GREAT HEALTHCARE

PROFESSIONAL SERVICES AGREEMENT

(All Products)

GREAT HEALTHCARE

Contract Facesheet

This facesheet is for informational purposes only and should remain as part of your files for your reference and does not constitute a term and condition of the contract.

Practitioner Contracting Entity: *[Practice Name]* Date: xx/xx/xxxx

I. Compensation and Payment

Reimbursement methodology [check one]: ☒fee for service ☐capitation ☐other

Administrative Guidelines and Payment Policies are incorporated into this contract by reference. See Administrative Guide and Policy Manual for more details.

The fee schedule is based on ***XXXX* Year of the Medicare Fee Schedule** as noted below:

CPT4 Procedure Code Group	Base Relativity Factor
Surgical Codes	XXX%
Evaluation & Management Codes	XXX%
Medicine Codes	XXX%
Laboratory & Pathology	XXX%

Factors for determining the ***XXXX* Medicare Fee Schedule** are included below:

- Relative Value Units (RVUs) from the Center for Medicare and Medicaid Services (CMS) for CPT code/modifier combinations for which they are available
- RVUs provided by an external public source for the remaining CPT code/modifier combinations (including clinical lab codes for which CMS reimbursement is based on flat rates rather than on RVUs).
- CMS geographical cost practice indices (GPCIs) and
- CMS conversion factors

- This fee schedule updates annually: **Yes** ☐ **No** ☒
  - (if Yes, date it will update XXXX)

- The following Covered Services will be reimbursed at the lesser of billed charges: Injectable drugs, immunizations, immunization administration, vaccines, toxoids; and routine venipuncture, as defined with the Current Procedural Terminology (CPT) coding system and published by the American Medical Society and as defined within the Healthcare Common Procedural Coding System (HCPCS) and published by CMS.
- This contract **does** ☒ **does not** ☐ have global OB and/or other case rates; if applicable refer to the rate exhibit for details
- The allowable for procedure codes for the Covered Services for which reimbursement has not been established, will be a 50% reduction from billed charges, until such time as the applicable RVUs become available.

<table>
<tr><td>II. Categories of Coverage</td><td>Plan/Product participation includes the following (check all that apply):

<table><tr><td>HMO</td><td>POS</td></tr><tr><td>PPO</td><td>Worker's Compensation</td></tr><tr><td>XYZ Network</td><td>Indemnity</td></tr></table></td></tr>
<tr><td>III. Duration of Contract & Termination</td><td>The Initial Term of the contract is: <u>1 year</u> (amount of time in year[s] and/or months)
The contract is an Evergreen contract: <u>Yes</u> ☒ <u>No</u> ☐
(Evergreen means the contract automatically renews each anniversary date)
This agreement may be terminated <u>with cause</u> or <u>without cause</u> by GREAT HEALTHCARE or Group with 60 days written notification.
Additional details regarding Term and Termination can be found in Section <u>9</u> of your Agreement.</td></tr>
<tr><td>IV. Party responsible for processing claims</td><td>The entity responsible for processing claims for payment is GREAT HEALTHCARE. However, some or all of the administrative functions related to claim processing may be performed by GREAT HEALTHCARE Affiliates or other third parties in the ordinary course of business. Please refer to the back of the member's ID card for information about where claims should be sent for payment.</td></tr>
<tr><td>V. Dispute Resolution</td><td>DISPUTE RESOLUTION.

Cooperation - Provider and Plan will consult and cooperate on a continuing basis with one another in the establishment of mutually acceptable standards and procedures for selection and assignment of Personnel, handling of requests for Covered Services, billing procedures and other matters incidental to the fulfillment of the provisions of this Agreement.

Arbitration - Plan and Provider agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement. Any controversy, dispute or claim arising out of or relating to this Agreement, or the breach hereof, shall be settled by arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association, and judgment on the award by the arbitrator(s) may be entered in any court having jurisdiction thereof.

See Section 5 of your contract for more detail on dispute resolution

See Administrative Guidelines for more details about the process for submitting an Appeal</td></tr>
<tr><td>VI. Order of Addenda</td><td>EXHIBIT I - Description of Services and Specified Rates for Coverage
EXHIBIT II - Practice Demographic Information
EXHIBIT III - Amendments</td></tr>
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EXHIBITS

GREAT HEALTHCARE, INC.

PROFESSIONAL SERVICES AGREEMENT

This Agreement between _____ ("Provider") and Great Healthcare, Inc. ("Plan"), is entered into as of the 1st day of June, 2019 ("Effective Date").

WHEREAS, Plan or Affiliate will operate as a health maintenance organization ("HMO") under the Health Maintenance Organization Act, Article 16, Colorado Insurance Code and the rules and regulations thereunder ("Act"), as well as a managed care organization in the State of Colorado, and will provide or arrange for health care services and perform administrative services for individuals and for employee welfare benefit plans; and

WHEREAS, Payors maintain insurance policies, HMO, preferred provider organization ("PPO") and point of service ("POS") plans or arrangements whereby persons covered by such policies, plans or arrangements are entitled to receive, or are entitled to indemnification or reimbursement of the cost of health care services rendered by health care providers; and are entitled to a higher level of service, payment or reimbursement if they use certain designated health care providers, thereby encouraging the covered person to use the designated providers; and

WHEREAS, Plan maintains contracts with such Payors whereby those Payors are entitled to designate Plan's Contracting Providers as described in the above paragraph. Plan desires to contract with Provider in order to enable Payors to designate Provider. Provider desires to contract with Plan in order to obtain designation from Payors; and

WHEREAS, Provider is engaged in the business of providing those services and/or supplies listed in Exhibit I, or employing qualified individuals ("Personnel") to provide Services; and

WHEREAS, Plan desires to contract with Provider on behalf of Plan and Provider desires to contract with Plan to provide services;

NOW, THEREFORE, in consideration of the premises and the mutual covenants and undertakings hereinafter set forth, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. DEFINITIONS. For purposes of this Agreement:

   (a) "Affiliates" means any entity controlled by or which controls Plan or Provider. Control will mean the right to direct the management of the affairs of the other entity.

   (b) "Agreement" means this Professional Services Agreement by and between Provider and Plan, any Exhibits or amendments thereof, and any applicable state or federal requirements required by law to be incorporated as a part of this Agreement.

(c) "Covered Services" means only care, treatment, prescription drugs and supplies that: 1) are provided by Provider to Members under the care of physicians; 2) are reimbursable under the terms of the Member's contract issued by Plan; and 3) are provided in accordance with the terms of this Agreement. Provision of Covered Services must comply with all utilization review procedures contained in the Provider Handbook.

(d) "Member" means any employee or dependent of an employee who is covered under a group subscriber contract or another contract issued or administered by Plan or Payor.

(e) "Payor" means any self-insured employer, preferred provider organization, health maintenance organization, network organization, insurance company, third party administrator, or any other entity and/or the clients of any of these entities who have been authorized by Plan to designate one or more of Plan's Contracting Providers, who have agreed to provide certain financial incentives for Members to use designated Contracting Providers, and who have financial responsibility for payment of Covered Services.

(f) "Quality Assurance" or "Quality Assurance Program" means the processes and programs established by Plan or Payors to monitor, maintain and improve the quality of care and services provided to Members.

(g) "Utilization Review" or "Utilization Review Program" means the processes or programs administered by Plan or Payors, and contained within the Provider Handbook, with the specific goal of determining whether or not care or treatment meets the requirements of utilization review, prospective review, concurrent review, retrospective review, and/or case management standards established by Plan or Payors.

2. RESPONSIBILITIES OF PROVIDER.

(a) Services. Provider will provide Services to Members upon the request of Plan or Member's physician. Hours of Service, specimen pickups, emergency services, equipment provided to Members or other matters related to the delivery of Services will remain as specified in Exhibit II. Services shall be rendered in the same manner as those services are provided to all other patients or clients of Provider and Provider shall not discriminate against any Members in the provision of Services, including any Member who is also a participant in a publicly financed program. Provider shall not discriminate and shall render Services in a manner which assures availability, adequacy and continuity of care to Members, both during the term of this Agreement and upon termination hereof. Provider shall remain solely responsible for the quality of medical and/or health care services

provided and shall render such services in accordance with generally accepted practice and professionally recognized standards.

(i) The Provider shall: Ensure that Covered Services are available from Provider within a reasonable time from the date of request for Covered Services; be available as appropriate to attend to Member's emergency needs; keep reasonable office hours; and provide coverage by other Providers when Provider is not available.

(ii) If a Member's coverage is terminated other than for nonpayment of premium, fraud, or abuse, Provider shall continue to care for or treat those Members being treated on an in-patient basis until the Member is discharged. Plan or Payor will continue to compensate Provider in accordance with this Agreement and the Fee Schedule then in effect for covered services until the time of such discharge.

(b) Personnel and Provider Criteria. Provider will, in the selection of medical directors, laboratory or imaging directors, general supervisors, technologists and other related Personnel, verify the individual's (i) current license or registration to practice in the state, if appropriate; (ii) professional work experiences; (iii) educational qualifications; and (iv) previous work references and personal character references. The Provider who utilizes the services of individuals physically and directly involved in a patient's care shall, in addition to those items listed above, verify the individual's CPR certification, if applicable.

(i) Provider represents to Plan that at the time this Agreement is entered into it possesses all necessary licenses and or other permits required by federal or state law and that, if possible, it participates in the Medicare program (Title XVIII of the Social Security Act of 1972, as amended), and complies with the rules and regulations thereof. Provider agrees to maintain in good standing all such licenses, certification and accreditation during such period of time as this Agreement is in effect. Plan reserves the right to terminate this Agreement immediately upon notice in writing to Provider if Provider fails to so maintain all licenses, certifications, and accreditations during the period of time this Agreement is in effect.

(c) Personnel Evaluation. Provider will evaluate the qualifications of all Personnel before assignment, will ensure that they maintain such qualifications and will be responsible for maintaining high standards of performance for Covered Services under this Agreement. Provider shall also ensure that the above individuals will comply with the appropriate standards of care for the provision of Covered Services and, if applicable, will participate in the Medicare program (Title XVIII of the Social Security Act of 1972, as amended), and comply with the rules and regulations thereof.

(d) Sub-Contracting. In the event that Provider desires or plans to make arrangements with other health professionals to fulfill Provider's obligations under this Agreement, Provider will obtain prior written consent from Plan. Provider will also obtain written contracts with such health professionals, which will include a provision substantially similar to that contained in Section 6(b) herein, and in which they agree to abide by all the obligations of Provider under this Agreement. Provider must promptly supply to Plan a copy of each executed sub-contract. Provider will remain responsible for the quality of medical and health care services provided by other health professionals pursuant to this Section, and will ensure such services are rendered in accordance with professionally recognized standards.

(i) If Provider is authorized by health care providers to negotiate and execute contracts with Plan on behalf of such providers, it shall include in each and every one of its underlying contracts authorizing said intermediary to negotiate and execute contracts with Plan on behalf of the providers a provision substantially similar to the following:

Each and every contract which Provider negotiates and executes with Plan, on behalf of the providers covered by this intermediary-provider contract, shall contain a provision stating that: 1) No individual or group of providers covered by the contract shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of Plan or an entity representing or working for Plan; 2) Plan or an entity representing or working for Plan shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of an individual or group of providers covered by the contract; and 3) Plan shall not terminate any contract executed by Provider because any individual or group of providers covered by the contract (a) expresses disagreement with a decision by Plan or an entity representing or working for Plan to deny or limit Covered Services to a Member, or (b) assists the Member to seek reconsideration of the Plan's decision, or (c) discusses with a current, former, or prospective Member any aspect of the Member's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the providers' personal knowledge of the health needs of such Members.

(ii) Provider shall cause participating sub-contracting providers to comply with all applicable requirements of C.R.S. section 10-16-701, et seq.

(iii) Provider shall cause participating sub-contracting providers to agree to provide Plan or Payor with access to information necessary for Plan or Payor to monitor the capacity and legal authority of the provider.

(iv) Provider grants Plan the right to approve or disapprove of the inclusion of any and all sub-contracted providers in any network established by Provider, and shall cause all such providers or networks of providers with which Provider contracts to agree that Plan shall have the right to approve or disapprove of the inclusion of any sub-contracting provider in any network which delivers items or services to Members.

(v) Provider shall cause sub-contracting providers to transmit utilization documentation and claim paid documentation to Plan or Payor for purposes of monitoring the timeliness and appropriateness of payments made to participating providers and health care services received by Members.

(vi) In the event of Provider's insolvency, Plan has the right to obtain assignment of portions of Provider's sub-contracting provider agreements related to the sub-contracting provider's obligation to furnish covered services to Members.

(e) Orientation. Provider will ensure that all Personnel have received adequate instruction and training to properly conduct Covered Services. When appropriate, such instruction and training will include explanation and testing on proper use of the specific equipment operated by Provider. Plan shall not be liable for any damage to any equipment of Provider. For Covered Services to be rendered in the homes of Members, Provider will ensure that all Personnel have completed a home-care orientation.

(f) Health Clearance. Provider will ensure that all Personnel providing services to Members are in good health, have obtained a certificate of good health, will obtain pre-employment and periodic physicals, including, but not limited to, a negative tuberculin test and/or chest x-ray.

(g) Payroll Obligations. Provider will maintain sole and direct responsibility for compensation of Personnel, including payment of wages and other compensation, reimbursement of expenses, and compliance with federal, state, and local tax withholding requirements, workers' compensation, social security, unemployment and other obligations imposed on the employer of such Personnel.

(h) Medical and Financial Records. Provider and each of its Personnel will prepare and maintain appropriate financial, billing and medical records of Members. Such records shall be maintained in accordance with generally accepted medical, accounting and bookkeeping practices. Subject to any applicable legal restrictions, Provider and its Personnel agree to allow inspection and duplication by Plan and by any properly identified governmental regulatory authority of all billing and other financial records and all medical records maintained on

Members under this Agreement for the purposes of medical audit, quality assurance, research and for any other appropriate purposes.

(i) Provider agrees to comply with Plan's medical records procedure, to treat Member records as confidential and to comply with all federal and state confidentiality laws. Subject to confidentiality requirements, provider agrees to provide for a system, to the extent feasible, for the sharing of medical records with other treating providers and for making Member medical records available on a timely basis to each provider treating a Member. Provider further agrees, subject to confidentiality requirements, to make medical records available, upon request with reasonable notification, to Plan or governmental regulatory authority for determination that the content and quality are acceptable, as well as for peer review or grievance review. Such inspection and/or duplication of records by Plan shall occur during regular working hours upon receipt of seventy-two (72) hours prior written notice from Plan

(ii) Provider will be responsible for monitoring the quality of documentation maintained by Personnel. The Plan shall have access at all reasonable times upon demand to the books, records and papers of the Provider relating to the health care services provided to Members, to the cost thereof, to payments received by the Provider from Members (or from others on their behalf), and, unless the Provider is compensated on a fee-for-service basis, to the financial condition of the Provider

(iii) Provider will afford Plan opportunity and access to all records, reports, and other documents necessary for Plan to monitor the capacity and legal authority of Provider.

(iv) Plan will protect the confidentiality of such records in accordance with all applicable legal standards.

(v) Consent to Access Members' Medical Records. To the extent required by law, the party requesting access to a Member's medical records shall be required to furnish an appropriate Member consent form in order to obtain access. Provider shall cooperate with Plan an/or governmental authorities in obtaining and maintaining the proper consent forms from Members.

(i) Physician Instructions. Provider shall provide only those Covered Services specified by a Member's physician. Such specifications will not be altered in any way without the written consent of the Member's physician, unless there is an emergency situation such as, but not limited to, a sudden, unexpected episode of illness or an injury which could result in loss of life or serious physical impairment if not treated immediately.

(j) Record Maintenance. All records required to be maintained by the Provider under this Agreement shall be retained by the Provider for at least ten (10) years. The obligation under this section shall not be terminated upon the termination of this Agreement, whether by rescission or otherwise.

(k) Personnel Availability. If, for any reason, Provider is unable to fill a request by Plan for Personnel, Provider agrees to make reasonable efforts to assist Plan in finding an alternative Provider.

(l) Provider Limitations. Provider shall send written notice to Plan of any legal, governmental or other action initiated or consummated against the Provider or Personnel used by Provider, which could materially impair the ability of the Provider or Personnel used by Provider to carry out the duties and obligations of this Agreement, including, but not limited to, actions related to:

(i) Cancellation of the Provider's general and professional liability insurance;

(ii) Provider's suspension from participation in the Medicare or Medicaid program due to fraud or abuse or for any other reason.

(m) Utilization Review and Quality Assurance. Provider shall cooperate fully with Plan's Utilization Review and Quality Assurance Programs or such other Utilization Review and Quality Assurance Programs designated by Plan as set forth in the Provider Handbook. Failure to do so shall be deemed a material breach of this Agreement.

(n) Announcements. Provider agrees that Plan may use the name of Provider for the purpose of carrying out the terms of the Agreement. This includes the distribution of an announcement by Plan to the media that an arrangement has been established between the Plan and Provider.

(o) Plan Post-Termination Responsibilities.

(i) Upon such termination or withdrawal of a Provider, whether by termination of this Agreement or otherwise, the Plan shall continue to be liable to pay in accordance with this Agreement, including the Exhibit I in effect immediately prior to such termination, for Services rendered by Provider under the terms and conditions of this Agreement to any Member who is receiving Services from the Provider at the time of such termination or withdrawal. Provider shall continue to provide such Services until the current episode of Covered Service is completed, unless reasonable and medically appropriate arrangements for the assumption of such Covered Service by another provider are made in accordance with Section 2(p).

(ii) Plan will make a good faith effort to provide written notice, to all Members who receive regular Services from Provider, of the termination of Provider as a Contracting Provider within fifteen (15) days after receipt or issuance of a notice of termination of this Agreement or privileges hereunder. If Plan terminates this Agreement without cause, and if notices of such termination are not timely given by Plan to Members, Provider shall continue to provide Services to Members for sixty (60) days following the date of termination. Plan or Payor shall continue to be liable to pay, in accordance with this Agreement including Exhibit I in effect immediately prior to termination, for Covered Services rendered by Provider during the sixty (60) day period.

(p) Provider Post-Termination Responsibilities.

(i) Upon termination or withdrawal of a Provider, the Provider shall be responsible for making reasonable and medically appropriate arrangements for the assumption by other providers of the services for Members who are under the care of the terminated or withdrawn Provider.

(ii) Provider shall, within five (5) days following receipt or issuance of a notice of termination of this Agreement or privileges hereunder, provide to Plan a list of those Members receiving Services from Provider and who are covered by Plan.

3. RESPONSIBILITIES OF PLAN.

(a) Needs Assessment. When appropriate, Plan will assess and/or coordinate the need for Covered Services to be provided under this Agreement in cooperation with the Member's physician.

(b) Physician's Plan of Treatment. When appropriate, Plan will request from Provider that Personnel be provided for assignment to render designated Covered Services to a Member. These requests will be made in accordance with a Plan of Treatment developed by the Member's physician in cooperation with Plan. Covered Services provided are to be within the scope and limitations set forth in the Plan of Treatment and will not be altered in any way by Provider or Personnel, unless consent is received from the Member's physician and Plan.

(c) Evaluation. In the event that Plan, at the discretion of its designated Medical Director in consultation with the Member's physician, determines Personnel performance to be unacceptable, lacking in medical appropriateness, quality of care or patient acceptance, Plan may request, and Provider shall comply with, the dismissal of individual Personnel from current and future activity for Plan.

(d) Payment. Plan agrees to pay or arrange to pay Provider, in accordance with the provisions of Section 6 of this Agreement, for Covered Services which are approved services under the contract issued by the Plan and under which the affected Member is covered.

(e) Licenses. Plan will comply with all requirements of the law relating to any business in which Plan is engaged relating to this Agreement, and shall obtain and maintain in effect all permits, licenses and governmental approvals necessary for that purpose.

4. MARKETING, ADVERTISING - PUBLICITY.

Plan and Provider, as applicable, each reserve the right to control its subscriber lists, name, symbols, trademarks or service marks presently existing or later established. In addition, neither party shall use the other party's name, symbols, trademarks or service marks in advertising or promotional materials or otherwise without the prior written consent of that party and shall cease any such usage immediately upon written notice from that party or upon termination of this Agreement, whichever is sooner. Provider agrees that Plan may use Provider's name, business address, telephone number and factual description in provider network directories.

5. DISPUTE RESOLUTION.

(a) Cooperation. Provider and Plan will consult and cooperate on a continuing basis with one another in the establishment of mutually acceptable standards and procedures for selection and assignment of Personnel, handling of requests for Covered Services, billing procedures and other matters incidental to the fulfillment of the provisions of this Agreement.

(b) Arbitration. Plan and Provider agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement. Any controversy, dispute or claim arising out of or relating to this Agreement, or the breach hereof, shall be settled by arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association, and judgment on the award by the arbitrator(s) may be entered in any court having jurisdiction thereof.

6. PAYMENT AND BILLING.

(a) Rates. For Covered Services which are approved services under the terms of the contract issued by the Plan and under which the affected Member is covered, the Plan shall pay or arrange to pay Provider, as full compensation for such Covered Services rendered by Provider. Such payment shall be at the rates indicated on Exhibit I attached hereto, minus any applicable deductibles, copayments, coinsurance and non-covered charges. Provider agrees that the payment rate for any particular service offered under this Agreement will not exceed the lowest rate

for that service which Plan may have previously negotiated and agreed upon with Provider, if such other previous agreement continues in force and effect during the term of this Agreement. Plan does not offer nor shall Provider interpret this compensation program to be a financial incentive program that directly compensates a provider for ordering or providing, less than medically necessary and appropriate care to the Members.

(b) Balance Billing.

(i) Provider shall not, under any circumstances, seek or require any Member to tender a deposit or similar payment during the Member's course of treatment, or anytime thereafter, with respect to Services rendered pursuant to this Agreement, other than any applicable deductible, encounter fees, coinsurance or copayments specified in the applicable contract issued by the Plan under which the affected Member is covered. Notwithstanding anything in this Agreement to the contrary, in no event, including, but not limited to, nonpayment by the Plan, the insolvency of the Plan or breach of this Agreement, shall any Member be liable for any amount owing to the Provider by the Plan, and the Provider shall not bill, charge, collect a deposit or other sum, or seek compensation, remuneration or reimbursement from, or maintain any action or have any recourse against, or make any surcharge upon a Member or any person acting on a Member's behalf. Whenever any such charge has occurred, the Provider shall refund such charge to the Member within fifteen (15) days of discovering, or receiving notification of, the charge. If the Plan receives notice of any such charge, the Plan may take appropriate action to remedy the situation, including, without limitation, offsetting any such charge against amounts due to the Provider and/or immediate termination pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments made in accordance with the terms of the Plan.

(ii) The obligations set forth in this Section 6(b) shall survive the termination of this agreement regardless of the cause giving rise to the termination and shall be construed for the benefit of the Members.

(iii) This provision supercedes any oral or written contrary agreement now or existing hereafter entered into between the Provider and Members or persons acting on their behalf insofar as such contrary agreement relates to liability for payment of services provided under the terms and conditions of this Agreement.

(iv) Any modification, addition or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the Commissioner has received written notification of proposed changes.

(c) Payment. Bills and claims for Provider Covered Services shall be sent by Provider to the address on the identification card of the Member or to the address as provided by the Member's physician. In the event this address is not known at the time of billing, claims for services shall be submitted to the address(es) set forth in the Provider Administrative Manual.

(d) Coordination of Benefits. When a party other than Plan or Payor is identified as having primary responsibility for payment of or reimbursement for Covered Services under the Coordination of Benefits provision of a Member's Evidence of Coverage, Provider will bill and make all reasonable efforts to collect from such party for the value of Covered Services. If Plan is other than primary under the coordination of benefits rules, Plan shall arrange to pay only those amounts which, when added to amounts to be received by Provider form other sources, equals up to the Plan's contract rate, less charges for any non-covered services, applicable deductibles, coinsurance and copayment amounts.

(e) Payment Upon Termination. Provider agrees that, upon termination of this Agreement for any reason, it will accept payment from Plan for the Covered Services provided prior to termination, at the rates in effect under this Agreement immediately prior to such termination.

(f) Billing/Payment Information. Provider shall complete the attached Exhibit III regarding Provider location(s), billing address and tax identification number for use by Plan in administering this Agreement.

7. INDEPENDENT CONTRACTOR, LIABILITY, INDEMNITY AND INSURANCE.

(a) Independent Contractors. Provider shall maintain a professional medical relationship with all Members receiving Services. Plan and Provider are independent entities. Nothing in this Agreement shall be construed to create a relationship of employee and employer or principal and agent or any relationship other than that of independent contractors working with each other solely for the purpose of carrying out the provisions of this Agreement.

(b) Liability Insurance. Provider, at its sole expense, agrees to maintain adequate insurance for professional liability and comprehensive general liability, and such other insurance as shall be reasonably adequate to insure Provider and Personnel against any event or loss which may impair the ability of Provider to fulfill its obligations as outlined in this Agreement, including its indemnification obligations. Provider will furnish to Plan evidence of such coverage upon request by Plan. In lieu of such insurance, Provider shall maintain the ability to respond to any and all damages which would be covered by such insurance.

(c) Indemnification.

(i) Provider shall be liable to Plan for all claims, costs, losses, liabilities, and expenses (including reasonable attorneys' fees and related legal expenses) incurred by Plan and arising from or out of any alleged intentional or negligent act or omission of provider, its agents, employees, or assigns in the performance of Provider's obligations under this Agreement.

(ii) Plan shall be liable to Provider for all claims, costs, and expenses incurred by provider arising from or out of the intentional or negligent acts or omissions of Plan, its agents, or employees in the performance of its obligations under this Agreement.

8. NON-EXCLUSIVITY. Nothing herein will be construed to restrict the rights of Group and Group Physicians or Plan to participate in other comparable provider plans, such as, but not limited to, preferred provider plans, health care maintenance organizations or other managed care systems. Nothing herein will be construed to restrict the rights of Plan to enter into contracts or arrangements for services with any other health care provider serving any geographic area.

9. TERM AND TERMINATION.

(a) Term and Termination. The initial term of this Agreement begins on the Effective Date of this Agreement. Thereafter, this Agreement will automatically be renewed for successive one (1) year terms until terminated. This Agreement may be terminated at any time, with or without cause, by either party by notifying the other party in writing at least ninety (90) days prior to such termination date. Notwithstanding the foregoing sentence, Plan may terminate this Agreement immediately upon written notice if it deems there may be any risk to a Member, which risk may be caused directly or indirectly by the actions of Provider or its Personnel.

(b) Service Provision. The terms of this Agreement shall apply to Covered Services that are provided on or after the effective date of this Agreement.

(c) Post-termination Duties. Following the effective date of termination of this Agreement, this Agreement shall be of no further force or effect except that: (1) each party shall remain liable for any obligations or liabilities arising from activities undertaken prior to the effective date of termination; (2) the Plan shall remain liable for payment for all Services rendered prior to the effective date of termination under the terms and conditions of this Agreement and the applicable schedule of Specified Rates described in Exhibit I; and (3) the terms of Sections 2(o) and 2(p) of this Agreement shall apply to Covered Services being rendered by Provider as of the effective date of that termination. For the purposes of this Agreement, Covered Services shall be deemed to have been "rendered" on the date that services or supplies comprising such Covered Services are received by the Member.

10. GENERAL PROVISIONS.

(a) Scope of Agreement; Governing Law; Amendment; Waiver. This Agreement, together with the Exhibits, contains the entire Agreement between Plan and Provider. It shall be construed and governed in accordance with the laws of Colorado. This Agreement may not be modified or amended except by mutual consent in writing by the duly authorized representatives of Plan and Provider. Waiver of breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or a different provision.

(b) Assignment and Sub-contracting. No assignment or sub-contracting of the rights, duties or obligations of this Agreement shall be made by either party without the prior express written approval of a duly authorized representative of the other party; provided, however, that Plan or Payor may assign any or all of its rights and obligations hereunder to an Affiliate.

(c) Attorneys' Fees. In the event that either Plan or Provider institutes any action, suit or arbitration proceeding to enforce the provisions of this Agreement, the prevailing party shall recover costs and reasonable attorneys' fees.

(d) Confidentiality/Records Maintenance. Plan and Provider agree to keep confidential, and to take all reasonable precautions to prevent the unauthorized disclosure of any and all records of the other party required to be prepared and/or maintained by this Agreement.

(e) Good Faith Reporting. Provider shall not be penalized by Plan because Provider, in good faith, reports to state or federal authorities any act or practice by Plan that jeopardizes patient health or welfare, or because Provider discusses the financial incentives or financial arrangements between Provider and Plan.

(f) Disagreement with a Medical Decision. The following provisions shall apply to those situations where a disagreement arises concerning a medical decision:

(i) No individual or group of providers covered by this contract shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of Plan or an entity representing or working for Plan;

(ii) Plan or an entity representing or working for Plan shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of an individual or group of providers covered by this contract; and

(iii) Plan shall not terminate this contract because a provider covered by this contract expresses disagreement with a medical decision by Plan or an entity representing or working for Plan to deny or limit Covered Services to a Member or because the provider assists the Member to seek reconsideration of the Plan's decision, or because a provider discusses with a current, former, or prospective Member any aspect of the Member's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a providers' personal recommendations regarding selection of a health plan based on the provider's personal knowledge of the health need of such Members.

(g) Notices. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing, postage prepaid, and shall be sent by certified mail, return receipt requested, to Provider at the address below, and to Plan at the address below. Any such notice shall be effective on the date indicated on the return receipt.

TO PLAN:

GREAT HEALTHCARE, INC.
1600 Pennsylvania Ave
Washington, DC 90210
Attn: Manager, Provider Relations

TO PROVIDER:

Attn:

(h) Severability. In the event that any court of competent jurisdiction shall determine that any provision, or any portion thereof, contained in this Agreement shall be unreasonable or unenforceable in any respect, then such provision shall be deemed limited to the extent that such court deems it reasonable and enforceable, and as so limited shall remain in full force and effect. In the event that such court shall deem any such provision, or portion thereof, wholly unenforceable, the remaining provisions of this Agreement shall nevertheless remain in full force and effect.

(i) Headings. The headings of the various sections of this Agreement are merely for convenience and do not, expressly or by implication, limit, define, or extend the terms of the sections to which they apply.

(j) Entire Contract. This Agreement and attachments constitute the entire contract between each Plan and Provider regarding the provision of Covered Services to Members. Any agreements, promises, negotiations or representations not

expressly set forth in this Agreement are of no force or effect. This Agreement may be executed in any number of counterparts, each of which will be deemed to be the original.

(k) Interpretation. The parties hereto acknowledge and agree that (i) each party has reviewed the terms and provisions of this Agreement; (ii) the rule of construction to the effect that any ambiguities are resolved against the drafting party shall not be employed in the interpretation of this Agreement; and (iii) the terms and provisions of this Agreement shall be construed fairly as to all parties hereto and not in favor of or against any party, regardless of which party was generally responsible for the preparation of this Agreement.

(l) Amendments. This Agreement is subject to the amendments as found in Exhibit IV. The parties agree to comply with any and all provisions in Exhibit IV and further agree that, in the event of any conflict between the provisions in Exhibit IV and any provisions elsewhere in this Agreement, the provisions in Exhibit IV shall take precedence. No amendment or modification will be effective unless made in writing and signed by both parties. All amendments required by the Colorado Division of Insurance or federal laws or regulations will be deemed effective upon receipt by the Provider from the Plan and incorporated into and made part of this Agreement without either party's execution.

(m) Third Party Liability. Nothing in this Agreement shall be construed to make Plan or Provider, or their respective agents or representatives, liable to persons not parties hereto. Nor shall anything herein be construed as, or be deemed to create, any rights or remedies in any third party, including, but not limited to, any Members.

(n) Replacement of Other Contracts. This Agreement supersedes any and all prior agreements, either oral or in writing, between the parties relating to the provision of health care services to Members. This Agreement also supersedes any and all prior agreements, either oral or in writing, between Provider and Private Health Care Systems which were negotiated on behalf of Great Annuity Insurance Company and/or The New Jersey Turnpike. Provider hereby agrees to indemnify Plan and hold it harmless from and against any and all losses (including reasonable attorneys' fees and related legal expenses) arising from any claim, action, cause of action, contest or dispute brought by Private Health Care, The New Jersey Turnpike or Great Annuity Insurance Company against the Plan. This provision shall survive the termination of this Agreement.

(m) Change in Law or Programs. In the event there is a change in federal or state laws, or regulations governing the delivery of medical care by physicians, such that the provision of any services or the payment of any compensation or benefits pursuant to this Agreement would violate applicable law, regulations, or governmental policy, or impose unreasonable burdens on either party not existing

on the date of this Agreement, Plan and Provider agree to negotiate in good faith to restructure their relationship to comply with any such change. If any such restructuring is not feasible, either party may terminate this Agreement upon written notice thereof, notwithstanding any other provision of this Agreement.

IN WITNESS HEREOF, the Parties have executed this Agreement through a duly authorized officer as of the date noted below.

PROVIDER:

By: _____

Print Name: _____

Title: _____

Date: _____

PLAN: GREAT HEALTHCARE

By: _____

Print Name: Todd Welter

Title: President, Provider Network Management and Contracting

Date: _____

EXHIBIT I

Description of Services and Specified Rates for Coverage

The Plan shall pay or arrange to pay the Provider, as full compensation, the lesser of the Provider's usual charge or the Specified Rates for Services rendered by Provider, minus any applicable deductibles, copayments, coinsurance and non-covered charges.

Payment Rates:

Rates have been excluded on purpose.

Refer back to Chapter 3 for more information on how to calculate contracted reimbursement.

EXHIBIT II

Practice Tax I.D./Name	Service Location Phone #	Billing Address

EXHIBIT III

Amendments

The terms and conditions specified in the Great Healthcare, Inc. Professional Services Agreement are further subject to the amendments put forth herein as Exhibit III.

PROVIDER:

By: _____

Print Name: _____

Title: _____

Date: _____

PLAN: GREAT HEALTHCARE**,** INC.

By: _____

Print Name: Todd Welter

Title: President, Provider Network Management and Contracting

Date: _____