appeal to the Plan or, if applicable, IPA, a decision denying Professional Provider additional compensation to which Professional Provider believes he or she is entitled under the terms of the Participation Agreement or the Plan Documents.

[N.J.A.C. §8:38B-5.2(a)4]

3. Monitoring. Professional Provider's activities and records relevant to the provision of health care services may be monitored from time to time either by IPA, the applicable Plans, or another contractor acting on behalf of the Plans in order for IPA or the Plans to perform quality assurance and continuous quality improvement functions.

[N.J.A.C. § 8:38B-5.2(a)5]

4. Quality Assurance. Professional Provider shall comply with the quality assurance program of each health care benefit plan or program in which Professional Provider participates under the Participation Agreement, as established by the applicable Plans and adopted by IPA under the Plan Documents.

(a) Unless otherwise specified in the Plan Documents, the Plans are responsible for the day-to-day administration of the quality assurance programs.

(b) Unless otherwise specified in the Plan Documents, Professional Provider may lodge complaints regarding the quality assurance programs with the applicable Plans, in accordance with the terms and conditions specified under the Plan Documents.

(c) IPA shall seek feedback from Professional Provider concerning the operations of IPA and of the applicable Plans through both formal and informal inquiries, as outlined in IPA's policies and procedures.

[N.J.A.C. § 8:38B-5.2(a)6]

5. Utilization Management. Professional Provider shall comply with the utilization management program of each health care benefit plan or program in which Professional Provider participates under this Agreement, as established by the applicable Plans and adopted by IPA under the Plan Documents.

(a) Unless a third party is identified in the Plan Documents, the Plans are responsible for the day-to-day administration of the utilization management programs. Professional Provider shall comply with the utilization management standards and protocols set forth in the Plan Documents, including the methods for obtaining and appealing utilization decisions.

(b) Professional Provider understands that Professional Provider is entitled to, and that the Plan or other person or entity responsible for the utilization management program is obligated to provide to Professional Provider, the name and telephone number of the Professional Provider denying or limiting an admission, service, procedure or length of stay.

(c) IPA may assist Professional Provider by providing information concerning the applicable utilization protocols, but Professional Provider understands that the Plan Documents set forth the utilization protocols and any parameters that may be placed on the use of one or more protocols. Professional Provider should consult the Plan Documents to review the protocols and Professional Provider should direct comments on the protocols to the Plans, either directly or through IPA, in accordance with the procedures set forth in the Plan Documents or as otherwise adopted by IPA from time to time.

(d) Professional Provider understands that Professional Provider has the right to rely upon the written or oral authorization of a service if made by the Plan or another person or entity identified as being responsible for the day-to-day operations of the applicable utilization management program, and that the retroactive denial of services as not medically necessary is prohibited except in the case of a material misrepresentation of the facts to the Plan or to the other person or entity responsible for the day-to-day operations of the utilization management program, or the case of fraud.

[N.J.A.C. § 8:38B-5.2(a)7]

6. Utilization Appeals. Professional Provider understands that each Enrollee, and Professional Provider acting on behalf of an Enrollee with the Enrollee's consent, may appeal any utilization management determination resulting in a denial, termination, or other limitation of Covered Services. The appeal process, under N.J.A.C. § 8:38-8 and N.J.A.C. § 8:38A-3.5, should be set forth in the Plan Documents, and should consist of an informal internal review by the Plan (a stage 1 appeal), a formal internal review by the Plan (a stage 2 appeal), and a formal external review by an independent utilization review organization (a stage 3 appeal) in accordance with the Independent Health Care Appeals Program established under N.J.S.A. 26:2S-11.

(a) Professional Provider understands that consent of the Enrollee is ordinarily required to appeal utilization management decisions under the appeal process described above, and that unless otherwise provided in the Plan Documents, without consent of

the Enrollee, Professional Provider's dissatisfaction with a utilization management decision may only be addressed through the Plan's Professional Provider complaint and grievance process. Professional Provider further understands that even if the Plan Documents authorize Professional Provider to appeal a utilization management decision without the Enrollee's consent, 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 Enrollee's specific consent to the appeal is obtained.

(b) Professional Provider understands that the right to submit an appeal on behalf of an Enrollee is not limited only to situations in which the Enrollee may be financially liable for the costs of the health care services.

[N.J.A.C. § 8:38B-5.2(a)8]

7. Governing Law. The Participation Agreement is governed by New Jersey law.

[N.J.A.C. § 8:38B-5.2(a)9]

8. Term and Termination. The Participation Agreement is deemed executed on the date set forth in the introduction to the agreement. The termination and renewal rights, and obligations of the parties with respect to termination and renewal are set forth under Article VIII of the Participation Agreement, as modified or supplemented by this addendum.

(a) Professional Provider may be terminated from any health care benefit plan or program in which it participates under the Participation Agreement for any reason or reasons permitted or required under the Plan Documents, which reason or reasons may differ from the reasons for termination of the Participation Agreement.

(b) Professional Provider may elect not to participate in a health care benefit plan or program issued or administered by a Plan without also terminating the Participation Agreement, but only if such an election is permitted under Section 3.2 of the Participation Agreement, and Professional Provider complies with the terms and conditions of the Participation Agreement in making such an election.

(c) When Professional Provider's participation in any health care benefit plan or program is terminated pursuant to the Participation Agreement, written notice will be issued to Professional Provider no less than ninety days prior to the date of termination, except that the ninety-day prior notice requirement does not apply when the contract or other agreement with the Plan is being terminated upon its date of renewal, or upon its anniversary date, if no annual renewal date is specified, or it is being terminated because of a breach, alleged fraud, or because, in the opinion of the medical director of IPA or the Plan, Professional Provider presents an imminent danger to one or more Enrollees, or the public health, safety or welfare.

(d) Professional Provider is entitled to receive a written statement setting forth the reasons for termination of Professional Provider's participation in any health care benefit plan or program. If the written notice of termination does not include such a statement, Professional Provider may submit a written request for such a statement to the Plan or, if applicable, IPA, as permitted under the Plan Documents.

[N.J.A.C. §§ 8:38b-5.2(a)10-11]

9. Hearing Upon Termination. Professional Provider may request a hearing with the applicable Plan following a notice that the Professional Provider's participation with a health care benefit plan or program is being terminated pursuant to the Participation Agreement, except that the right to a hearing does not apply when the contract or other agreement with the Plan is being terminated upon its date of renewal, or upon its anniversary date, if no annual renewal date is specified, or is being terminated because of a breach, alleged fraud, or because, in the opinion of the medical director of IPA or the Plan, Professional Provider presents an imminent danger to one or more Enrollees, or the public health, safety or welfare. The procedures for requesting a hearing from a Plan are set forth in the Plan Documents, and should be consistent with the requirements of N.J.A.C. § 8:38-3.6 or § 8:38A-4.9, as appropriate.

[N.J.A.C. §§ 8:38B-5.3(a)-(d)]

10. Responsibility for Enrollees Subsequent to Termination. Upon termination of Professional Provider's participation with a health care benefit plan or program, or upon termination of the Participation Agreement, regardless of the party initiating the termination, Professional Provider remains obligated to provide Covered Services to Enrollees during the periods described below:

(a) For up to four months following the effective date of termination in cases where it is medically necessary for the Enrollee to continue treatment with Professional Provider, except as Sections 10(b) through 10(e) below apply;

(b) In cases of the pregnancy of an Enrollee, through the postpartum evaluation of the Enrollee, up to six weeks after delivery;

(c) In the case of post-operative care, up to six months following the effective date of the termination;

(d) In the case of oncological treatment, up to one year following the effective date of the termination; and

(e) In the case of psychiatric treatment, up to one year following the effective date of the termination.

[N.J.A.C. § 8:38B-5.3(e)]

11. Exception to Continuing Care. Notwithstanding Section 10 of this addendum, Professional Provider may be required to discontinue the provision of any and all Covered Services, in which case, neither the Plans nor IPA will be obligated to pay for any services

rendered by Professional Provider following the effective date of termination, if the termination is based upon a breach of the contract or other agreement with the Plan or the Participation Agreement, or alleged fraud, or because, in the opinion of the medical director of either IPA or the Plan, Professional Provider presents an imminent danger to one or more Enrollees, or to the public health, safety or welfare.

[N.J.A.C. § 8:38B-5.3(g)]

12. Restrictions on Enrollee Billing. Professional Provider is prohibited from billing or otherwise pursuing payment from an Enrollee for Covered Services, or for any other benefits that are payable under the Enrollee's health care benefit plan or program, except for the applicable Coinsurance, Copayment or Deductible, regardless of whether Professional Provider agrees with the amount paid or to be paid, for the services or supplies rendered.

[N.J.A.C. § 8:38B-5.2(a)12]

13. Credentialing. Professional Provider must be credentialed and otherwise eligible to participate with each of the health care benefit programs with which it is contractually obligated to participate. Professional Provider cooperate with the credentialing process, including, without limitation, by timely submitting all information necessary for credentialing and recredentialing, as and when required under IPA's policies and procedures, or the policies and procedures set forth in the Plan Documents.

[N.J.A.C. § 8:38B-5.2(a)13]

14. Malpractice Liability Insurance. The malpractice liability insurance must have limits of not less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

[N.J.A.C. § 8:38B-5.2(a)14]

15. Services and Supplies. Professional Provider shall provide to Enrollees the full range of health care services that Professional Provider regularly provides to Professional Provider's other patients, including, services and supplies described as Covered Services under the applicable Plan Documents.

[N.J.A.C. § 8:38B-5.2(a)15]

16. Communication with Enrollees. Professional Provider has the right and the obligation to communicate openly with all Enrollees regarding diagnostic tests and treatment options. Professional Provider may not be terminated or otherwise penalized because of complaints or appeals that Professional Provider files on his or her own behalf, or on behalf of an Enrollee, or for otherwise acting as an advocate for Enrollees in seeking appropriate, medically necessary health care services covered under the Enrollee's health care benefit plans or programs.

[N.J.A.C. §§ 8:38B-5.2(a)16 and 17]

17. No Discrimination. Professional Provider shall not discriminate in his or her treatment of Enrollees.

[N.J.A.C. § 8:38B-5.2(a)18]

18. Claims Submission. Professional Provider understands that the procedures for submitting and handling claims, 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 Professional Provider to dispute the handling or payment of a claim are set forth in the applicable Plan Documents. Professional Provider understands that such provisions must be consistent with the laws concerning the submission and payment of electronic and paper claims, including the requirements of the Health Information Network and Technology Act, P.L. 1999, c.154, as well as the prompt payment laws and regulations. Professional Provider also understands that health care benefit plans or programs with which Professional Provider Participates, or the applicable Plans, are responsible for directly paying to Professional Provider interest for late payment of claims

[N.J.A.C. § 8:38B-5.2(a)19]

19. Internal Complaints and Grievances. Professional Provider may submit complaints and grievances to the Plans, and seek resolution of such complaints and grievances, separate and apart from submitting complaints and grievances on behalf of an Enrollee, and complaints addressing compensation and claims issues:

(a) Professional Provider may submit complaints and grievances in writing to the applicable Plan in accordance with the procedures set forth in the Plan Documents. Professional Provider understands that the Plans are required to resolve the complaints or grievance within thirty days after they are submitted.

(b) Professional Provider may submit complaints and grievances to the New Jersey Department of Health and Senior Services, the New Jersey Department of Banking and Insurance or the New Jersey Department of Human Services, depending upon the issue involved, if Professional Provider is not satisfied with the resolution of the complaint or grievance through the available internal complaint mechanism of the Plans.

[N.J.A.C. § 8:38B-5.2(a)20]

20. Confidentiality. Professional Provider shall comply with the confidentiality requirements set forth under the contracts or other agreements between Professional Provider and the Plans, as well as the confidentiality provisions of the Participation Agreement, including, without limitation, the requirements set forth under Article VII concerning medical records, and the requirements set forth under Sections 9.6 an 9.7 concerning the terms and conditions of the Participation Agreement and proprietary information of IPA.

[N.J.A.C. § 8:38B-5.2(a)21]

21. Availability; Responsibilities; Privileges. Professional Provider understands that it is the mutual responsibility of Professional Provider and the Plans to assure twenty-four-hour per day, seven-day per week emergency and urgent care coverage to Enrollees, and to comply with the utilization management protocols set forth in the Plan Documents and as otherwise required by law to assure proper utilization of Covered Services. Professional Provider shall acquire and maintain such medical staff membership and such admitting and clinical privileges as necessary to fully perform the Covered Services under each of the health care benefit plans or programs in which Professional Provider participates under the Participation Agreement.

[N.J.A.C. § 8:38B-5.5]

22. Third-Party Rights. Notwithstanding anything to the contrary contained in the Participation Agreement, each Plan that issues or administers health care benefit plans or programs with which Professional Provider participates under the Participation Agreement is a third party beneficiary of the Participation Agreement and will have privity of contract with Professional Provider such that the Plan will have standing to enforce the Participation Agreement in the event that IPA fails to do so.

[N.J.A.C. § 8:38B-5.7]

23. Survival. This Section 23 and the following Sections of this addendum survive the expiration or termination of the Participation Agreement: 7, 9, 10, 11, 12, 20, and 22.

* * *

ADDENDUM TO VISTA HEALTH SYSTEM, LLC
PRIMARY CARE PROFESSIONAL PROVIDER
PARTICIPATION AGREEMENT
MEDICARE ADVANTAGE
TERMS AND CONDITIONS OF PARTICIPATION

The following provisions are CMS requirements for Medicare Advantage Plan participation agreements with Medicare Advantage Plan participating providers. These terms and conditions are incorporated into the Primary Care Professional Provider Participation Agreement by and between Vista Health System, LLC and Professional Provider [attached hereto] (the "Agreement") and apply to all Medicare Advantage Plans in which Professional Provider participates under the Agreement. In the event of any conflict between the terms of this Addendum and the Agreement, the terms of this Addendum shall control and shall supersede and replace any inconsistent provisions of the Agreement as to Professional Provider's participation in any Medicare Advantage Plan under the Agreement in order to ensure compliance with CMS requirements. This Addendum may be unilaterally updated and amended at any time in order to comply with federal laws, rules or regulations, the Medicare Advantage Plan's CMS Contract (hereinafter defined) or CMS instructions. Professional Provider will be notified regarding these changes as soon as practicable after changes have been announced.

1. **Confidentiality of Records.** For any medical records or other information Professional Provider maintains with respect to any Medicare beneficiary who is eligible and enrolled to received Medicare Advantage Plan covered services (for purposes of this Addendum only "Covered Services") under a Medicare Advantage Benefit Plan (hereinafter "Members"), Professional Provider must establish procedures to safeguard the privacy of any information that identifies such Member; release information from, or copies of, records only to authorized individuals; and ensure that unauthorized individuals cannot gain access to or alter Member records. The Medicare Advantage Plan and Professional Provider shall comply with the confidentiality and Member record accuracy requirements, including: (1) abiding by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (2) ensuring that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; (3) maintaining the records and information in an accurate and timely manner; and (4) ensuring timely access by Members to the records and information that pertain to them. [42 C.F.R. § 422.504(a)(13) and 42 C.F.R. § 422.118.]

2. **Prompt Payment.** The Medicare Advantage Plan must agree to comply with the prompt payment provisions set forth in this Agreement. [42 C.F.R. § 422.520(b).]

3. **Hold Harmless.** Professional Provider shall accept as payment in full for Covered Services provided to Members the compensation specified in the Medicare Advantage Plan provider participation agreement. Professional Provider may not hold any Member liable for payment of any fees that are the legal obligation of the Medicare Advantage Plan. [42 C.F.R. §§ 422.504(g)(1)(i) and 422.504(i)(3)(i).] Professional Provider agrees that in no event, including, but not limited to nonpayment by the Medicare Advantage Plan or its designee, the Medicare Advantage Plan's insolvency, or breach of its Medicare Advantage

Plan provider participation agreement shall Professional Provider bill, charge, collect a deposit from, or seek compensation, remuneration, or reimbursement from, or have any recourse against Members or persons other than the Medicare Advantage Plan acting on Member's behalf for services provided under the Medicare Advantage Plan's provider participation agreement. This provision shall not prohibit Professional Provider from collecting from Members any applicable Cost-sharing (as defined by 42 C.F.R. § 422.2) or fees for non-Covered Services delivered to a Member provided that Professional Provider has complied with the Medicare Advantage Plan's provider participation agreement requirements for holding Members financially responsible for non-Covered Services. With respect to Covered Services furnished prior to the termination of a Medicare Advantage Plan provider participation agreement, this Section shall survive the termination of such agreement (regardless of the reason for termination, including insolvency of the Medicare Advantage Plan), shall be construed to be for the benefit of Members, and supersedes any oral or written contrary agreement now existing or later entered between Professional Provider and a Member or persons acting on a Member's behalf. Provider acknowledges that in the event of a Medicare Advantage Plan's insolvency or other cessation of operations, benefits to Members will continue through the period for which payment from CMS to such Medicare Advantage Plan has been paid, and benefits of Members who are inpatients in a hospital on the date of insolvency or other cessation of operations will continue until their discharge. No changes in the insolvency protection or continuation of benefits provisions under this Section shall be made without prior written approval of CMS, if applicable. [42 C.F.R. § 422.504(g).]

4. **Access to and Maintenance of Records.** Professional Provider hereby agrees that the Department of Health and Human Services ("DHHS"), the Comptroller General, or their designees have the right to audit, evaluate, and inspect: (a) the quality, appropriateness, and timeliness of services furnished to Members; and (b) the facility where services are provided. Professional Provider further agree that DHHS, the Comptroller General, or their designees may audit, evaluate, or inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to the Medicare Advantage Plan's CMS contract (the "CMS Contract")) through ten (10) years from the final date of the contract period or the completion of any audit, whichever is later. [42 C.F.R. § 422.504(i)(2)(i), (ii), and (iv).] Such information shall include medical records, patient care documentation, and other records of Professional Provider (or its assignee) that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the CMS Contract, or as the Secretary of the DHHS may deem necessary to enforce the CMS Contract. Professional Provider agrees to maintain records, including medical records, to the extent necessary to comply with the foregoing, and to make available, for the purposes specified in this Section, their premises, physical facility and equipment, records relating to Members, and any additional relevant information that CMS may require.

5. **Compliance with Law.** Professional Provider agrees to comply with Medicare laws, regulations, and CMS instructions [42 C.F.R. § 422.504(a)(1)-(13) and 422.504(i)(4)(v)].

Professional Provider agrees to comply with federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. § 3729 *et seq.*) and the anti-kickback statute (42 U.S.C. § 1320a-7b(b)); the HIPAA administrative simplification rules at 45 C.F.R. parts 160, 162 and 164; and all laws applicable to recipients of federal funds. [42 C.F.R. § 422.504(h)(1)].

6. **Federal Funds.** Professional Provider acknowledges that payments Professional Provider receives from a Medicare Advantage Plan to provide services to Members are, in whole or part, from federal funds. Therefore, Professional Provider and any of its Downstream Entities (as defined in 42 C.F.R. § 422.500) are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 C.F.R. Part 80; the Age Discrimination Act of 1975 as implemented by 45 C.F.R. Part 91; the Americans with Disabilities Act; Section 504 of the Rehabilitation Act of 1973 as implemented by 45 C.F.R. Part 84. [Medicare Managed Care Manual, Chapter 11, Section 120]

7. **Accountability**. Professional Provider hereby acknowledge and agree that the Medicare Advantage Plan shall oversee the provision of services hereunder and be accountable under the CMS Contract for services provided to Members by Professional Provider on an ongoing basis. [42 C.F.R. § 422.504(i)(4)(iii).]

8. **CMS Contract.** Professional Provider acknowledges that services or other activity performed under this Agreement shall be consistent and comply with the Medicare Advantage Plan's contractual obligations under the CMS Contract. [42 C.F.R. § 422.504(i)(1); 422.504(i)(3)(iii).]

9. **Delegated Activities.** In the event the Medicare Advantage Plan delegates to Professional Provider any of the Medicare Advantage Plan's activities or responsibilities under the CMS Contract, Professional Provider agrees to enter into a written agreement: (a) specifying the delegated activities and reporting responsibilities; (b) providing for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the Medicare Advantage Plan determines that Professional Provider has not performed satisfactorily; (c) specifying that the performance of Professional Provider is monitored by the Medicare Advantage Plan on an ongoing basis; (d) specifying that either (i) the credentials of medical professionals affiliated with Professional Provider will be either reviewed by the Medicare Advantage Plan, or (ii) the credentialing process will be reviewed and approved by the Medicare Advantage Plan; (e) in the event that the Medicare Advantage Plan delegates the selection of providers, written arrangements must state that the Medicare Advantage Plan retains the right to approve, suspend, or terminate such arrangement; and (f) specifying that Professional Provider must comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. § 422.504(i)(4); 42 C.F.R. § 422.504(i)(5)].

10. **Compliance with Medicare Advantage Plan Policies and Procedures.** Professional Provider represents and warrants that, in performing under this Agreement, he/she/it shall

comply with all applicable governmental laws and regulations and all policies and procedures of the Medicare Advantage Plan, including without limitation written standards for the following: (a) timeliness of access to care and Member services; (b) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); (c) Professional Provider consideration of Member input into the provider's proposed treatment plan; (d) quality improvement; and (e) medical management (i.e., utilization management). [42 C.F.R. § 422.112(a)(6); 422.504(i)(4)(v); 422.202(b); 422.504(a)(5); Managed Care Manual, Chapter 11, Section 100.4.]

11. **Discrimination Prohibited.** Professional Provider shall not deny, limit, or condition the furnishing of benefits to a Member on the basis of any factor that is related to health status, including, but not limited to the following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; or (g) disability. Professional Provider further agrees to comply with Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under the Medicare Advantage Plan. [42 C.F.R. § 422.110(a). HPMS Email dated May 27, 2016].

12. **Emergency Services.** The Medicare Advantage Plan must pay for Covered Services that are Emergency services (as defined by 42 C.F.R. § 422.113(b)) rendered to a Member to treat an Emergency medical condition (as defined by 42 C.F.R. § 422.113(b)) or for which the Medicare Advantage Plan instructed the Member to seek treatment within or outside the licensed service area or the Medicare Advantage Plan's provider network. [42 C.F.R. § 422.100(b).]

13. **Urgently Needed Services**. The Medicare Advantage Plan must pay for all Covered Services constituting Urgently needed services (as defined by 42 C.F.R. § 422.113(b)) rendered to a Member. [42 C.F.R. § 422.100(b).]

14. **Renal Dialysis Services**. The Medicare Advantage Plan must pay for all Covered Services constituting renal dialysis services provided to a Member while the Member was temporarily outside the licensed service area. [42 C.F.R. § 422.100(b)(iv).]

15. **Screening Mammography, Influenza Vaccine, and Pneumococcal Vaccine**. Professional Provider acknowledges that Members may directly access (through self-referral) Covered Services constituting screening mammography and influenza vaccine. [42 C.F.R. § 422.100(g)(1).] Professional Provider may not bill or collect Cost-sharing from Members for influenza vaccine and pneumococcal vaccine. [42 C.F.R. § 422.100(g)(2).]

16. **Direct Access to Women's Health Specialist**. The Medicare Advantage Plan must acknowledge and agree that female Members are allowed to directly access a women's health specialist who is a participating provider for women's routine and preventive health care services. The Medicare Advantage Plan must not deny payment for a Covered Service on the basis that a female Member did not obtain a referral for such services. [42 CFR. § 422.112(a)(3).]

17. **Access to Benefits.** Professional Provider shall make Covered Services available and accessible to Members twenty-four (24) hours per day, seven (7) days per week, when medically necessary (as defined in the applicable Medicare Advantage Plan), and with reasonable promptness and in a manner which assures continuity in the provision of Covered Services. [42 C.F.R. 422.112(a)(7)].

18. **Marketing**. Professional Provider agrees to remain neutral when assisting beneficiaries with enrollment decisions. Professional Provider acknowledges and agrees that any and all marketing activities related to any Medicare Advantage Benefit Plan must conform to the requirements of the Medicare Advantage Program, including the requirements of the Medicare Communications and Marketing Guidelines. [42 C.F.R. § 422.2262 and Medicare Communications and Marketing Guidelines at § 60.3.]

19. **Provision of Services.** Professional Provider agrees to provide Covered Services in a manner consistent with professionally recognized standards of health care. [42 C.F.R. § 422.504(a)(3)(iii).] Professional Provider agrees further to provide Covered Services in a culturally competent manner to all Members by making a particular effort to ensure that those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled. [42 C.F.R. § 422.112(a)(8).]

20. **Exchange of Information.** Professional Provider shall maintain each Member's medical record in accordance with standards established by the Medicare Advantage Plan and shall cooperate with the Medicare Advantage Plan to ensure that there is appropriate and confidential exchange of information. [42 C.F.R. § 422.112(b).]

21. **Advance Directives.** Professional Provider shall: (a) document in a prominent part of each Member's medical record whether or not the Member has executed an advance directive; (b) not condition the provision of care or otherwise discriminate against a Member based on whether or not the individual has executed an advance directive; (c) comply with the Medicare Advantage Plan's policies and procedures regarding advance directives contained in the Medicare Advantage Plan's Provider Manual; and (d) comply with requirements of state and federal law regarding advance directives, including without limitation the rules and regulations under the Medicare Advantage Program. [42 C.F.R. § 422.128.]

22. **Reporting Requirements**. Professional Provider agrees to provide all documents and information necessary for the Medicare Advantage Plan to comply with the Medicare Advantage Plan's requirements for submitting information required by the CMS Contract

and pursuant to 42 C.F.R. § 422.503. Professional Provider further agrees, as a condition to receiving payment under the Medicare Advantage Plan's provider participation agreement, to provide certification to the best of Professional Provider's knowledge, information, and belief, the accuracy, completeness, and truthfulness of the encounter and/or claims data Professional Provider submits to the Medicare Advantage Plan under its provider participation agreement and in accordance with the provisions of 42 C.F.R. § 422.504(l), as may be amended from time to time. [42 C.F.R. §§ 422.310, 422.504(a)(8), 422.504(d)-(e), 422.504(i)(2)-(4), and 422.504(l)(1) and (3).]

23. **Excluded Providers.** Professional Provider acknowledges that the Medicare Advantage Plan is prohibited from employing or contracting with an individual or entity who is excluded from participation in the Medicare program (or with an entity that employs or contracts with such an individual) for the provision of any of the following: (a) health care; (b) utilization review; (c) medical social work; or (d) administrative services. Professional Provider agrees to immediately notify the Medicare Advantage Plan in the event Professional Provider or any of Professional Provider's employees or contractors, is excluded from participation in the Medicare program or any administrative or regulatory proceedings is initiated that could lead to the exclusion of the Professional Provider or any of the Professional Provider's employees or contractors from the Medicare program. [42 C.F.R. § 422.752(a)(8) and (12).] In such event, the Medicare Advantage Plan may immediately terminate the Professional Provider's provider participation agreement. Professional Provider may be responsible for any loss, cost, or liability incurred by the Medicare Advantage Plan as a result of the exclusion of Professional Provider or any of Professional Provider's employees or contractors from the Medicare program.

24. **Dual Eligibles and Cost Sharing**. A dual eligible individual ("Dual Eligible") means a Medicare managed care recipient who is also eligible for Medicaid, and for whom the state has responsibility for payment of cost sharing obligations under the state plan. Dual Eligible Members will not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. The Medicare Advantage Plan must inform its participating providers of Medicare and Medicaid benefits, and rules for Members eligible for Medicare and Medicaid. The Medicare Advantage Plan may not impose Cost-sharing that exceeds the amount of Cost-sharing that would be permitted with respect to the individual under Title XIX if the Member were not enrolled with a Medicare Advantage plan. Professional Provider shall comply with the foregoing by accepting the Medicare Advantage Plan's payment as payment-in-full or by billing the appropriate state source. [42 C.F.R. § 422.504(g)(1)(iii).]

25. **Medicare as Secondary Payor.** Professional Provider shall not be entitled to payment by the Medicare Advantage Plan for the provision of Covered Services to the extent that the Medicare program is not the primary payor, as determined in accordance with the relevant provisions of Section 1862(b) of the Social Security Act and 42 C.F.R. Part 411. Professional Provider agrees to assist the Medicare Advantage Plan in identifying payors that are primary to the Medicare program, determining the amounts payable by those payors and coordinating Covered Services with the benefits of the primary payer in accordance with the Medicare Advantage Plan's Provider Manual relating to coordination

of benefits. Professional Provider is authorized to charge other individuals or entities for Covered Services provided to a Member for which Medicare is not the primary payor, as follows: if such Covered Services are also covered under (a) state or federal workers' compensation, any no-fault insurance or any liability insurance policy or plan, including a self-insured plan, Professional Provider may charge: (i) the insurance carrier, (ii) employer, (iii) any other entity that is liable for payment for the Covered Services as a primary payor, or (iv) the Member (to the extent such Member has been paid by the carrier, employer, or entity for such Covered Services); and (b) a group health plan or large group health plan, Professional Provider may charge: (i) the group health plan or large group health plan; or (ii) the Member, to the extent that such Member has been paid by either such plan. [42 C.F.R. § 422.108.]

26. **Quality Improvement Program.** Professional Provider agrees to comply with the Medicare Advantage Plan's Quality Improvement Program. [42 C.F.R. § 422.202(b)]. Professional Provider acknowledges that the Medicare Advantage Plan is required under the Medicare Advantage Program to have an agreement with an independent quality review and improvement organization approved by CMS to perform an external review of the Medicare Advantage Plan's Quality Improvement Program. [42 C.F.R. § 422.504(a)(5).] Provider agrees to comply with the activities of the Medicare Advantage Plan's independent quality review and improvement organization in accordance with the applicable Medicare Advantage Program requirements, including, without limitation, (a) allocating adequate space at Professional Provider's facility for use of the review organization whenever it is conducting review activities; and (b) providing all pertinent data, including without limitation, patient care data, at the time the review organization needs the data to carry out the review and make its determination. [42 C.F.R. § 422.152.]

Professional Provider acknowledges that the Medicare Advantage Plan is permitted to use Professional Provider performance data for quality improvement activities and shall disclose to CMS the quality and performance indicators for its Benefit Plan(s) in connection with: (a) disenrollment rates for Members enrolled for the previous two (2) years; (b) Member satisfaction; and (c) health plan outcomes. [42 C.F.R. § 422.504(f)(2)(iv).] The Medicare Advantage Plan must disclose to CMS all information necessary to administer and evaluate its Benefit Plans and to establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. [42 C.F.R. §§ 422.64; 422.504(a)(4); 422.504(f)(2).]

27. **Member Grievance and Appeals Procedures.** Professional Provider agrees to comply with the Medicare Advantage Plan's procedures for Member grievances, organization determinations, and Member appeals set forth in the Benefit Program Requirements for Benefit Programs under the Medicare Advantage Program, as described in 42 C.F.R. § 422.562, and others, as applicable.

28. **Fraud Waste and Abuse.** Professional Provider shall comply and cooperate with training and education given as part of the Medicare Advantage Plan's compliance plan to prevent, detect, and correct fraud, waste, and abuse ("FWA"). Professional Provider shall make information about the Medicare Advantage Plan's FWA requirements available to all of its

employees, including how a report may be directly made to the Medicare Advantage Plan. [42 CFR §422.503]

29. **Services Performed Outside the United States**. Professional Provider shall not perform or contract with any third parties to perform any of the services to be provided under the Medicare Advantage Plan's provider participation agreement outside of the United States without the prior written approval of the Medicare Advantage Plan. Professional Provider shall not utilize an offshore subcontractor to receive, process, transfer, handle, store, or access beneficiary protected health information in connection with the Medicare Advantage Plan's provider participation agreement. Should the Medicare Advantage Plan in its discretion grant such approval, Professional Provider agrees to supply the Medicare Advantage Plan timely with the information necessary for the Medicare Advantage Plan to comply with, and attest to compliance with, all applicable CMS requirements regarding any such approved offshore arrangement within 30 days after its effective date. [HPMS Memos 07/23/2007 and 09/20/2007]

30. **Subcontracts**. If Professional Provider contracts with any Downstream Entity (as defined at 42 C.F.R. § 422.500) for the provision of services to Members, such contract shall incorporate the requirements of this Addendum including any changes or amendments to this Addendum.