EMBLEMHEALTH PARTICIPATING PRACTITIONER AGREEMENT

Group Health Incorporated and the other EmblemHealth companies listed on the attached addendum, if any, and their affiliated and successor companies (referred to hereinafter as "EmblemHealth"), is pleased to contract with the undersigned Practitioner ("Practitioner") for the provision of Covered Services to Members. Practitioner shall render Covered Services to Members according to the terms and conditions of this Agreement, EmblemHealth's Administrative Guidelines, Provider Manual and policies and procedures, and each Member's Benefit Program listed on **Attachment B**. Practitioner agrees to abide by the Quality Improvement, Utilization Management, Claims Submission and other applicable rules, policies and procedures of EmblemHealth. This Agreement (consisting collectively of this page, the body of the agreement that follows, the Prevailing Plan Fee Schedule and terms annexed hereto as **Attachment A**, plus the Addendums and Attachments which are incorporated herein and the Administrative Guidelines, as they may be amended from time to time and published on the EmblemHealth website, constitutes the complete and sole contract between the parties regarding the subject matter of the Agreement and, except as otherwise provided herein, supersedes any and all prior or contemporaneous oral or written communications not expressly included in the Agreement. The Start Date of this Agreement shall be forty-five (45) days after counter execution of this Agreement by EmblemHealth _____ ("Start Date"). If Practitioner is a professional corporation this Agreement shall apply to each Member of such corporation as if each is a party to this Agreement. In consideration of the mutual covenants and promises stated herein and other good and valuable consideration and intending to be legally bound hereby, EmblemHealth and Practitioner enter into this Agreement to be effective as of the Start Date.

Practitioner	
By *(Signature)*	
Name *(Print)*	Date
Organization	
Address	
Telephone	State License #
Email	State of License
NPI#	Group NPI #

Group Health Incorporated
Date: Name: Signature:

ATTACHMENT B

NETWORK PARTICIPATION & BENEFIT PROGRAMS

This Agreement applies to the Networks listed below and all of the Benefit Plans associated with such Networks. EmblemHealth reserves the right to add, delete, or modify the Benefit Plans associated with the Networks listed below. Provider shall be deemed participating in all Benefit Plans associated with the Networks listed below and may not terminate participation in an individual Benefit Plan.

A full list of Benefit Plans associated with the below Networks may be found in the provider section of the EmblemHealth website: www.emblemhealth.com/providers. Providers are encouraged to subscribe to receive updates to the Provider Networks and Member Benefit Plans Chapter of the Provider Manual by clicking the subscribe icon within that chapter.

Company	Network Participation	Benefit Plan
GHI	**Commercial:** CBP Network, National Network, Tristate Network	EmblemHealth CBP EPO EmblemHealth CBP PPO
	Network Access Network	Network Access Plan
	Medicare: Medicare Choice PPO Network	EmblemHealth Medicare ASO EmblemHealth Medicare PPO Medicare Dual Eligible (PPO) SNP

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EMBLEMHEALTH PARTICIPATING PRACTITIONER AGREEMENT

ABOUT EMBLEMHEALTH

This Agreement (the "Agreement") is made by and among the Practitioner listed on the signature page (page 1) and the EmblemHealth organization listed on the signature page (page 1) and the other EmblemHealth entities set forth on attached EmblemHealth Entities Addendum, with their offices located at 55 Water Street, New York, New York 10041, all under the common control of EmblemHealth, Inc., and whose operations are administered by EmblemHealth Services Company, LLC (collectively referred to hereinafter as "**EmblemHealth**" or "Plan") and the Practitioner listed on the signature page (page 1).

The EmblemHealth companies are corporations which operate as managed care organizations, licensed insurers or third party administrators for the purpose of providing or arranging for the provision of health care services to Members of the Benefit Programs. Through this Agreement, Practitioner agrees to join the EmblemHealth network (subject to the differing Prevailing Fee Schedules) as a participating provider for the Benefit Programs set forth on **Attachment B**.

In consideration of the aforementioned premises and the mutual promises and provisions contained herein, and intending to be legally bound hereby, the parties agree as follows:

I. DEFINITIONS

1. "**Administrative Guidelines**" means the instructions issued by EmblemHealth to Participating Providers, inclusive of the EmblemHealth Provider Manual, policies and procedures, posting on the EmblemHealth website at **www.emblemhealth.com,** newsletters and other communications from EmblemHealth to Participating Providers that sets forth the protocols and procedures that Participating Providers shall follow with respect to Covered Services provided under the Benefit Programs. The Administrative Guidelines and Provider Manual and the rules, policies and procedures stated thereto, as they may be amended from time to time via the EmblemHealth website, is expressly incorporated herein by reference and made a part of this Agreement. In the event of any inconsistency between this Agreement and the Administrative Guidelines and Provider Manual, the most recent revision of the Administrative Guidelines and Provider Manual shall control.

2. **Benefit Program**" and "**Benefit Plans**" means any health coverage set forth in **Attachment B** to this Agreement which is made a part hereof and incorporated herein.

3. **"Covered Services"** means those Medically Necessary services which: (i) a Member is entitled to receive under the terms and conditions of his/her Benefit Program, (ii) are within the scope of the Practitioner's practice; and (iii) the Practitioner has been credentialed and is privileged by EmblemHealth to provide and is authorized to render pursuant to the terms of this Agreement.

4. "**Member**" or "**EmblemHealth Member**" means any person covered under an EmblemHealth Benefit Program.

5. "Payor" means an employer, third party administrator, labor union, organization or other person or entity which: (i) has contracted with EmblemHealth to administer a Benefit Program that is not underwritten or insured by EmblemHealth; (ii) has agreed to be responsible for funding benefit payments for Covered Services provided to Members under the terms of such Benefit Program; and (iii) which has been authorized by EmblemHealth to access Covered Services under this Agreement, based on EmblemHealth's determination, following commercially reasonable due diligence efforts, that such Payor is financially stable and capable of paying those claims for which it is responsible.

6. "**Practitioner"** means the licensed professional identified on the signature page (page 1).

II. PRACTITIONER'S OBLIGATIONS

A. COMPLIANCE WITH LAWS.

1. The parties shall comply with all state and federal laws, regulations and guidelines applicable to their respective operations and practices and to their participation in governmental health care programs, including, as applicable, Medicare (see Medicare Addendum attached hereto and incorporated herein) and all other laws applicable to recipients of federal funds. Nothing in this Agreement shall be construed to relieve EmblemHealth from any obligations it may have pursuant to any applicable federal, state or local law, regulation or contract. Notwithstanding any other provision of this Agreement, the parties shall comply with: (i) the Managed Care Reform Acts; (ii) the Health Insurance Portability and Accountability Act, (iii) the HIV Confidentiality requirements of Article 27-F of the Public Health Law and Mental Hygiene Law; (iv) Title VI of the Civil Rights Act of 1964; (v) Title II of the Americans with Disabilities Act; (vi) the Age Discrimination Act of 1975, and (vii) all applicable laws prohibiting discrimination against any Member on the basis of Plan membership, source of payment, color, race, ethnicity, creed, sex, age, national origin, religion, place of residence, health status, health care needs, HIV status, mental or physical disability or medical condition or handicap or other disability, sexual orientation, marital status, veterans status, claims experience, medical history, evidence of insurability (including condition arising out of acts of domestic violence), genetic information or type of illness or condition in rendering services pursuant to this Agreement.

2. Practitioner shall treat Members in the same manner and in accordance with the same standards and priority as Practitioner treats its other patients regardless of the source of payment. Care will be provided in a manner to support positive relationships with patients in accordance with professional standards of conduct, striving for a high level of patient satisfaction.

3. Practitioner agrees to comply with any and all applicable laws governing patient consent and advanced directives.

B. PROFESSIONAL REQUIREMENTS.

1. Practitioner represents and warrants that he/she shall, throughout the term of this Agreement, (i) be duly licensed or certified to practice medicine or provide Covered Services for which Practitioner is otherwise licensed or certified to provide in the state issuing the license; (ii) remain board certified/eligible, where applicable; and (iii) maintain staff privileges in at least one EmblemHealth participating hospital, where applicable. Practitioner shall meet the credentialing requirements of EmblemHealth prior to rendering any services hereunder and cooperate with EmblemHealth's process for confirming credentialing status. Practitioner shall ensure that allied health professionals and support staff employed by or associated with Practitioner are appropriately licensed and/or certified and/or qualified in accordance with applicable state law and meet EmblemHealth's credentialing standards, when applicable. Practitioner agrees that only persons who meet all the requirements set forth in this Agreement will be allowed to provide Covered Services to Members under this Agreement and only after complying with all of EmblemHealth's credentialing and recredentialing requirements and being advised of the EmblemHealth's credentialing committee's approval.

C. PROVISION OF COVERED SERVICES.

1. Practitioner shall be reimbursed for rendering Covered Services to Members in accordance with this Agreement, the Administrative Guidelines, Provider Manual, EmblemHealth's policies and procedures and the Member's Benefit Program. Practitioner shall verify an individual's eligibility for Covered Services by complying with the identification and verification procedures established from time to time by EmblemHealth.

2. Practitioner agrees to interact with EmblemHealth on an electronic platform for purposes including but not limited: (i) obtaining Member eligibility, benefits information, referrals, and prior approvals, (ii) submitting claims, and (iii) viewing claim dispositions, member panel reports, Clinical Practice Guidelines, drug formularies, listings of EmblemHealth participating providers, the provider newsletter, and updates to the Administrative Guidelines.

3. Practitioner shall perform all obligations required hereunder in accordance with the professional standards applicable to the professional practice and rules of ethics/conduct promulgated by all applicable regulatory agencies and medical professional bodies.

4. This Agreement applies only to Covered Services and is not intended to prohibit Practitioner in any way, from offering or rendering non-Covered Services to Members. Prior to rendering the non-Covered Service, Practitioner shall: (i) notify the Member that the service is a non-Covered Service; (ii) have the Member agree in writing to pay such non-Covered Service; and (iii) collect payment for all non-Covered Services directly from the Member.

5. Practitioner hereby agrees to participate, cooperate and comply with the decisions, rules, policies, procedures and regulations established by EmblemHealth's Quality Improvement, Utilization Management, Claims and Grievance and Appeals programs, including, but not limited to, maintaining conformance with the standards of satisfactory performance under the QI Program as well as complying with quality investigations, and as applicable per the Member's Benefit Program, prior approval of elective admissions and procedures, referral process, and reporting of clinical encounter data, as more fully described in the Administrative Guidelines and Provider Manual.

6. From time to time EmblemHealth may enter into agreements with third party payors or provider organizations ("Carve- Out Vendor") to provide or arrange for the provision of certain Covered Services through the Carve-Out Vendor's own network. Practitioner agrees that during the duration of this Agreement and EmblemHealth's agreement with the Carve-Out Vendor, this Agreement or a specific discrete subset of services rendered by Practitioner pursuant to this Agreement, shall upon notice by EmblemHealth to Practitioner: (i) remain or become "dormant"; and (ii) become "resurrected" and in full force and effect upon notice by EmblemHealth to Practitioner.

7. In the event Practitioner is participating with EmblemHealth by way of this Agreement as well as by way of a separate group or IPA Agreement, Practitioner agrees that: (i) the terms of the group or IPA Agreement governs for Covered Services rendered by Practitioner at those practice locations governed by such group or IPA agreement; and (ii) the terms of this Agreement governs for Covered Services rendered by Practitioner at all other locations.

D. RECORDS AND REPORTS

1. Practitioner shall document all Covered Services provided to Members in a format which is easily retrievable and which conforms with federal, state and local laws and regulations applicable to medical records. Practitioner shall permit EmblemHealth's representative(s) access, upon reasonable prior notice and during regular business hours, to inspect and copy (without charge) all medical, billing, and financial and statistical records relating to the provision of Covered Services to Members in accordance with all applicable laws and regulations and usual policies and procedures for the maintenance of such records.

Practitioner shall make Members' medical records available to EmblemHealth or its designated representative(s) for, among other purposes, assessing quality of care, Medical Necessity and appropriateness of care provided to Members. Practitioner shall comply with all federal, state and local laws and regulations applicable to the confidentiality, privacy, and maintenance of patient records, including requirements for maintaining such records for six (6) years (10 years for Medicare members) from the last date of treatment or, in the case of a minor, for three (3) years after majority or six (6) years from the date of service whichever is longer, or for such period of time as required by law, whichever is longer. EmblemHealth agrees that it will obtain consent directly from Members at the time of enrollment or at the earliest opportunity or alternatively, Practitioner will obtain consent from Members at the time Covered Services are rendered for disclosure of medical records to EmblemHealth and third parties. Record maintenance and audit access shall survive the termination of this Agreement regardless of the cause giving rise to such termination.

2. Practitioner shall, no later than ten (10) business days after receipt of written request, provide a copy of all relevant portions of a Member's medical records, encounter data or financial and statistical records relating to services rendered to Members to EmblemHealth, NYSDOH, NYSDFS, and to any other federal, state or local governmental agency involved in assessing the quality of care or investigating Member grievances or complaints, including the Comptroller General of the State of New York, the Department of Health and Human Services and the Comptroller General of the United States and their authorized representatives. Upon such request from any federal, state, or local government, Practitioner shall provide prior written notice of such request to EmblemHealth within four (4) business days of such request. All requests for records shall be supplied to EmblemHealth at Practitioner's expense. This provision shall survive termination of this Agreement regardless of the cause giving rise to such termination.

3. Practitioner shall maintain and provide any other records EmblemHealth may reasonably request (without cost to EmblemHealth) for regulatory compliance or program management purposes and shall cooperate with EmblemHealth in all fiscal and medical audits, site inspections, peer review, Utilization Management, credentialing and recredentialing and any other monitoring required by federal, state or local regulatory or accreditation agencies, including Utilization Review Accreditation Commission ("URAC") and the National Committee for Quality Assurance ("NCQA"). Any record required by a regulatory or accreditation agency shall, at Practitioner's expense, be delivered to EmblemHealth within the time frame requested by the requesting agency, but in no event more than four (4) business days of its request. Practitioner shall promptly comply with all directives and recommendations issued as a result of any such inspection or audit to the extent applicable to Practitioner and necessary for regulatory compliance or compliance with EmblemHealth policies. Practitioner shall retain all financial and administrative records relating to this Agreement for seven (7) years after the termination of this Agreement, or for such period of time as required by law, whichever is longer. This provision shall survive termination of this Agreement regardless of the cause giving rise to such termination.

E. INSURANCE.

1. Practitioner warrants and represents that he/she shall procure and maintain, at his/her own cost and expense throughout the initial and any renewal term of this Agreement, insurance with a reputable carrier, and in amounts in accordance with industry standards, to insure Practitioner, its directors, officers, employees and agents against any claim or claims for damages arising by reason of property damage, personal injury or death occasioned directly or indirectly in connection with the performance by Practitioner and Practitioner's employees and agents, under this Agreement. This shall include, without limitation, professional liability insurance in the minimum amounts of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.

2. Evidence of the insurance coverage required hereunder and a description of the insurance policies shall be provided to EmblemHealth on request and Practitioner shall provide EmblemHealth with no less than thirty (30) days prior written notice of any material modification, reduction or termination of any such coverage. Upon request of EmblemHealth, Practitioner shall provide evidence of workers compensation coverage for its employees.

F. CONFIDENTIAL AND PROPRIETARY INFORMATION; NON-SOLICITATION.

1. Practitioner shall treat as confidential this Agreement (including the compensation provisions herein), utilization data, reports and procedures, quality improvement procedures, utilization review, credentialing procedures and all other information of EmblemHealth that Practitioner may gain access to through performance under this Agreement (hereinafter collectively referred to as "Information") and shall not disclose such Information to any other party, except to Practitioner's accountants, attorneys, consultants or other authorized representatives, who shall be required to abide by the terms of this Section. Information shall not include information which: (i) is or becomes known as public information through no fault of Practitioner; (ii) is learned by Practitioner from a third party legally entitled to disclose such information; or (iii) was already known to Practitioner at the time of disclosure. All Information is the exclusive property of EmblemHealth. Upon termination of this Agreement, Practitioner shall cease and desist from all uses of Information and shall return, or destroy, all Information (and any copies thereof) then in Practitioner's possession to EmblemHealth. Practitioner shall ensure all persons who render services to Members on behalf of Practitioner comply with this requirement. This provision shall survive termination of this Agreement, regardless of the reason for termination. Notwithstanding anything herein to the contrary, this Agreement shall not be deemed to restrict Practitioner from complying with a government or court order or decree or a request from any regulatory authority having jurisdiction to disclose any Information of EmblemHealth; provided, however, that in such event, Practitioner will provide EmblemHealth with prompt written notice so that EmblemHealth may

seek a protective order or other appropriate remedy and/or waive compliance with the provisions of this Agreement. In the event that such protective order or other remedy is not obtained, or EmblemHealth waives compliance with the provisions of this Agreement, Practitioner will furnish only that portion of the Information which is legally required and will exercise its commercially reasonable efforts to obtain reliable assurance that confidential treatment will be accorded the Information.

2. During the term of this Agreement and for a period of three years thereafter, Practitioner shall not solicit Members, directly or indirectly, to enroll in any other health care plan other than those offered by EmblemHealth, including, but not limited to, health maintenance organizations, preferred provider organizations, exclusive provider organizations, consumer directed plans and point of service plans.

3. Practitioner agrees that any violation of this Section by Practitioner will result in irreparable injury to EmblemHealth. Therefore, in addition to and without limiting or waiving any other remedies available to EmblemHealth at law or in equity, EmblemHealth shall be entitled to seek an injunction restraining Practitioner and any other related persons from violating this Section and, in such event, a defense shall not be raised that the remedies available at law are adequate.

G. PROTECTION OF MEMBERS.

1. Except as otherwise provided in Paragraph IV below, in no event, including, but not limited to, non-payment by EmblemHealth or a Payor, EmblemHealth or a Payor's insolvency or any other breach by EmblemHealth of the terms of this Agreement, shall Practitioner bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or maintain any action or have any recourse against, any Member or person(s) acting on a Member's behalf, for Covered Services provided under this Agreement. Practitioner agrees not to impose any administrative fees or surcharges to Members under any circumstances. This provision does not prohibit Practitioner from collecting Copayments (up to the Prevailing Plan Fee Schedule), Coinsurance or Deductibles as specifically stated in the Remittance Advice and provided in accordance with the terms of the Member's Benefit Program

2. Practitioner agrees that the provisions set forth in this Section shall survive the termination of this Agreement, regardless of the cause giving rise to the termination, including insolvency of EmblemHealth, and shall be construed to be for the benefit of Members.

H. INDEMNIFICATION.

Each Party (the "Indemnitor") shall indemnify and hold harmless the other Party and its directors, officers, employees, and agents, from and against any and all claims, liabilities, losses, damages, causes of action and expenses (including, without limitation, reasonable attorney's fees and costs) (collectively, the Indemnified Amounts) which may be imposed on, incurred by or asserted against the other Party and which in any way arise out of or relate to any acts of the Indemnitor or any director, officer, employee, or agent thereof in connection with its obligations under this Agreement, excluding, however, Indemnified Amounts that result from negligence or misconduct on the part of the other Party, its directors, officers employees, or agents.

III. EMBLEMHEALTH'S OBLIGATIONS

A. Member Identification and Eligibility. EmblemHealth shall maintain a system of Member identification including, but not limited to, Member identification cards, website and interactive voice response systems, to enable Practitioner to determine a Member's eligibility for Covered Services. Practitioner understands and acknowledges that an individual presenting an EmblemHealth identification card shall not be deemed conclusive evidence that such person is a valid Member at the time services are rendered.

B. Determination of Ineligibility. The determination of an individual's status as a Member, or lack thereof, under any Benefit Program shall be made by EmblemHealth in the exercise of their sole discretion. Compliance with the verification procedures and EmblemHealth's confirmation of an individual's status as a Member, or lack thereof, does not constitute a guarantee of eligibility and payment for Covered Services. In the event that Practitioner provides what would have been a pre-authorized Covered Service to an individual after complying with EmblemHealth's membership verification and preauthorization process, and EmblemHealth subsequently determines that such individual was not entitled to coverage as a Member, EmblemHealth may deny the claim except as provided by Section 3238 of the New York Insurance Law, for applicable claims. In such event, Practitioner may seek payment from such individuals to whom Covered Services were provided on or after the date on which the individual became ineligible for coverage.

C. Quality Improvement, Member Grievances, Claims and Utilization Management EmblemHealth will maintain and Practitioner agrees to cooperate with and participate in EmblemHealth's Quality Improvement, Claims, Member Grievance and Utilization Management Programs which include peer review, quality investigations, prior authorization requirements, provider credentialing and recredentialing and medical policy development as more fully described in the Provider Manual and the provision of all required HEDIS data via claims, encounter and/or clinical data systems. Practitioner understands that EmblemHealth's utilization management program promotes adherence to accepted medical treatment standards and that as part of such program EmblemHealth conducts utilization management reviews which include but are not limited to, pre-admission screenings for all elective admissions, concurrent review with respect to all hospitalized Members, retrospective chart reviews for discharged Members and post-payment reviews. EmblemHealth's utilization management policies shall, from time to time, be revised and shall not constitute modifications to this Agreement.

D. **Availability of Personnel**. EmblemHealth shall make appropriate personnel available during regular business hours in the event Practitioner has any questions or concerns relating to the provision of Covered Services pursuant to this Agreement.

E. **Credentialing.** Practitioner understands and acknowledges that EmblemHealth has sole responsibility to review applications and perform all credentialing and recredentialing activities under this Agreement. Practitioner understands and agrees that he/she may not perform Covered Services under this Agreement until EmblemHealth has notified Practitioner that all applicable credentialing criteria and requirements have been met.

F. **Administrative Operations**. EmblemHealth shall conduct the day-to-day administrative operations of the Benefit Programs, including but not limited to: setting premiums; establishing new and revising existing Benefit Plans; making benefit determinations, claims adjudication and any other functions that are necessary and appropriate for the proper administration and support of the arrangement for Covered Services to be provided to Members.

IV. PAYMENT

A. Practitioner shall submit claims for Covered Services rendered to Members within one hundred twenty (120) days from the date of service or, in the event that there is a coordination of benefits issue, within ninety (90) days from the date the Explanation of Benefits was issued by the primary payor or any greater period as set forth in the Administrative Guidelines and Provider Manual. Claims for Covered Services shall be submitted to EmblemHealth or Payor in accordance with the instructions issued on the Member's identification card. Neither EmblemHealth nor Payor will pay claims submitted later than the applicable period, except as required by law. Practitioner shall be paid for Covered Services rendered in accordance with the provisions set forth in **Attachment A**, or Practitioner's charges, whichever is less. EmblemHealth shall use its best efforts to adjudicate or facilitate adjudication of applicable claims in accordance with the time frames provided in the Administrative Guidelines and Provider Manual. Practitioner agrees that in the event of any overpayment to Practitioner by EmblemHealth, Practitioner shall promptly reimburse EmblemHealth the amount of any such overpayment, or be subject to offset by EmblemHealth in accordance with applicable law. Claims denied for untimely filing shall not be billed to the Members.

B. When contracted rates are based on a standardized fee schedule such as the Medicare Fee Schedule, claims will be processed and payments will be made in accordance with the Fee Schedule that is loaded into EmblemHealth's claims processing system at the time the claim is adjudicated "Prevailing Plan Fee Schedule"). Practitioner shall accept any applicable copayment (up to the amount of the Prevailing Plan Fee Schedule) and/or coinsurance and the payments described herein as payment in full. Practitioner shall not be entitled to any additional reimbursement by any third party (including Medicare) for Covered Services rendered to Members, except as may be required to comply with EmblemHealth's coordination of benefits program. Any amount so collected by Practitioner shall be reported and paid to EmblemHealth.

C. EmblemHealth is not responsible to pay Practitioner for non-Covered Services. Practitioner shall, prior to rendering any non-Covered Service: (i) notify the Member that the service is a non-Covered Service; (ii) have the Member agree in writing to pay for such non-Covered service; and (iii) collect payment for all non-Covered Services directly from the Member.

D. If the service is otherwise a Covered Service but Practitioner is not credentialed or privileged by EmblemHealth to provide such services to Members Practitioner agrees that the claim will be denied and that he/she may not bill the Member for such services.. If the service is otherwise a Covered Service but Practitioner: (i) treats a Member at a contracted but not credentialed location; (ii) treats a commercial Member in an emergency or with EmblemHealth's approval and Practitioner does not participate in such program under this Agreement, Practitioner agrees to accept reimbursement in accordance with the terms of this Agreement at the applicable Prevailing Plan Fee Schedule then in effect pursuant to **Attachment A** of this Agreement. In the event Practitioner renders Covered Services to a Member covered under a government program, (e.g. a Medicare or Medicaid/Family Health Plus Member) and Practitioner does not participate in such government program under this Agreement, Practitioner shall accept reimbursement at the then prevailing fee schedule payable under that government program that is then currently loaded into EmblemHealth's reimbursement system and not Practitioner's charges billed for such Covered Services.

E. If Practitioner does not comply with the requirements for Member referrals or prior approvals, as set forth in the Administrative Guidelines and in accordance with this Agreement, Practitioner may be held directly responsible for the full or partial reimbursement to EmblemHealth of charges resulting from such non-conforming referral or prior approval. Practitioner acknowledges that referrals made to Non-Participating Providers, including laboratories, in contravention of the terms contained herein may result in Practitioner being held financially responsible by EmblemHealth for costs associated with such unapproved referrals.

F. If Practitioner has health coverage under a Benefit Program, Practitioner may not select himself/herself as a primary care physician or otherwise select himself/herself as the primary care physician for any of his/her dependents. Practitioner shall not be reimbursed by EmblemHealth for any services provided by him/her to any of his/her dependents.

G. If Practitioner participates in EmblemHealth's Network Access Plan, the following requirements apply:

1. The Payor, and not EmblemHealth, shall be solely liable and responsible for claims processing and reimbursing Practitioner at the Prevailing Plan Fee Schedule, in accordance with **Attachment A.** Practitioner shall have no right of recourse against EmblemHealth in the event of non-payment of such claims by Payor.

2. Practitioner may not bill or seek payment from EmblemHealth or Members except for seeking payment from Members for the applicable copayment, coinsurance and deductibles (up to the Prevailing Plan Fee Schedule).

3. Practitioner shall be reimbursed at the applicable Prevailing Plan Fee Schedule set forth on **Attachment A** directly from the Payor identified on the Member's identification card.

4. If a Payor fails to pay claims for Covered Services that are not reasonably in dispute when due and is in arrears for more than sixty (60) days from the date payment was due, then Practitioner may notify EmblemHealth that Practitioner will seek payment from such Payor at its full charges and that the benefit of the fee schedule set forth on **Attachment A** has been lost. EmblemHealth shall attempt to resolve the payment dispute by contacting the Payor and using commercially reasonable efforts to get the claim paid. In the event that EmblemHealth is unable to resolve the payment dispute, Practitioner may seek payment from the applicable Payor at his/hers full charges.

H. If Practitioner participates in EmblemHealth's Administrative Services Only Benefit Plan, the following requirements apply:

1. While EmblemHealth may perform claims processing services on behalf of Payors under the ASO Plan, the Payor, and not EmblemHealth, shall be solely liable and responsible for payment and reimbursing Practitioner at the Prevailing Plan Fee Schedule. Practitioner shall have no right of recourse against EmblemHealth in the event of non-payment of such claims by the applicable Payor. All Members shall present an identification card bearing EmblemHealth's logo and applicable cost sharing information.

2. Practitioner may not bill or seek payment from EmblemHealth or Members except for seeking payment from Members for copayments, coinsurance and deductibles (up to the applicable Prevailing Plan Fee Schedule).

3. Practitioner shall be reimbursed at the applicable Prevailing Plan Fee Schedule set forth on **Attachment A.**

4. Practitioner understands and agrees that payment from EmblemHealth for services rendered to Members enrolled in ASO Benefit Programs is subject to and contingent upon such Payor providing sufficient funds for EmblemHealth to pay or authorizer payment. In the event that EmblemHealth, on behalf of the applicable Payor, fails to make full payment in accordance with the rates set forth on **Attachment A** when due, Practitioner may notify EmblemHealth that Practitioner intends to seek payment from such Payor at its full charges and that the benefit of the discount has been lost. Practitioner may do so only if: (i) he/she first inquires in writing to EmblemHealth as to whether Payor has defaulted; (ii) EmblemHealth confirms, in writing, that the Payor has defaulted, and (iii) Practitioner has provided EmblemHealth fifteen (15) days prior written notice of its intention to seek payment from the Payor. EmblemHealth shall attempt to resolve the payment dispute by contacting the Payor and using commercially reasonable efforts to get the claim paid. For purposes of this paragraph, a default is either: (a) a systematic failure by a Payor to fund clean claims payments related to Members covered through that Payor; or (b) a single failure by a Payor to fund payment for more than sixty (60) days after the receipt of Practitioner's clean claim. A default does not occur in the case of a dispute as to whether certain claims should be paid or the amounts that should be paid for certain claims related to the application of the terms of this Agreement and/or cases where the dispute resolution process as defined in this Agreement is being followed.

I. Practitioner agrees and represents that she/he/it has the authority to enter into this Agreement on behalf of all other practitioners sharing the same tax identification number or NPI number as Practitioner. Practitioner agrees that all claims for Covered Services submitted to EmblemHealth having the same tax identification number or NPI number of Practitioner, as well as all subsequent tax identification numbers or NPIs of Practitioner, shall be adjudicated in accordance with the terms of this Agreement whether or not such Covered Services were performed by a provider participating with EmblemHealth or at contracted but not credentialed location.

J. Practitioner shall determine whether Members have other insurance or third party coverage for Covered Services. If another party or payor may be responsible for Covered Services provided to a Member, Practitioner shall cooperate with EmblemHealth as requested, including submitting bills to such party or payor and submitting a copy of the EOB along with the claim to EmblemHealth. Practitioner will not withhold or refuse to render Covered Services to Members or require Members to pay for Covered Services pending a decision about whether another payor is primarily responsible for paying for such services. All coordination of benefits in this Agreement shall be in compliance with any applicable state and federal laws. Practitioner agrees to maintain and make available to EmblemHealth or their designee, records reflecting collection of coordination of benefit, subrogation or other proceeds received by Practitioner and the amounts thereof. In the case where a Member has more than one insurance coverage for a Covered Service and EmblemHealth is the secondary coverage, EmblemHealth shall pay any member responsibility up to the applicable Prevailing Plan Fee Schedule set forth in **Attachment A** of this Agreement

K. The parties acknowledge that neither party may seek a correction for commercial members claims (other than FEHB members) that it believes was not paid correctly in accordance with the provisions of this Agreement more than twenty-four (24) months after the claim adjudication.

V. REPRESENTATIONS AND WARRANTIES OF PRACTITIONER

Practitioner represents and warrants to EmblemHealth as follows:

A. Practitioner is in compliance and shall continuously throughout the term of this Agreement continue to be in compliance with all applicable local, state and federal laws that relate to arranging for medical services.

B. Practitioner requires all employees, contractors and other health care professionals to perform their duties in conformity with all applicable standards of professional ethics and practices.

C. Practitioner has full authority to bind all practitioners sharing the same tax identification number or NPI number as Practitioner to the terms and conditions of this Agreement.

D. Practitioner is not excluded from participating in the Medicare or Medicaid programs and further, that no agent, employee or subcontractor who is excluded from participating in the Medicare or Medicaid programs shall provide services under this Agreement.

E. Neither Practitioner nor any of Practitioner's principal owners or any individual or entity it employs or has contracted with to carry out his/her obligations under this Agreement is an Ineligible Person. "Ineligible Person" means an individual or entity who: (i) is currently excluded, debarred, suspended or otherwise ineligible to participate in (a) Federal health care programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (b) Federal procurement or nonprocurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration, (ii) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for federal health care programs as described in Section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (iii) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or nonprocurement programs as determined by a State governmental authority.

VI. TERM AND TERMINATION

A. The initial term of this Agreement shall be from the Start Date through December 31st of that year. Unless earlier terminated as described below, this Agreement shall automatically renew for the following calendar year, and every anniversary thereafter unless either party gives notice of its intent not to renew to the other not less than sixty (60) days prior to the expiration of the then existing term.

B. Notwithstanding the foregoing, this Agreement may be earlier terminated as follows:

1. Practitioner may terminate this Agreement, for any or no cause, upon one-hundred and twenty (120) days prior written notice to EmblemHealth.

2. Subject to any applicable reconsideration or hearing rights required by state or federal law, EmblemHealth may terminate this Agreement upon sixty (60) days prior written notice to Practitioner in the event of: (i) a loss, suspension or restriction of Practitioner's hospital privileges, (ii) failure of Practitioner to notify EmblemHealth of any changes in location in his/her practice; (iii) failure of Practitioner to be available to provide services to Members for a period in excess of thirty (30) days; (iv) failure of Practitioner to timely supply requested information in connection with EmblemHealth's recredentialing process or failure to meet EmblemHealth's credentialing/recredentialing standards; (v) failure of Practitioner to comply with EmblemHealth's QI, Claims, Member Grievances or UM Programs; (vi) failure of Practitioner to continuously maintain (or the termination of any) the types or amounts of insurance required to be continuously maintained by Practitioner by this Agreement, (vii) failure of Practitioner to remain a member in good standing of the staff of a designated participating facility; and (viii) in the event that Practitioner's participation in the Medicare or Medicaid program is restricted, suspended or terminated, or there is a threat of such restriction, suspension or termination..

3. Either party may terminate this Agreement, upon sixty (60) days prior written notice, if the other party is unable to pay its debts, files or has filed against it a petition in bankruptcy, commences or has commenced against it any other insolvency proceedings which are not dismissed within such sixty (60) day period or seeks reorganization or an arrangement with creditors.

4. EmblemHealth may terminate this Agreement immediately: (i) if Practitioner's DEA number or license or certification to practice medicine is revoked, suspended, surrendered or not renewed; (ii) upon a reasonable determination by EmblemHealth that the continued provision of services by Practitioner under this Agreement may result in imminent harm to Members; or (iii) upon a reasonable determination by EmblemHealth that Practitioner has committed a fraud or has misrepresented a material fact.

5. EmblemHealth may terminate this Agreement, subject to any applicable reconsideration or hearing rights under applicable state or federal law, upon sixty (60) days prior written notice to Practitioner in the event of a breach of this Agreement.

C. Termination shall not affect Practitioner's right to payment for Covered Services rendered prior to the effective date of termination.

D. When required under applicable state or federal Law, Practitioner shall be advised of the reason(s) for termination and his or her rights to a hearing as set forth in EmblemHealth's credentialing policies and the Administrative Guidelines and Provider Manual.

E. Not less than thirty (30) days prior to Practitioner terminating his/her status as a Participating Provider, Practitioner shall notify all Members that may be affected by the termination of this Agreement, that Practitioner will no longer be available to provide services except for applicable continuity of care. After termination and upon EmblemHealth's request, Practitioner agrees that it shall continue to provide Covered Services to Members pursuant to the terms of this Agreement until EmblemHealth can arrange their transfer to other Participating Providers; provided, however, that this obligation shall not exceed ninety (90) days from the effective date of termination. Practitioner further agrees that Covered Services rendered to Members who are inpatients on the date of termination shall continue until the Member is discharged or EmblemHealth can arrange his or her transfer to other Participating Providers. EmblemHealth shall pay Practitioner for such services in accordance with the terms of this Agreement. In the event of termination of this Agreement, Practitioner agrees to assist in the orderly transfer of Members to other Participating Providers.

VII. GENERAL PROVISIONS

A. Amendments.

1. **Regulatory Approval/Changes**.. If, at any time during the term hereof, any city, state or federal statutes or regulations or any governmental or regulatory agency or body, including URAC, NCQA, governing health care service plans require or mandate modification of the terms and conditions of this Agreement, upon notice to Practitioner this Agreement shall be deemed to be automatically amended to conform to the requirements of such statutes, regulations or governmental or regulatory body and the requirements of any Benefit Program or amendments thereto.

2. **Other Amendments**.

(a) EmblemHealth may amend any provision of this Agreement and any Exhibits, Schedules or Attachments including the Prevailing Plan Fee Schedule (**Attachment A**) hereto upon: (a) thirty (30) days prior written notice to Practitioner for (i) non-fee schedule changes, (ii) non-adverse fee schedule changes, (iii) adverse fee schedule changes that is the result of a Regulatory Change as set forth in Paragraph1 above, and (iv) adverse fee schedule changes that is the result of changes to Prevailing Plan Fee Schedules or payment policies established by government agencies or CPT codes or contractual references to a specific fee schedule, reimbursement methodology, or indexing mechanism. Such amendment shall become effective upon the expiration of such thirty (30) notice period without action on the part of Practitioner. If Practitioner objects to the amendment, Practitioner may terminate this Agreement upon sixty (60) days prior written notice to EmblemHealth; however the amendment shall be in full force and effect during the termination notice period.

(b) Except for those adverse reimbursement schedule changes noted in subparagraph (a) above, EmblemHealth may amend the Prevailing Plan Fee Schedule (**Attachment A**) hereto upon ninety (90) days prior written notice to Practitioner for all other adverse reimbursement schedule changes (Adverse Fee Schedule Notice). Such amendment shall become effective upon the expiration of the ninety (90) day notice period without action on the part of Practitioner. If Practitioner objects to the adverse fee schedule amendment, Practitioner may terminate this Agreement by providing notice to EmblemHealth within thirty (30) days of receipt of the Adverse Fee Schedule Notice. The effective date of Practitioner's termination shall be the effective date of the new Prevailing Plan Fee Schedule.

3. **EmblemHealth's Policies.** Practitioner acknowledges that EmblemHealth has the right, in its sole discretion, to change any of its Administrative Guidelines and the terms of the Administrative Guidelines and Provider Manual upon notice to Practitioner via the EmblemHealth website. Such revisions by EmblemHealth from time to time of the Administrative Guidelines, policies and procedures, including the Administrative Guidelines and Provider Manual, shall not constitute modifications, amendments or alterations subject to the terms of this Agreement. The most recent notification issued by EmblemHealth via the EmblemHealth website shall control. Practitioner shall be responsible for reviewing the EmblemHealth website for policy changes.

B. Notices. Any notice relating to breach, termination or indemnification given under this Agreement to EmblemHealth shall be sent in writing by certified mail, return receipt requested, postage prepaid, or by overnight courier service, with a copy to General Counsel, at 55 Water Street, New York, New York 10041, Attn: Senior Vice President, Provider Network Management. Any notice given under this Agreement to Practitioner shall be in writing and sent: (i) by overnight carrier, (ii) by posting on the EmblemHealth website, (iii) electronically to a designated contact at an agreed upon e-mail address; or (iv) by regular or certified mail, return receipt requested at the address set forth at the beginning of this Agreement. Notice shall be effective in the case of (i) overnight courier service, on the next business day after the notice is sent; (ii) regular or certified mail, three business (3) days after the letter is deposited, postage prepaid, in a United States post office depository; and (iii) upon posting on the EmblemHealth website or sent electronically. Routine notices between the parties are not governed by this Section.

C. Independent Contractors. EmblemHealth and Practitioner are independent parties contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither party is, or is to be considered, the agent, servant, employee or partner of the other party for any purpose whatsoever. None of the provisions of this Agreement are intended to create or shall be construed as creating any agency, partnership, joint venture or employer-employee relationship between EmblemHealth and Practitioner or any of their respective employees, servants, agents or representatives. EmblemHealth shall have no responsibility in relation to Practitioner or Practitioner's personnel to comply with federal, state and city withholding requirements pertaining to taxes, workers' compensation, social security, unemployment compensation, disability and other insurance requirements and obligations imposed on an employer of

personnel and will not withhold monies from the payments made to Practitioner with respect to same. EmblemHealth shall not cover Practitioner or Practitioner's personnel under any pension or other fringe benefit offered to EmblemHealth's employees. EmblemHealth shall have no responsibility for incidents of employment or other actions or inactions by Practitioner or Practitioner's personnel. Practitioner shall indemnify EmblemHealth, their officers and staff from and against any claim arising out of an allegation that the Practitioner or Practitioner's personnel are an employee of EmblemHealth. The provisions of this Section will survive termination of this Agreement, regardless of the cause giving rise to such termination.

D. Sales and Marketing. Practitioner agrees that EmblemHealth may use Practitioner's name, address, and telephone number, type of practice, hours of service, hospital affiliation, board status and any information relevant to Practitioner's practice in marketing or administrative materials and provider directories that EmblemHealth may distribute. Practitioner may not use EmblemHealth's name or the names of any of its affiliates, nor any of their service marks without the prior written consent of EmblemHealth, except that it may advertise that it is a provider participating in EmblemHealth's networks.

E. Assignment.

1. **Assignment by Practitioner**: Practitioner may not assign, delegate, subcontract or otherwise transfer its rights under this Agreement. Any such assignment shall render this Agreement null and void.

2. **Assignment, Transfer, Subcontract by or Conversion of EmblemHealth**. EmblemHealth may, without Practitioner's prior consent, assign, transfer, delegate or subcontract its rights or obligations, and/or this Agreement to (i) an affiliated or related entity, or (ii) a parent entity or an entity that controls, is controlled by, or that is under common control with it now or in the future, or (iii) an entity or entities which succeed to all or part of EmblemHealth's business through a sale, merger, corporate reorganization, conversion or other corporate transaction involving EmblemHealth and/or its affiliates and related entities.

3. **Delegation**. EmblemHealth may delegate certain administrative and /or management functions to certain entities.

F. Entire Agreement/Invalid Provisions/Headings/Counterparts. This Agreement and the Exhibits, the Administrative Guidelines and Provider Manual, Addendums and Attachments hereto constitute the entire Agreement between the parties and supersede as of the Start Date all prior agreements, oral or written, with respect to the subject matter hereof. The illegality, unenforceability or ineffectiveness of any provision of this Agreement shall not affect the legality, enforceability of effectiveness or any other provision of this Agreement. The headings in this Agreement are merely for the purpose of convenience of reference and do not limit, define or construe the provisions of this Agreement. This Agreement may be executed in one or more counterparts each of which shall be deemed an original and shall constitute one and the same Agreement.

G. Governing Law. This Agreement shall be governed by and construed under the laws of the State of New York without giving effect to the conflict of laws principles thereof.

H. Remedies. All rights and remedies hereunder shall be cumulative and not alternative.

I. Disputes Concerning Non-Clinical Matters. The parties will work together in good faith to resolve any dispute arising under this Agreement. All non-clinical disputes, controversies or claims arising out of or under this Agreement or its performance, if not resolved through EmblemHealth's Grievance and Appeal process shall be resolved as set forth in this paragraph.

If any nonclinical dispute between the parties: (i) arises out of or relates to this Agreement, (ii) Practitioner has exhausted all internal appeals and grievance procedures provided in the Administrative Guidelines and Provider Manual; (iii) the parties cannot settle such dispute by good faith negotiation within thirty (30) business days, and (iv) the dispute concerns an amount less than $750,000, then the parties agree that the dispute shall be resolved through binding arbitration. The binding arbitration shall be conducted in New York, New York in accordance with the American Health Lawyers Association (AHLA) Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and which to the extent of the subject matter of the arbitration, shall be binding not only on all parties to this Agreement, but on any other entity controlled by, in control of or under common control with the party, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Notwithstanding the rules of the AHLA, the arbitrator shall not be permitted to award punitive or exemplary damages. To the extent feasible, the arbitrator shall conduct the arbitration and render a decision within fifteen (15) days from the date the arbitrator is selected. The parties agree to defer commencing arbitration if one is pending related to a dispute arising from this Agreement until the completion of the pending arbitration or the parties and the arbitrator agree to include the new claim in the pending arbitration. Depositions shall not be permitted in any arbitration unless the arbitrator decides otherwise upon good cause shown by a party. Each party shall bear its own fees and expenses, including attorneys' fees. The fees and expenses of the arbitrator and the cost of the arbitration shall be borne equally by the parties. In no event shall the arbitration's award exceed $750,000. There shall be no right or authority for any dispute, controversy, or claim brought by Practitioner to be arbitrated on a class action basis or on any basis in a representative capacity on behalf of any other person or entity, even if similarly situated. No disputes, controversies, or claims brought by Practitioner may be joined or consolidated in the arbitration with disputes, claims, or controversies brought by other providers, unless otherwise agreed to in writing by all parties.

J. Non-waiver. No waiver of any breach of any provision of this Agreement shall be deemed a waiver of any subsequent breach of the same or a breach of any other provision of this Agreement.

K. Patient-Practitioner Relations/Anti-Gag Clause. Nothing in this Agreement shall be construed to require Practitioner to provide any treatment which it deems professionally unacceptable. EmblemHealth shall not interfere with Practitioner's relationships with patients and only administers coverage. Any determination by EmblemHealth denying coverage for a particular service shall not relieve Practitioner from providing or recommending such service if medically appropriate. EmblemHealth encourages a strong provider-patient relationship, and therefore does not interfere, prohibit, or otherwise restrict participating providers from freely communicating with or advising Members concerning the Member's health status, medical care or treatment options or serving as an advocate on behalf of a Member regarding the care or treatment options, regardless of benefit coverage limitations determined to be in the Member's best interests.

MEDICARE ADVANTAGE ADDENDUM

EmblemHealth has a contract with CMS for the provision of services to Medicare Enrollees. Accordingly, Practitioner agrees to provide all services under the Agreement in compliance with the following provisions.

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements and includes EmblemHealth.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual, including Practitioner, who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation and includes Practitioner as defined on the first page of this Agreement.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

Required Provisions:

Practitioner agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and 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 CMS' contract with EmblemHealth, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

2. Practitioner will comply with the confidentiality and enrollee 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 enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(iii)]

4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Practitioner 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 individual were not enrolled in such a plan. Practitioner will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(iii)]

5. Any services or other activity performed in accordance with a contract or written agreement by Practitioner are consistent and

comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between Practitioner and the provider. Practitioner and EmblemHealth agree that the agreed upon prompt payment provisions are set forth in the Provider Manual which is incorporated into this Agreement [42 C.F.R. §§ 422.520(b)(1) and (2)]

7. Practitioner and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

8. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

(i) The delegated activities and reporting responsibilities are specified in writing**.**

(ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) The MA organization will monitor the performance of the parties on an ongoing basis.

(iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

(v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement. [42 C.F.R. §§ 422.504(i)(4) and (5)].

9. Practitioner agrees to comply with the MA organization's policies and procedures.

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.

ATTACHMENT A

FEE SCHEDULE

Provider shall be reimbursed according to the standard GHI fee schedules.

EMBLEMHEALTH ENTITIES ADDENDUM

This Agreement shall apply to Members covered under the Benefit Plans set forth on Attachment B which are administered, underwritten and/or sponsored by the EmblemHealth entities listed on the first page of this Agreement (Group Health Incorporated).