ACEP MODEL EMERGENCY PHYSICIAN

SERVICES AGREEMENT

WITH MANAGED CARE ORGANIZATION

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Editor's Note

This agreement has a number of provisions in it that many managed care organizations may be unwilling to accept. Since this is a model document, designed to protect the interests of emergency physicians, it is certainly appropriate that it do so in every possible way. However, users of this model should be aware that it includes a number of provisions that Payors will view as unusual and in some cases unacceptable.

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[optional provisions in brackets]

This Emergency Physician Services Agreement ("Agreement") is effective as of the _____ day of _____, 199___, by and between _____, a _____ ("Payor"),[1/] and _____, a _____ ("Provider Group").

RECITALS

A. Payor is a [licensed HMO/licensed health care service plan/IPA/PPO/PHO/other] organized to deliver comprehensive health care services to residents of [county and/or state].

B. Provider Group is a [professional corporation/professional association/professional partnership/other] which employs and/or contracts with emergency physicians who are licensed in the state of _____ to practice medicine.

C. Payor and Provider Group desire to enter into a contractual relationship whereby Provider Group will render medical services on behalf of Payor to Payor's Members.

D. The parties desire to enter into this Agreement in order to provide a full statement of their respective rights and responsibilities in connection with the provision of health care services to such Members.

NOW, THEREFORE, the parties do hereby agree as follows:

1. DEFINITIONS

A. Clean Claim - An electronic or paper claim submitted on a HCFA 1500 form or other form agreed upon by the parties that contains the following components: patient's name and social security number or plan identification number; date and location of service; patient's diagnosis code

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[1/] The Payor may be a licensed HMO (as designated by applicable state law) or an IPA, PPO, PHO or other managed care payor. The term "Payor" is used here because it is generic; depending upon which type of entity is involved in this contract, it may be appropriate to use "Plan", "IPA", or some similar term which is more specific than "Payor". Certain special terms that are applicable only to intermediate contracting entities such as IPAs and PPOs are included in Exhibit D.

and E&M/CPT-4 code; and such other information as Provider Group and Payor may mutually agree upon in the Operations Policies.

B. Coordination of Benefits - The procedure by which Participating Providers seek to recover from an insurer or other third party payor that provides health care benefits to a Member those amounts due from such insurer or payor for services provided by the Participating Provider to the Member.

C. Copayment - Charges for Covered Services which are to be collected directly by the Participating Facility from a Member in addition to the compensation payable by Payor hereunder. [Except as otherwise expressly provided in the Operations Policies and applicable Member Agreement], [there is no Copayment for Covered Services rendered by Provider Group to Members hereunder.]

D. Covered Services - Those health care services, equipment and supplies to be furnished by Provider Group that are within the scope of benefits provided to a Member pursuant to his/her Member Agreement. [Covered Services are described on Exhibit A.][2/] All health care services, equipment and supplies provided to a Member who has an Emergency Medical Condition which are deemed Medically Necessary by a Provider Group Practitioner, and all examinations required to determine whether an emergency medical condition exists, are Covered Services.

E. Covering Physicians - Physicians other than Participating Physicians who are contracted, temporarily employed or otherwise designated by Provider Group to render Covered Services hereunder.

F. Emergency Medical Condition - A medical condition that manifests itself by symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the Member's health in serious jeopardy;

(2) serious impairment of bodily functions; or

(3) serious dysfunction of any bodily organ or part.

[2/] As a general rule, Covered Services should be described either on an exhibit or another document reviewed by Provider Group in advance and incorporated by reference into the Agreement.

G. EMTALA - The Emergency Medical Treatment and Active Labor Act, 42 USC § 1395dd. [All references herein to EMTALA shall be deemed to include the provisions of [designate analogous state emergency transfer law].][3/]

H. Medical Screening Examination (MSE) - As part of EMTALA (see above), every patient presenting to the ED must be examined by an emergency physician or other appropriately qualified health care professional to determine if an Emergency Medical Condition exists. This examination must include any appropriate diagnostic testing and consultation within the capability of the hospital, in order to make this determination.

I. Medically Necessary - Medical services, supplies and equipment provided after the Medical Screening Examination and stabilization of the Member that are necessary and appropriate for the treatment of a Member's condition, according to accepted standards of medical practice.

J. Member - A person who is eligible to receive Covered Services under Payor's health benefits plan.

K. Member Agreement - The subscriber agreement, evidence of coverage or other document that describes the terms under which a Member is entitled to receive Covered Services or reimbursement for Covered Services.

L. Non-covered Services - Those health care services, equipment and supplies that are not Covered Services, and may therefore be charged to the Member at Provider Group's Usual Charges.

M. Operations Policies - Policies agreed upon by Provider Group and Payor in writing that set forth detailed procedures relating to the performance of this Agreement, which may include, without limitation, Payor's authorization and referral procedures for non-emergency Covered Services, and Payor's utilization management and quality improvement procedures and criteria. A list and/or summary of the Operations Policies is attached hereto as Exhibit C. No policy, procedure or rule shall be binding upon Provider Group unless agreed to by Provider Group as part of the Operations Policies, nor shall any amendment thereto be binding upon Provider Group unless approved by Provider Group in the manner set forth in Article 7, Paragraph B.

N. Participating Facility - A licensed hospital, urgent care center or other health care facility that has entered into an agreement with Payor to provide health care services to Members.

O. Participating Physician - A physician, including but not limited to a Provider Group Physician, who is authorized by Payor to provide Covered Services to Members.

[3/] In some states (e.g., California), an analogous state transfer law exists.

P. **Participating Provider** - A Participating Physician, Participating Facility or other provider of health care services, equipment or supplies that has entered into an agreement with Payor to provide Covered Services to Members.

Q. **Primary Care Physician (PCP)** - A Participating Physician who is responsible for rendering primary care physician services to Members, and for coordinating non-emergency specialty and institutional care for Members assigned to such PCP.

R. **Provider Group Physician** - A Participating Physician providing Covered Services as an employee or independent contractor of Provider Group.

S. **Provider Group Practitioner** - a Provider Group Physician or Mid-level Practitioner (including, but not necessarily limited to, a physician assistant or nurse practitioner) who provides Covered Services to Members.

T. **Usual Charge(s)** - Provider Group's usual and customary charge(s), which are the amounts it bills to private patients who are not covered by any governmental program or contractual discount.

2. SERVICES

A. PROVIDER GROUP SERVICES.

Provider Group agrees to make available to Payor, for the use and benefit of Members, Covered Services at the following Participating Facilities: [list Participating Facilities at which Provider Group renders services.] [The Covered Services to be provided by Provider Group are described more specifically on Exhibit A.][4/]

B. REFERRAL SERVICES.

In the event a Member requires covered health care services not offered by Provider Group, Provider Group shall comply with the Operations Policies and shall refer such Member to other Participating Providers, except when the Member has an Emergency Medical Condition, no Participating Provider with the skills or facilities deemed appropriate by Provider Group to treat the Member is available, or the Member requests a referral to a Provider other than a Participating Provider.

4/ Because this is a model agreement, it is unnecessary to separately set forth emergency services, urgent care services, locum tenens services, etc. Rather, because each agreement is likely to be different in this regard, I suggest that the specific Covered Services and types of services to be provided under the Agreement be set forth on Exhibit A. If necessary, Exhibit A could have multiple parts or attachments delineating different categories of services.

C. MID-LEVEL PRACTITIONERS.

Provider Group may, at Provider Group's sole cost and expense, employ or contract with such non-physician professional personnel as Provider Group deems necessary or appropriate to perform Covered Services hereunder. Such personnel may include, without limitation, physician assistants, nurse practitioners or other licensed or certified personnel deemed qualified by Provider Group to assist Provider Group in performing Covered Services.[5/] Provider Group shall require such personnel to perform Covered Services in accordance with this Agreement and the Operations Policies.

D. COVERING PHYSICIANS.

In the event Provider Group does not have sufficient Provider Group Physicians available to render Covered Services when and as needed, Provider Group may utilize Covering Physicians [, subject to such procedures and requirements as may be set forth in the Operations Policies.] Provider Group shall assure that any Covering Physician shall: (1) accept the fees set forth in this Agreement as full payment for Covered Services [(except that, in the event Provider Group is paid a capitated rate hereunder, Provider Group shall be responsible for paying the Covering Physician)]; (2) accept and abide by the terms and conditions of this Agreement, including the Operations Policies; and (3) not bill Members, except to the extent specifically permitted under this Agreement or by the Operations Policies.

E. INDEPENDENT CONTRACTOR RELATIONSHIP.

In the performance of the work, duties and obligations of Provider Group under this Agreement, it is mutually understood and agreed that Provider Group is an independent contractor that determines the methods and means of performing Covered Services hereunder. Neither Provider Group nor any Provider Group Practitioner or other employed or contracted personnel of Provider Group shall be deemed an employee of Payor for any purpose, including, without limitation, the Federal Unemployment Tax Act, workers' compensation or other employee mandates or benefits, or any state or federal withholding requirement.

3. CREDENTIALING

A. UNIFORM CREDENTIALING.

The credentials of each Provider Group Physician shall be submitted to Payor prior to the effective date of this Agreement. Payor agrees to accept a copy of a credentialing application submitted by each Provider Group Physician that includes all information required to meet NCQA

[5/] An increasing number of Payors require that these practitioners be separately credentialed. A possible addition here is: "Such personnel shall be credentialed in accordance with the Operations Policies."

standards and is accompanied by an attestation by such physician that no change has occurred in such information since completion of the application.

B. ADDITIONAL PROVIDER GROUP PHYSICIANS.

Provider Group shall submit the credentials information set forth in Paragraph 3.A. above for any new Provider Group Physician [as soon as reasonably possible] [on an annual basis] after such physician begins rendering Covered Services hereunder.[6/]

4. MEMBER IDENTIFICATION; TREATMENT AUTHORIZATION

A. MEMBER IDENTIFICATION.

Payor shall require that every Member have an identification card identifying such individual as a Member and, if Payor's Members are covered by multiple benefit packages, specifying the benefit package applicable to such Member. In the absence of such proof of membership and other information required by Provider Group to bill Payor hereunder, Provider Group shall be entitled to bill the Member directly at its Usual Charges until such information is provided to Provider Group's accounting department.

B. ELIGIBILITY VERIFICATION.

Payor shall maintain, at its sole cost and expense, a telephonic or other electronic mechanism permitting Provider Group or a Participating Facility on Provider Group's behalf to verify the eligibility of each Member and to determine whether the services rendered or proposed to be rendered constitute Covered Services pursuant to the applicable Member Agreement. Such mechanism shall be in operation twenty four (24) hours a day, three hundred sixty five (365) days a year, and shall provide such verification and information as promptly as reasonably possible, and in all cases within thirty (30) minutes of initial contact by Provider Group or a Participating Facility. In the event Provider Group or a Participating Facility obtains written, verbal or electronic verification of eligibility of a Member or that specified services constitute Covered Services, and Provider Group commences services in reliance thereon, such verification shall be binding on Payor and Payor shall not subsequently deny payment on the grounds that such information was erroneous. Upon request by Provider Group or a Participating Facility, any verbal authorization or information shall be confirmed in writing, but such written confirmation shall not be required to bind Payor.

[6/] This language does not specify that Provider Group Physicians may not render services under this Agreement *until* approved by the Payor, although this is not an unusual Payor requirement. As an alternative to this language, a provision could be added requiring advance approval, subject to a requirement that the Payor process the credentials information promptly. A requirement for "provisional approval" by the Payor upon submission of the application could also be added.

C. MEMBERS WITH EMERGENCY MEDICAL CONDITION.

Payor acknowledges that EMTALA requires Provider Group to provide a Medical Screening Examination to every individual who presents to a hospital seeking treatment to determine whether such individual has an Emergency Medical Condition. Further, EMTALA requires that in the event the Member is determined to have an Emergency Medical Condition, Provider Group is required to render such medical services as may be required to stabilize such condition. Payor acknowledges that the requirements of EMTALA do not permit Provider Group or a Participating Facility to request prior authorization for any such Medical Screening Examination or stabilizing treatment. Consequently, Provider Group shall not be required to obtain authorization prior to performing such services, and each Medical Screening Examination and such treatment as the Provider Group may deem appropriate to stabilize a Member's Emergency Medical Condition shall constitute a Covered Service.

D. MEMBERS WITHOUT EMERGENCY MEDICAL CONDITION.

In the event a Member is determined by Provider Group to not have an Emergency Medical Condition, or in the event Provider Group determines that the Member's Emergency Medical Condition has been stabilized, Provider Group (or the Participating Facility on Provider Group's behalf) shall seek authorization from Payor to the extent required by, and in the manner specified in, the Operations Policies, before providing further Covered Services; provided, however, that in the event Provider Group does not receive either a definitive authorization or a denial from the Payor or PCP within thirty (30) minutes of the initial request for such authorization, Payor agrees to pay for all Covered Services deemed to be Medically Necessary by Provider Group.

5. BILLING AND COMPENSATION

A. BILLING.[7/]

Provider Group shall bill for Covered Services by submitting claims on a HCFA 1500 claim form or such other form as Payor and Provider Group may agree upon. Provider Group shall use its best efforts to submit Clean Claims to Payor within sixty (60) days of receipt by Provider Group of all information required to prepare such claims; or, in the event the Member is covered by another primary payor, within sixty days from payment by such Payor; or, in the event the Member is a Medicare or Medicaid beneficiary, within sixty days of notification from such program that Payor is the primarily responsible payor. The foregoing shall not be construed as precluding Provider Group from billing Payor prior to receipt of payment from any other potentially responsible Payor; provided, however, that Provider Group shall refund such amounts as may be required by applicable Coordination of Benefit rules in the event Provider Group receives duplicative payment for Covered Services.

[7/] In the event Provider Group is capitated, language should be added stating that Paragraphs A through F are applicable only for "carved out" services which are reimbursable on a fee for service basis.

B. PAYMENT.

Payor shall compensate Provider Group for Covered Services at the rates set forth on Exhibit B[8/] within thirty (30) [working] days of receipt of a Clean Claim, and shall accompany such compensation by remittance advice in the form specified in the Operations Policies. Payment shall not be withheld or delayed beyond such thirty (30) day period pending utilization or medical necessity review, nor shall payment be delayed pending receipt of a claim from a Participating Facility. Clean Claims not adjudicated within this thirty (30) day period may be deemed denied, in Provider Group's discretion. Further, Provider Group shall be entitled to those remedies set forth in Article 8 below and as provided by applicable law.

C. DOWNCODING.

Payor shall utilize CPT-4 guidelines in determining the compensation due Provider Group for Covered Services. In no event shall Payor utilize a different coding methodology to downcode claims submitted by Provider Group. Further, in the event Payor downcodes any claim submitted by Provider Group, Payor shall provide written notice to Provider Group of such downcoding, along with reasonable justification, within the thirty (30) day claims adjudication period set forth in Paragraph B above. Payor's failure to provide both such notification and justification within the specified claims adjudication period shall be deemed an approval of Provider Group's claim at the rate payable for the CPT-4 code specified by Provider Group in such claim. Provider Group's acceptance of compensation at a downcoded rate, or any other reduced rate, shall not constitute a waiver of, or otherwise limit, Provider Group's right to seek payment at the rate originally claimed by Provider Group through the appeals process specified in the Operations Policies, or to pursue its other available legal remedies. Payor and Provider Group agree to review downcoding issues regularly and to confer regarding mutually acceptable parameters for appropriate CPT-4 coding.

D. DENIAL OF CLAIMS.

In the event any Clean Claim submitted by Provider Group, or any part thereof, is denied by Payor or deemed denied pursuant to Paragraph B above, the services for which such claim has been denied shall be considered a Non-covered Service and may, in Provider Group's discretion, be billed to the Member at Provider Group's Usual Charges. Further, Provider Group shall be entitled to pursue its reconsideration and appeal rights as set forth in Section 8, Paragraph D, and to pursue such other remedies as may be permitted by law.

8/ Rather than set forth the different compensation methodologies (e.g., discounted fee for service based on RBRVS or some other methodology, or capitation), I suggest that the compensation methodology and amounts be spelled out on Exhibit B. Provider Groups can, of course, include the Exhibit B language directly in the body of the Agreement. However, as a general rule, specifying compensation methodologies and amounts on an exhibit works better.

E. MEDICAL SCREENING EXAMINATION FEE.

For all claims or parts thereof denied as non-emergent and/or non-authorized, Payor shall reimburse Provider Group for the Medical Screening Examination based upon the level of service specified by Provider Group in its claim. [Upon receipt of such denial, Provider Group shall resubmit the claim for services provided during the Medical Screening Examination. Payor shall reimburse Provider Group for the CPT code listed on the resubmitted claim at the rate specified on Exhibit B for each CPT code.] Evaluation and Management Codes 99281 - 99285 are the appropriate codes for this service as evidenced by the variability and intensity of diagnostic evaluation and medical decision making involved in this function. Provider Group may bill the Member at its Usual Charge for the services other than the Medical Screening Examination rendered to the Member, which shall be deemed as Non-covered Services. Acceptance of reimbursement for the services provided during the Medical Screening Examination by Provider Group shall not be deemed a waiver by Provider Group of its right to seek full payment for all Covered Services specified in its claim through the appeals procedure described in Article 8 below or to pursue other available legal remedies.

Further, Payor shall pay for such qualified personnel and transportation equipment, including the use of necessary and medically appropriate life support measures during transfer, as may be deemed Medically Necessary by Provider Group in its medical judgment.

F. ECONOMIC TRANSFERS OF STABLE MEMBERS.

Payor, Members or PCPs may sometimes request a transfer from a health care facility which is not a Participating Facility to a Participating Facility, or may request other transfers for economic or other non-medical reasons. Provider Group shall be obligated to order such transfers only if a Provider Group Physician determines, in his or her medical judgment, that the Member has been stabilized; the other conditions set forth in EMTALA are satisfied; and the Member or a surrogate decision maker authorized under state law to act on the Member's behalf has consented to the transfer. In the event a Provider Group Physician determines that such conditions are not met, Payor shall continue to reimburse Provider Group for Covered Services deemed Medically Necessary by Provider Group. Payor acknowledges that arranging for such transfers and complying with the requirements of EMTALA entail substantial time, effort and medical judgment for which Provider Group should be reimbursed. Any transfer requested or authorized by Payor or the Member's PCP shall be deemed a Covered Service and shall be reimbursed to Provider Group at the rate set forth on Exhibit B.[9/] In the event such transfer is requested by a Member or a family member or other surrogate decision maker on the Member's behalf, without approval or authorization by Payor or a PCP, Provider Group shall be entitled to bill for such service as a Non-covered Service at its Usual Charges.

After a Member is stabilized, the Provider Group will contact the Plan to obtain authorization for further Medically Necessary services (other than emergency services) identified by the Provider

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[9/] Exhibit B must obviously include a transfer fee to implement this provision.

Group Physician within 30 minutes of the point that the Provider Group Physician determines the Member is stabilized. The Plan will either deny or approve the request within 30 minutes of the time when it is notified. If the Plan denies the request, the Provider Group Physician may request a consultation with one of the Plan's Participating Physicians within 30 minutes of the time the Plan is notified of the request for consultation. If the Provider Group does not call the Plan, the Plan is not responsible for payment of any services provided after stabilization of the Member. If the Plan does not respond to the Provider Group within thirty (30) minutes of the time the Plan receives the request, the Plan will not retrospectively deny payment for post-stabilization services unless those services were subsequently determined to be medically unnecessary or not a Covered Service.

G. LATE PAYMENT.

If Payor fails to pay any Clean Claim in the full amount required by this Agreement within the time period set forth in Paragraph B above, Payor shall be required to pay Provider Group at its Usual Charges for all Covered Services for which full payment is not timely received. Further, if Payor does not compensate Provider Group within sixty (60) days of Provider Group's submission of a Clean Claim, Payor shall pay Provider Group interest on Provider's Usual Charges for the Covered Services included within such claim in the amount of ____% per month (___% per annum), not to exceed the maximum amount permitted by law.

6. COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY

A. OTHER COVERAGE.

Provider Group agrees to cooperate with Payor, and Payor agrees to cooperate with Provider Group, for proper determination of Coordination of Benefits and in billing and collecting from other payors the charges for which such other payors are responsible. Provider Group shall report to Payor all COB collections received by it, and Payor shall report to Provider Group all COB collections received by it, for Covered Services rendered by Provider Group.

B. THIRD PARTY LIABILITY.

In the event that any third party shall be liable for the cost of services rendered by Provider Group, whether in tort or otherwise, Provider Group and Payor agree to cooperate with each other in taking all reasonable steps necessary to collect such proceeds, to the full extent permitted by law.

C. ENTITLEMENT TO PROCEEDS.

In the event of any collection as a result of Coordination of Benefits or third party liability as set forth in Paragraphs A or B above, Provider Group shall be entitled to all such proceeds for services rendered by it; provided, however, that the total of payments by Payor and such other proceeds received by Provider Group shall not exceed Provider Group's Usual Charges. Further, Provider Group and Payor agree to make such refunds and repayments as may be required by applicable law.

D. TIMING OF PAYMENTS.

Provider Group shall not be required to collect the proceeds payable by any other payor or of any third party liability claim prior to billing Payor, nor shall Payor be entitled to withhold payment to Provider Group as a result thereof; provided, however, that Provider Group shall make any refund that may be due to Payor upon collection of such proceeds.

7. COMPLIANCE WITH APPLICABLE STANDARDS, LAW, AND OPERATIONS POLICIES

A. APPLICABLE LAWS.

In the performance of their respective duties under this Agreement, both Provider Group and Payor shall comply with all applicable laws, rules and regulations governing such performance.

B. OPERATIONS POLICIES.

Provider Group and Payor shall each comply with all policies, procedures and rules governing the performance of this Agreement, as set forth in the Operations Policies described or summarized on Exhibit C. In the event Payor proposes to change any of the Operations Policies, it shall provide Provider Group with a copy of such proposed change at least thirty (30) days in advance of the proposed effective date thereof. Provider Group shall either agree in writing to such proposed change or shall notify Payor of any objection or proposed modification thereto at least ten days prior to the proposed effective date. In the event of any objection to a proposed amendment or modification, the parties shall meet and confer within such ten (10) day period in an attempt to resolve such issue. No revision or addition to the Operations Policies shall be binding on Provider Group without its approval.

C. MEDICAL STANDARDS AND ETHICS.

Provider Group agrees at all times to perform its professional duties hereunder in a manner consistent with prevailing standards of medical practice in the community. Additionally, Provider Group agrees at all times to adhere to applicable professional ethics. Payor agrees that it shall not take any action which impairs Provider Group's ability to comply with such medical standards and ethical codes. Payor agrees at all times to perform its duties hereunder in a manner consistent with

prevailing community standards and ethics governing Payors. Provider Group agrees that it shall not take any action which impairs Payor's ability to comply with such standards and ethics.

8. UTILIZATION MANAGEMENT/QUALITY IMPROVEMENT

A. UR/QI PROGRAMS.

Payor shall maintain utilization management (UM) and quality improvement (QI) programs which shall be included within the Operations Policies. Provider Group agrees to make good faith and reasonable efforts to cooperate in the implementation and operation of the UM and QI programs. Payor agrees to compensate Provider at Provider's Usual Charge for UM and QI activities, as set forth on Exhibit B, for time spent by Provider Group Practitioners when participating in Payor's UM and QI programs.

B. CONTENT OF UM/QI PROGRAMS.

Payor's UM and QI programs shall meet the standards established by NCQA or the American Accreditation Health Care Commission. Payor's UM program as set forth in the Operations Policies shall specify the procedures and criteria Payor uses to determine whether specified procedures provided after the Medical Screening Examination and stabilization of the patient are Medically Necessary and/or whether to authorize such services.

C. RECONSIDERATION AND APPEAL OF UM AND QI DECISIONS.

Payor shall provide a prompt and easily accessible avenue for Provider Group to request reconsideration of any adverse UM or QI decision, including but not limited to a refusal to authorize a service. Such reconsideration process shall include review by a physician with current clinical competence, education, training and expertise comparable to that of Provider Group Physicians whose services are under review. Such reviewers must be actively practicing in the same specialty in the same state. The reconsideration process required by this paragraph shall apply to claims that are contested on the basis of any clinical issue, including the appropriateness of treatment and/or the type of treatment proposed or utilized.

D. APPEAL OF ADVERSE UM OR QI DECISIONS.

In the event the reconsideration process described in Paragraph C above does not resolve the issue to Provider Group's satisfaction, Provider Group shall be entitled to formally appeal any UM or QI decision in the manner set forth in this paragraph. Such appeal shall be coordinated with the appeal, if any, of the Member. Provider Group shall give written notice of appeal to Payor within [ten (10)] calendar days of the contested decision. The issue shall be conclusively resolved in the following manner: [*option 1*: The appeal shall be referred to a physician or committee appointed by the County Medical Society in the applicable county or, if the County Medical Society does not handle such appeals, to the State Medical Association, in accordance with their established UM appeal process. [*option 2*: Within [ten (10) days] of the notice of appeal, Provider Group shall submit the name of a physician (who shall not be a Provider Group Physician); Payor shall designate

a second physician (who shall not be an employee or regular contractor of Payor); and the two physicians so appointed shall designate a third licensed physician. The three physicians so appointed shall constitute an appeal committee and shall review and resolve the appeal within [ten (10)] days of the initial notice of appeal.] The cost of the physician or committee hearing the appeal shall be borne by Payor as an expense of its UM and QI program. In the event Provider Group shall substantially prevail in the appeal, as determined by the physician or committee hearing the appeal, all costs and expenses incurred by Provider Group in connection with the appeal, including Provider Group's Usual Charges for the time of the Provider Group Practitioners involved, shall be payable by Payor within thirty (30) days of the decision.

9. GRIEVANCES

A. MEMBER GRIEVANCES.

Provider Group agrees to keep summaries of Payor's grievance procedures and grievance encounter forms available for Members upon request.[10/] Provider Group further agrees to comply with and abide by Payor's membership grievance procedure, which is included within the Operations Policies.

B. PARTICIPATING PHYSICIAN GRIEVANCES.

Payor has established and shall maintain a system to process and resolve grievances by Participating Providers, including Provider Group and Provider Group Physicians. Such process is included within the Operations Policies. [Upon request, Payor shall provide Provider Group or any Provider Group Physician with a provider grievance form. Payor shall also maintain a log, including the date, nature, and resolution, if any, of grievances submitted by Provider Group or any Provider Group Physician within the past five years. Payor shall make this log available to Provider Group and shall provide copies to Provider Group upon request. Payor shall protect the confidentiality of Members and Provider Group Physicians and the log shall not include information that would allow a Member or Provider Group Physician to be identified. Any grievance which is not resolved to both party's satisfaction shall be subject to the dispute resolution process as set forth in Article 15 below.]

[10/] This sentence should perhaps be included only if required by law, as is the case for many licensed HMOs.

10. MARKETING LITERATURE[11/]

Provider Group agrees to submit to Payor the name [specialty, address and telephone number] of each Provider Group Physician so that Payor may list such information in its roster of Participating Physicians. Provider Group reserves the right to review such roster for accuracy before publication. Payor shall have the right to list the foregoing information in its list of Participating Providers distributed to Members [or to organizations with which Payor contracts.] However, Payor shall not use such information in any other manner without the prior written authorization of Provider Group.

11. INSURANCE COVERAGE

A. WORKERS' COMPENSATION INSURANCE.

Provider Group agrees to provide, at its sole cost and expense, workers' compensation insurance for its employees throughout the entire term of this Agreement, in accordance with the laws of the state of _____.

B. PROFESSIONAL LIABILITY INSURANCE.

Provider Group shall maintain [or require its contracted Provider Group Practitioners to maintain], at no expense to Payor, throughout the entire term of this Agreement, an insurance policy covering Provider Group and each Provider Group Practitioner for professional liability issued by an insurance company or mutual self-insurance cooperative authorized to do business in the state of _____. Such policy or policies shall provide coverage in the minimum amount of the lesser of (1) the amount required by [state law] [the bylaws of the applicable Participating Facility] or (2) $_____ per claim and $_____ in the annual aggregate. In the event such coverage is provided on a "claims made" basis, Provider Group [or its contracted Provider Group Practitioners] shall either maintain such coverage or shall purchase a "tail" policy with the same policy limits for a period of not less than five years following the effective termination date of this Agreement.

C. PAYOR'S INSURANCE.

Payor shall maintain, at no cost to Provider Group, throughout the entire term of this Agreement, professional liability and/or errors and omissions coverage covering Payor and its agents for all insurable risks normally incurred in the conduct of its business, including but not limited to potential liability under state and federal law in performing UM, QI and related functions. Such policy or policies shall be issued by an insurance company authorized to do business in the state of _____ and shall provide coverage in the minimum amount of $_____ per claim

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[11/] This section, which is a somewhat standard provision in a managed care contract, may not be necessary or appropriate in the emergency physician setting, and is generally not required by law. Therefore, it can generally be deleted.

and $_____ in the annual aggregate. In the event such coverage is provided on a "claims made" basis, Payor shall maintain such coverage or procure "tail" coverage with the same limits for a period of not less than five years following the effective termination date of this Agreement.

12. TERM OF AGREEMENT

A. TERM.

This Agreement shall be in effect for a period of one (1) year and shall be automatically renewed for an additional term of one (1) year unless terminated as set forth below.

B. RENEGOTIATION OF COMPENSATION.

Payor agrees to renegotiate the compensation terms of this Agreement no later than ninety (90) days prior to its anniversary date. In the event the parties have not reached agreement on revised compensation terms sixty (60) days prior to the anniversary date, Provider Group may at any time thereafter, in its discretion, terminate this Agreement, effective on the later of (I) the anniversary date hereof or (ii) thirty (30) days after notice of such termination. In the event the parties continue negotiation, and agreement is not reached until after the anniversary date hereof, any increase in compensation agreed upon by the parties shall be retroactive to such date. Upon completion of such negotiations, the parties shall execute and attach an amended Exhibit B.

13. TERMINATION

A. NON-RENEWAL.

Either party may terminate this Agreement by notifying the other party in writing, at least ninety days prior to the anniversary date hereof, of its intent not to renew the agreement.

B. MATERIAL BREACH.

In the event of a material breach of this Agreement, the non-breaching party may provide the other party with written notice specifying with particularity the nature of the breach (the "Breach Notice"). If such breach is not cured within thirty days of such notice, the non-breaching party may provide the other with notice of termination (the "Termination Notice") specifying the effective date of termination, which shall not be less than ten (10) nor more than thirty (30) days from the date of such notice.[12/]

[12/] This termination provision builds in a time period for transition following the last day to cure if the breach is not cured. As indicated in subsequent provisions, however, certain breaches are deemed non-curable.

C. TERMINATION BY PROVIDER GROUP.

Notwithstanding Paragraph B above, Provider Group may terminate this Agreement:

I. Immediately upon notice, in the event any license or permit required for Payor to conduct its business is suspended or revoked;

ii. Upon ten (10) days written notice, in the event Payor is delinquent in paying Provider Group the lesser of $_____ or _____ days of average daily billings by Provider Group to Payor (as reasonably determined by Provider Group), excluding any amounts which are disputed in good faith by Payor;

iii. Immediately, upon loss by Payor of any insurance coverage required by Article 11, Paragraph C above;

iv. Upon thirty (30) days written notice, in the event any [health plan, employer or any other payor][13/] with which Payor contracts either (a) terminates Payor's contract with cause; or (b) terminates Payor's contract without cause, or declines to renew such contract, if such [health plan, employer or other payor] terminating without cause accounts for more than _____% of Payor's Members treated by Provider Group during the three (3) calendar months prior to the month of such termination;

v. Immediately, upon a finding by any court of competent jurisdiction that Payor is insolvent, or in the event a petition in bankruptcy or insolvency or for reorganization or the appointment of a receiver, trustee or conservator of all or a portion of Payor's property has been filed, or if Payor makes an assignment for the benefit of creditors.

[vi. Upon thirty (30) days written notice, in the event the event the number of Members residing in the [county of _____ or other specified service area] [drops below _____] [decreases by more than _____% from the commencement date of this Agreement];[14/]

[13/] The types of entities listed here will vary depending on whether Payor is an intermediate entity.

[14/] This provision is sometimes called a "low enrollment guarantee." In the event Provider Group has entered into this Agreement based on the expectation that Payor has a certain number of Members, this provision permits termination if membership declines below a certain threshold. This type of provision is especially important in a capitation arrangement.

D. TERMINATION BY PAYOR.

Notwithstanding Paragraph B above, Payor may terminate this Agreement:

I. Immediately, upon loss by Provider Group of the insurance required by Article 11, Paragraph B above;

ii. Immediately, upon a finding by any court of competent jurisdiction that Provider Group is insolvent, or in the event a petition in bankruptcy or insolvency or for reorganization or the appointment of a receiver, trustee or conservator of all or a portion of Provider Group's property has been filed, or if Provider Group makes an assignment for the benefit of creditors if such petition is not dismissed within ninety (90) days;

iii. Immediately, upon the exclusion of Provider Group from participating in Medicare or Medicaid;

iv. As to Covered Services performed by Provider Group in a particular Participating Facility, upon the loss by Provider Group of its contract to provide services in such facility, effective upon the effective termination date of such contract;

v. As to Covered Services performed by any Provider Group Practitioner, the termination or suspension of such practitioner's license to practice, DEA certificate or medical staff privileges in any Participating Facility.

In the event this Agreement is terminated as to services performed in any Participating Facility (pursuant to part iv above) or any Provider Group Practitioner (pursuant to part v above), this Agreement shall otherwise remain in full force and effect.

E. MEET AND CONFER REQUIREMENT.

In the event Payor shall give Provider Group notice of termination either without cause or for cause, Provider Group shall be entitled, upon a request in writing delivered to Payor within five (5) days after such notice has been received, an opportunity to meet with a committee [of Board Members] [designated by the Board of Directors] of Payor to discuss the circumstances surrounding the termination. That initial meeting shall be held within ten (10) days of Provider Group's request for such meeting. If Provider Group is dissatisfied with results of the initial meeting, it shall be entitled to attend a meeting of the [Board of Directors] of Payor regarding the circumstances of the termination, so long as Provider Group shall have requested such a meeting within five (5) days following the initial meeting (or, if a written response to Provider Group is promised at such initial meeting, within five (5) days following the receipt of such response; provided, however, that such response shall be delivered to Provider Group within five (5) days of such meeting.) The subsequent meeting shall be held within ten (10) days following Provider Group's request therefor. The meetings provided for in this paragraph shall be informal in nature and shall not constitute legal hearings or proceedings; provided, however, that in the event either party shall so request, legal counsel for both parties may attend. The meetings provided for in this paragraph shall not constitute

a condition of, nor be deemed in lieu of, recourse to the dispute resolution provisions set forth in Article 15 below.

F. CONTINUATION OF SERVICES.

In the event Payor ceases operation, becomes insolvent as defined under applicable law, fails for any reason to pay its obligations to Provider Group as required by this Agreement, or in the event of termination of this Agreement for the foregoing or any other reason, Provider Group shall only be responsible for requiring Covered Services to Members following such event to the extent required by applicable law, including EMTALA. In the event Provider Group is required by EMTALA or other applicable law to render Covered Services to Members following such event, Provider Group shall be entitled to bill such Members its Usual Charges, except as prohibited by applicable law.[15/]

G. POST-TERMINATION CHARGES.

Subsequent to the effective date of the termination of this Agreement, Payor shall pay Provider Group at its Usual Charges for all Covered Services rendered to Members.

14. NOTICE OF ADVERSE ACTION

Provider Group shall notify Payor in writing within five (5) days following the occurrence of any of the following events:

I. The license to practice or DEA certificate of any Provider Group Practitioner is suspended, revoked, terminated or subject to terms of probation or other restrictions;

ii. The medical staff privileges of any Provider Group Practitioner at any Participating Facility are denied, suspended, restricted, revoked or voluntarily relinquished in lieu of disciplinary action, except if such action is solely related to delinquent records;

iii. Provider Group is required to pay damages and any malpractice action in excess of [$25,000] by way of judgment or settlement;

iv. Any Provider Group Practitioner is convicted of a felony;

v. Provider Group becomes aware of a material change in the credentialing information submitted by Provider Group for any Provider Group Physician;

[15/] Please note that, particularly if Provider Group is capitated, most states have specific laws governing continuity of care obligations and Provider Group's right to bill Members. Therefore, this provision may need to be amended from state to state to comply with these laws.

vi. The exclusion or suspension by Medicare or Medicaid of any Provider Group Practitioner;

vii. The cancellation or exclusion from coverage under Provider Group's insurance policy of any Provider Group practitioner.

15. DISPUTE RESOLUTION

A. MEET AND CONFER.

If any dispute or controversy shall arise between the parties arising from or under this Agreement, the parties agree to meet and confer in good faith to resolve their dispute or controversy. If the parties cannot resolve the dispute, or if either of them determines that no progress is being made toward resolution of the dispute within ten (10) days after the initial conference, then the issue shall proceed to arbitration as set forth below.

B. ARBITRATION.

Either party may demand arbitration by sending notice to the other party at the address set forth in Article 18, Paragraph D of this Agreement. The arbitration shall be held in the [County/City] of _____ and shall be governed by the [State Arbitration Act], [except as specifically set forth herein.] Within ten (10) days after the demand for arbitration, the parties shall attempt to agree upon a single arbitrator. If the parties are unable to so agree, then each party shall, within twenty days of the demand for arbitration, designate an arbitrator. The two arbitrators so selected shall select a third, neutral arbitrator.

C. DISCOVERY.

[Option 1: The parties shall be entitled to conduct discovery in accordance with the provisions of Section ____ of the _____ Arbitration Act.]

[Option 2: Discovery shall be at the discretion of the arbitrator[s], and shall be allowed upon a showing of good cause using the following guidelines:

I. The arbitrator(s) shall have discretion to order pre-hearing exchange of information, including but not limited to the production of requested documents and exchanges of summaries of testimony and proposed witnesses.

ii. The deposition of the claimants and respondents shall be allowed as a matter of right. One set of interrogatories approved by the arbitrator(s) shall be allowed. There shall be an early and prompt designation and exchange of the names and addresses of expert witnesses who may be called upon to testify at the arbitration hearing. Depositions of experts and all other discoveries shall be allowed by the arbitrators upon a showing of good cause.]

D. BINDING DECISION.

The award of the arbitrator(s) shall be final and binding. [At the discretion of the arbitrator(s),] [t]he prevailing party in such arbitration shall be entitled to reimbursement by the other party of that party's attorney's fees and costs and any arbitration fees and expenses incurred in connection with the arbitration hereunder. Judgment thereon may be entered thereon in any court of competent jurisdiction.

E. EXCEPTIONS.

Notwithstanding the foregoing:

I. Because time is of the essence of this Agreement, the parties specifically reserve the right to seek a judicial temporary restraining order, preliminary injunction or other similar short term equitable relief, and grant the arbitrator(s) the right to make a final determination of the parties' rights, including whether to make permanent or dissolve such court order.

ii. The parties shall not be obligated to arbitrate any bona fide claim brought in good faith if coverage for that claim (as to either damages or defense) that would otherwise exist is inapplicable if that claim is arbitrated; provided, however, that the covered party shall use its diligent best efforts to obtain the permission of the carrier to arbitration.

iii. Arbitration shall not be required for any malpractice or personal injury claim brought by Members or other third parties.

F. WORKERS' COMPENSATION.[16/]

Provider Group agrees that if a Member who is covered for workers' compensation benefits by workers' compensation carrier affiliated with Payor seeks services for work-related illness or injury, Provider Group shall provide a Medical Screening Examination and such subsequent medical services as it deems Medically Necessary and shall complete a [Doctor's First Report of Injury or other state-required document.] As payment for such services rendered, Provider Group agrees to accept _____% of the state workers' compensation fee schedule. Provider Group further agrees to refer such Member only to a physician or facility which is a contracting or Participating Provider in Payor's workers' compensation provider network, which list of providers shall be provided to Provider Group.

16. RECORDS

A. MEDICAL RECORDS.

Provider Group agrees to make such entries in Member medical records as may be required by applicable law, the bylaws of the applicable Participating Facility and the Operations Policies. As provider-based physicians, Provider Group does not own or control access to medical records, which are owned and maintained by the Participating Facility in which Members are treated. Provider Group agrees to use reasonable efforts to facilitate access to Member medical records by Payor and other Participating Providers who require such records for continuity of care purposes.

B. FINANCIAL RECORDS.

Provider Group shall maintain financial records regarding Covered Services rendered to Members, and shall maintain such records for [a period of at least two years or] such period as may be required by law. To the extent required by law, Provider Group shall provide access to such records to Payor and government agencies with jurisdiction over the performance of this Agreement, subject to compliance with applicable laws regarding the confidentiality rights of Members.

C. COPYING COSTS.

In the event Payor (or any governmental agency, accreditation, body or other organization performing survey, review or accreditation activities regarding Payor) requests any record maintained by Provider Group, or in the event any Participating Provider or other practitioner requests such records for referral or continuity of care purposes, Payor shall reimburse Provider Group for its copying and related clerical costs in making such records available at the rates set forth on Exhibit B.

[16/] This provision will not be applicable or appropriate in some situations, and would also need to be reviewed for compliance with state law.

17. CONFIDENTIALITY OF INFORMATION

Payor shall protect from unauthorized disclosure, to the fullest extent permitted by law, all credentialing, peer review, quality improvement and related information collected and maintained by or for Payor regarding Provider Group and Provider Group Practitioners. In the event Payor proposes to release any such information, Payor shall provide Provider Group with at least ten (10) days advance notice of such release. In the event Provider Group [or any Provider Group Physician] objects to such disclosure, Payor shall not release such information, except to the extent required by law. No such information shall be disclosed to any entity which is not protected by [applicable state peer review confidentiality statute] without the express written consent of Provider Group [and the affected Provider Group Physician].

18. GENERAL PROVISIONS

A. NON-DISCRIMINATION.

Provider Group agrees not to differentiate or discriminate in its provision of Covered Services to Members based on race, color, national origin, ancestry, religion, sex, disability or insurance status. Further, Provider Group shall render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to patients who are not Members, consistent with existing medical and ethical requirements.

B. ASSIGNMENT.

Neither party shall assign any right nor delegate any obligations hereunder, except as specifically provided in this Agreement, without the written consent of the other party. Any such attempt at assignment or delegation shall be ineffective and shall constitute a breach hereof. Notwithstanding the foregoing, Provider Group may assign this agreement as part of a sale, merger or organization of Provider Group.

C. GOVERNING LAW.

This Agreement shall be interpreted, construed, enforced and given effect according to the laws of the state of _____.

D. NOTICES.

Any and all notices, requests, demands or other communications required or permitted to be served on or given to either party by the other shall be in writing and shall be delivered personally or sent by U.S. mail (certified or registered, return receipt requested), or by facsimile transmission (provided that such facsimile machine has a confirmation verification mechanism) or overnight mail, addressed as follows:

If to Payor:

_____

_____

_____

Telecopier:_____
Attn: _____

If to Provider Group:

_____

_____

_____

Telecopier:_____
Attn: _____

If personally delivered, such notice shall be effective upon delivery. If sent by mail or by overnight mail, such notice shall be effective as of the date delivered. If sent by facsimile transmission, such transmission shall be effective upon receipt. Either party may change its address as indicated above by giving written notice of such change to the other party in the manner specified in this paragraph.

E. WAIVER OF BREACH.

No assent or waiver, express or implied, of any breach of any one or more of the covenants, conditions or provisions hereof, shall be deemed or taken to be a waiver of any other covenant, condition or provision hereof, or a waiver of any subsequent breach of the same covenant, condition or provision hereof.

F. CAPTIONS.

The captions used as headings of the various paragraphs hereof are for convenience only, and the parties agree that such captions shall not be construed to be part of this agreement or used in determining or construing the intent or context of this agreement.

G. SEVERABILITY.

If any clause, sentence, provision or other portion of this agreement is or becomes illegal, void or unenforceable for any reason, or is held by any court of competent jurisdiction to be so, the remaining portions shall remain in full force and effect.

H. ENTIRE AGREEMENT.

This agreement supersedes any and all other agreements, either oral or in writing between the parties with respect to the subject matter hereof, and contains the entire agreement between the parties relating to said subject matter. This agreement may not be amended except in writing, signed by authorized representatives of the parties.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed on this _____ day of _____, _____.

[Payor Name] [Provider Group Name]

By:_____ By:_____

Its:_____ Its:_____

EXHIBIT "A"
COVERED SERVICES

[List Covered Services. Distinguish, as appropriate, between ED services, urgent care services, industrial medicine services, etc. If this is a capitated or partially capitated agreement, identify carefully which services are included within the capitation and which ones are carved out and payable in a fee-for-service or other basis.]

EXHIBIT "B"
COMPENSATION
[Option 1 - Capitation.]

A. CAPITATION AMOUNTS.

Payor shall compensate Provider Group on a capitated basis by paying Provider Group, on a monthly basis, the following amounts for each type of Member designated below:

Medicare	$_____ per Member per month (PMPM)
Commercial	$_____ PMPM
Medicaid	$_____ PMPM
Other	$_____ PMPM

B. PAYMENT DATE; REPORT.

No later than the fifteenth (15th) day of each month, Provider Group shall receive from Payor a capitation check which shall include a capitation payment for every Member enrolled with Payor within the applicable service area [need to define/describe] as of the first of such month. Along with such payment, Payor shall furnish Provider Group with a report setting forth the following:

1. The name and other identifying information as specified in the Operations Manual for each member;

2. Categorization of Members as Medicare, Medicaid or Commercial;

3. The total amount being paid Provider Group, with a breakdown based on Member categories;

4. [The current age/sex adjusted rate for Members for the month being paid];

5. A "cost of care" or "fee for service equivalency" calculation for each category of Member, which shall be determined by taking the capitation amount payable for each category of Members and comparing such amount to the fee-for-service amount Provider Group would have received for the Covered Services rendered, as set forth more fully in the Operations Manual.[17/];

[17/] Setting forth the manner which a cost of care calculation will be performed is a complex undertaking that should be addressed at length in the Operations Manual.

6. Adjustments to capitation based on retroactive additions and deletions, subject to Paragraph C below;

C. RETROACTIVE ADJUSTMENT.

A retroactive addition to Provider Group's capitation payment shall occur when Members are incorrectly excluded from previous capitation reports for prior months. A retroactive recoupment may occur when Members were incorrectly included in previous capitation reports. The statement set forth in Paragraph B above shall identify each Member retroactively added or deleted, and shall present corrected enrollment data along with the corresponding adjustments to such prior capitation statements.

Capitation shall be adjusted retroactively to the first day of the month of which a Member's enrollment status changed. [A recoupment may occur only where Provider Group knew or should have known that the Member was not a covered member.] Payor shall not retroactively recoup capitation payments made more than 90 days before the notice of error was given to Provider Group. In the event of a retroactive addition, such addition shall occur regardless of whether Covered Services were provided.

D. STOP LOSS.

The capitation payment PMPM as defined in paragraph _____ is up to _____ ED visits per one thousand (1,000) members per month. ED visits over _____ per one thousand (1,000) members per month will be compensated a rate of _____ Dollars ($_____) per visit.

The stop-loss compensation will be calculated by Provider Group and submitted to Plan at the end of each quarter. Payment will be made to Provider Group within 30 days of reconciliation.

The stop-loss compensation will not apply for non-covered services or to ineligible patients. Such patients shall be billed by Provider Group at Usual Charges.

E. SERVICES EXCLUDED FROM CAPITATION.

Covered Services which are not included within the scope of capitation payments, as described on Exhibit "A", shall be reimbursable to Provider Group Based on the [rates] [compensation methodology] set forth below. Such fee-for-service payments shall be subject to all terms and conditions of this Agreement, including but not limited to the provisions of Articles 4 and 5.
[Specify compensation methodology for "carve out" services.]

F. OTHER CHARGES.

[If not included in capitation, specify special charges for UM/QI service, records, copies, transfer fees, etc.]

EXHIBIT "B"
COMPENSATION
[Option 2 - Fee for Service]

A. RBRVS METHODOLOGY.

Payor shall reimburse Provider Group ____ times the current 199__ or 200__ Medicare allowable rates (RBRVS) for the state of _____, locality _____.

[Other FFS might also be used.]

B. SPECIAL CHARGES.

Include all special charges, such as transfer fees, screening examination fees, records charges, hourly charges for UM and QI activities, etc.

EXHIBIT "C"
OPERATIONS POLICIES

[This exhibit should list or describe with specificity each and every policy, procedure or rule that will govern the performance of this Agreement, including UM plans, authorization and referral policies, QI plans, credentialing requirements, etc. These policies and procedures should be identified by date, to establish a benchmark for any changes that may be made. Pursuant to the Agreement, any such changes require notice to, and agreement by, Provider Group. If desired, these Operations Policies can be placed in a separate notebook, so that they are easily referenced and reviewed.

EXHIBIT "D"
PROVISIONS FOR AGREEMENTS
WITH INTERMEDIATE ENTITIES[18/]

A. NATURE OF RELATIONSHIP.

The parties acknowledge that Payor has entered into, or intends to enter into, contracts with [health care service plan/licensed HMOs/other], insurers, employers, unions, preferred provider organizations and other entities which pay for or arrange for the payment of medical services (collectively, "Primary Payors"), to provide Covered Services to Members. The parties further agree that Provider Group is entitled to determine which Primary Payors it provides services to through this Agreement, and that Provider Group is entitled to review and approve the terms of any agreement between Payor and any Primary Payor which may affect Provider Group or its rights hereunder.

B. PRIMARY PAYORS.

Only the following Primary Payors are covered by this Agreement, and Provider Group shall have no obligations pursuant to this Agreement with respect to patients who are not enrollees, members or beneficiaries of such Primary Payors:

[List Primary Payors]

C. PRIVATE PAYOR AGREEMENTS; AMENDMENTS.

In the event Payor proposes to add any new Primary Payor to this Agreement, or to amend any existing agreement with any Primary Payor covered by this Agreement in a manner which affects Provider Group's rights hereunder, Payor shall furnish Provider Group with a copy of its agreement with such Primary Payor (or a summary of terms acceptable to Provider Group), or a copy of the applicable amendment, at least thirty (30) days prior to the effective date thereof. Provider Group shall review such agreement (or the summary of terms thereof) or amendment and shall notify Payor in writing within twenty (20) days whether it agrees to include such Primary Payor or amendment within its obligations under this Agreement. Provider Group shall have no obligation under this Agreement with respect to any Primary Payor or amendment without its express written approval.

[18/] This exhibit will only be applicable when Payor is an IPA, PPO or other intermediate contracting entity.