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THIS AGREEMENT CONTAINS AN ARBITRATION PROVISION PRIMARY CARE PHYSICIAN AGREEMENT Dear Primary Care Physician: * * * * **3.0**

COMPENSATION 3.1 Payment. Company's compensation methodologies are designed to promote Member access to quality care. Company shall, or when it is not the applicable Payor shall notify each Payor to, pay Physician for Primary Care Services rendered to Members in accordance with: (a) the Physician Compensation Model as described in the Compensation Schedule; (b) any other applicable Attachment; or (c) the fee schedule then in effect as applicable to such Members' Plans; any of which may be modified from time to time. Physician's compensation for non-capitated Covered Services rendered to Members shall be (A) the lower of (i) the compensation arrangement in effect hereunder, or (ii) Physician's reasonable and customary billed charge, (B) minus any applicable Copayments, Coinsurance or Deductibles. Payments for non-capitated Covered Services are subject to any and all valid and applicable laws related to claims payment. Except for capitated services, in the event Company fails to pay a Clean Claim within forty-five (45) days of submission, upon written notice from Physician of such event, Company shall pay a contracted penalty of **[VARIABLE: one to twenty]** percent **[VARIABLE: (1-20%)]** per month simple interest on the eligible, unpaid portion of such Clean Claim(s), beginning on the 46th day after submission of that Clean Claim through the date on which payment is made. Physician shall not be entitled to billed charges for any Clean Claim. Physician shall not be entitled to receive either billed charges or the contracted penalty for claims under self-funded Plans.

Physician shall notify Com-

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pany of any overpayments or payments made in error within ten (10) business days of becoming aware thereof, and shall return or arrange the return of any such overpayments or payments made in error to Company, or to Payor or Member, as applicable. Physician shall hold Company, Affiliates, Sponsors, Members and Payors harmless against any and all claims by covering providers related to or arising out of payment for Covered Services rendered to Members. Notwithstanding anything to the contrary in this Agreement, to the extent Company has communicated approval of payment for Covered Services, Company shall pay for such Covered Services absent: (a) fraud; (b) materially changed condition of the Member's health status (meaning a material change in the Member health status between the time that Company communicates approval of payment for Covered Services and the time that those Covered Services are provided, such that the Covered Services for which Company has communicated approval of payment are not medically necessary due solely to the material change in the Member's health); or (c) the individual receiving the services was not a Member at the time such care is delivered. Notwithstanding anything in this Agreement to the contrary, during such time as Physician is a member of a Group, Physician seeks to seek compensation solely from Group for those Covered Services provided to Members and for which Group is compensated by Company on behalf of Physician, and Physician shall in no event bill Company, its Affiliates, Payors or Members for any such Covered Services (except for the collection of Copayments, Coinsurance, Deductibles in accordance with Section 3.2). When Company is not the Payor, Company shall have no obligation to pay Physician in the event that the Payor or Member fails to pay Physician. Company agrees that it shall not

offer Physician compensation arrangements that: provide additional compensation for not exceeding certain budgets, impose a penalty for incurring expenses that are medically necessary, make additional compensation available

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for limiting medically necessary services or will be affected by the actual (as opposed to projected) costs of services or the actual rate of utilization of services during the contract year. This will not prohibit Company from providing additional compensation to Physician for providing preventive care or in the event the actual costs or utilization of services were more than the projected costs or utilization. 3.2 Billing of Members. Under certain Plans, members may be required to pay Copayments, Coinsurance or Deductibles for certain Covered Services. Physician shall collect any applicable Copayments, Coinsurance and Deductibles from Members. Such amounts collected must be based only on the compensation herein. Co-payments shall be collected at the time that Covered Services are rendered. Except for applicable Copayments, Coinsurance and Deductibles, Physician may bill Members only in the circumstances described below: 3.2.1 If the applicable Payor is not an HMO, Physician may bill a Member for Primary Care Services provided to the Member in the event that the Payor becomes insolvent or otherwise breaches the terms and conditions of its agreement to pay, provided that: (a) Physician shall have first exhausted all reasonable efforts to obtain payment from the Payor; and (b) Physician shall not institute or maintain any collection activities against a Member to collect any sums that are owed by a Payor to Physician unless Physician provides prior notice to Company of Physician's intent to institute such activities. 3.2.2 Services that are not Covered Services may be billed to Members by Physician only if: (a) the Member's Plan provides and/or Company confirms that the services are not covered; (b) the Member was advised in writing prior to the services being rendered that the specific services

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may not be Covered Services; and (c) the Member agreed in writing to pay such services. Noting in this section is intended to prohibit or restrict Physician from billing individuals who were not Members at the time that services were rendered. 3.3 Coordination of Benefits. When a Payor is the primary payor under applicable coordination of benefit principles, the Payor shall pay in accordance with this Agreement, and when a Payor is secondary under said principles, Payor's payment shall be limited as specified in the applicable Plan. If the Plan fails to specify coordination of benefits requirements, and unless prohibited by applicable law, Payor's payment shall be limited to the amount which, together with the amount paid by the primary payor following all reasonable efforts by Physician to collect same, equals the compensation due to Physician under this Agreement, or if the primary payor fails to pay, Payor's payment shall be in accordance with this Agreement. In no event shall amounts billed and retained under coordination of benefits for Covered Services exceed Physician's usual and customary billed charges for such services. 3.4 Claims Submission. Physician shall submit claims to Company or the applicable Payor for non-capitated Primary Care Services rendered to Members. Claims shall be submitted within ninety (90) days of the date of service or Physician's receipt of an explanation of benefits from a primary payor. Billings shall include detailed and descriptive medical and Member data and identifying information on HCFA 1500 forms or any subsequent form adopted for that purpose.

Physician shall submit bills electronically as required by Company or the applicable Payor. Company primarily utilizes CPT for the coding and description of services. If Physician has not billed Company or the applicable Payor within the stated time frame, Physician's claim shall be deemed waived, and Physician shall not bill any other person or entity, including, but not limited to, Company, the applicable

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Payor, Sponsor, or Member, for such services. Company may return to Physician any claims which are incomplete, inaccurate, or not in the proper format as required by Company. Statements made in any claim or related documentation submitted by or on behalf of Physician shall be considered statements made by Physician, regardless of whether such statements are prepared by Physician's employees, agents, or representatives. Any adjustments to claims submitted by Physician must be filed with Company or the applicable payor within thirty (30) days of the submission of the original claim, or the original claim will be deemed final. 3.5 Holding Members Harmless. If the applicable Payor is an HMO, Physician hereby agrees that in no event, including, but not limited to, non-payment by the HMO, insolvency of the HMO or breach of this Agreement, shall Physician bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons (other than the HMO) acting on a Member's behalf for Covered Services. This provision shall not prohibit collection of Deductibles, Coinsurance, or Copayments from Members in accordance with the terms of the Member's Plan. Physician further agrees that: (a) this provision shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) this provision supercedes any oral or written agreement to the contrary now existing or hereafter entered into between Physician and a Member or persons acting on a Member's behalf. Any modifications, additions or deletions to the provisions of this clause shall become effective on a date no earlier than 15 days after the Commissioner of Insurance has received written notice or such proposed changes. * * * *