QUALCARE
PROVIDER NETWORK
PARTICIPATION AGREEMENT

This Agreement (the "**Agreement**") is made and entered into this ____ day of _____, 20___, (the "**Effective Date**") by and between QualCare, Inc., (hereinafter "**QualCare**") and _____ (hereinafter "**Physician**").

WITNESSETH:

WHEREAS, QualCare is a New Jersey business corporation certified as an organized delivery system ("**ODS**") that arranges for the provision of Covered Services (hereinafter defined) to Members (hereinafter defined) under a Payor's Health Benefits Plan (hereinafter defined) through a contracted network of providers (the "**Network**"); and

WHEREAS, Physician is a doctor of medicine or osteopathy who is duly licensed to practice medicine in the applicable jurisdiction where Covered Services will be furnished hereunder; and

WHEREAS, Physician desires to become a Participating Provider (hereinafter defined) of the applicable Network and desires to provide or arrange for the provision of Covered Services to Members of the applicable Payor's Health Benefits Plan in return for reimbursement in accordance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the premises and the mutual promises, covenants and conditions herein contained and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

ARTICLE 1

DEFINITIONS

"Adverse Benefit Determination" means a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because the Carrier determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the Carrier has rescinded the coverage.

"Authorization" or "Authorize" means a determination required under the applicable **Health Benefits Plan** that, based on the information provided, a service or supply satisfies the requirements under the **Member**'s **Plan** for **Medical Necessity**.

"Carrier" means an insurance company authorized to transact the business of insurance in New Jersey and doing health insurance business in accordance with N.J.S.A. 17B:17-1 et seq., a hospital service corporation authorized to transact business in accordance with N.J.S.A. 17:48-1, et seq., a medical service corporation authorized to transact business in accordance with N.J.S.A. 17:48A-1, et seq., a health service corporation authorized to transact business in accordance with N.J.S.A. 17:48E-1, et seq., or a health maintenance organization authorized to transact business pursuant to N.J.S.A. 26:2J-1, et seq.

"Clean Claim" means the claim is for a service or supply covered by the Health Benefits Plan that has been delivered to the proper billing address and has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that otherwise prevents timely payment being made on the claim. Providers shall be entitled to reimbursement on "Clean Claims" if: (a) The health care provider is eligible at the date of service; (b) The **Member** who received the health care service was covered on the date of service; (c) The claim is for a service or supply covered under the **Health Benefits Plan**; (d) The claim is submitted with all the information requested by the **Payor** on the claim form or in other instructions that were distributed in advance to the health care provider or **Member** in accordance with the provisions of section 4 of P.L.2005, c.352 (C.17B:30-51); and (e) The **Payor** has no reason to believe that the claim has been submitted fraudulently.

"Co-Insurance" means the percentage of the payment for **Covered Services** for which the **Member** is responsible under the applicable **Health Benefits Plan**, after the **Deductible** is satisfied.

"Coordination of Benefits" or "COB" means the administrative rules for avoiding the duplication of benefits when a **Member** is covered by more than one **Health Benefits Plan** and for determining the order in which the **Plans** pay their claims.

"Co-Payment" is a cost sharing arrangement in which the **Member** is required to pay a specified dollar amount for specified **Covered Services**, such as an office visit, out-patient visit, or emergency room visit, usually paid at the time of service.

"Covered Services" means, with respect to **Health Benefits Plans**, Medically Necessary services or supplies provided to a **Member** under the applicable **Health Benefits Plan** for which the Payor is obligated to pay benefits or provide services.

"Deductible" means the amount under a **Health Benefits Plan** that a **Member** must pay out-of-pocket before the **Plan** begins to pay for **Covered Services**.

"DOBI" means the New Jersey Department of Banking and Insurance.

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of

substance abuse such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an **Emergency** exists where: there is inadequate time to effectuate a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

"Generally Accepted Standards of Medical Practice" means standards that are based on: credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; physician and health care provider specialty society recommendations; and the views of physicians and health care providers practicing in relevant clinical areas.

"Health Benefits Plan" or "Plan" means a policy or contract for the payment of benefits for hospital and medical expenses or the provision of hospital and medical services delivered or issued for delivery in New Jersey by an applicable **Payor**.

"Hospital Services" means those **Emergency**, in-patient, out-patient, or other health care facility services which are generally and customarily provided to patients by or through a hospital.

"Material Change" means any change or amendment taken by QualCare or **Payor**, as applicable, that could reasonably be expected to have a material adverse impact on either the aggregate level of reimbursement to Physician or the administrative expenses incurred by Physician in complying with such change or amendment.

"Medical Necessity" or "Medically Necessary" means or describes a health care service that a **Provider**, exercising his/her/its prudent clinical judgment, would provide to a **Member** for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with **Generally Accepted Standards of Medical Practice**; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the **Member**'s illness, injury or disease; not primarily for the convenience of the **Member** or the **Provider**; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that **Member's** illness, injury or disease.

"Member" or "Members" means a person or persons who is/are enrolled in a **Health Benefits Plan**, including enrolled dependents, and who is or are eligible to receive **Covered Services** under the terms of the applicable **Plan**.

"Participating Hospital" means a general acute care facility licensed by the Commissioner of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), including rehabilitation, psychiatric and long-term acute facilities, that has entered into an agreement with QualCare to provide **Covered Services** to **Members**.

"Participating Physician" means a physician licensed pursuant to Title 45 of the New Jersey Revised **Statutes**, who has entered into an agreement with QualCare to provide **Covered Services** to **Members**, and who has privileges to admit patients to the acute care facilities of at least one Participating Hospital, if necessary or required.

"Participating Provider" means a Participating Hospital, Participating Physician and/or another health care provider that, under a contract with QualCare, has agreed to provide **Covered Services** or supplies to **Members** for a predetermined fee or set of fees.

"Payor" means a **Carrier**, third party administrator, or self-funded plan that is contractually obligated under the applicable **Health Benefits Plan** to make payment on behalf of **Members** with respect to **Covered Services**.

"Payor Agreement" means the contract between **Payor** and QualCare for the purpose of making available, through the applicable provider network, **Covered Services**.

"Provider" means any physician, other health care professional, hospital, health care facility, or any other person or entity who is licensed, certified, or otherwise authorized to provide health care or other services within the scope of his/her/its license, certification, or authorization in the state or jurisdiction in which the services are furnished.

"Quality Management" or "QM" means the process of measuring, evaluating and improving the provision of quality medical services, procedures and facilities to **Members**.

"Urgently Needed Services" means services for a non-life-threatening condition that requires care by a provider within twenty-four (24) hours.

"Utilization Management" or "UM" means a system for reviewing the appropriate and efficient allocation of health care services under a **Health Benefits Plan** according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a **Member** should or will be reimbursed, covered, paid for, or otherwise provided under the **Plan**. The system may include: pre-admission certification, the application of practice guidelines, continued stay review, discharge planning, pre-authorization of ambulatory care procedures, and retrospective review.

ARTICLE 2

RELATIONSHIP OF THE PARTIES

2.1 Independent Contractors. The parties hereto are independent contracting parties, and none of the provisions of this Agreement are intended to create or shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effectuating the terms and conditions of this Agreement. The Payor is a third party beneficiary of this Agreement with privity of contract and the right to enforce its terms and conditions if QualCare fails to do so.

2.2 Non-Exclusivity. Each party hereto shall be bound by, comply with, and perform, in a timely, competent, and professional manner, all of its/his/her duties and obligations under this

Agreement. Notwithstanding the foregoing, each party hereto may contract with any third-party with respect to identical or similar services or arrangements without being deemed in breach of this Agreement so long as such contract does not materially interfere with or prevent the party hereto from fulfilling its/his/her duties and obligations under this Agreement.

2.3 Rights of the Parties. Except as may be expressly provided herein, including without limitation as provided in **Section 2.1** above, or otherwise required by applicable law, rule, or regulation, this Agreement: (a) is not intended to confer any rights or remedies on, or bind or inure to the benefit of, any third-parties other than the parties to this Agreement and their respective heirs, personal representatives, executors, administrators, successors and assigns; (b) is not intended to relieve or discharge the duty, obligation, or liability of any third-parties to any party to this Agreement; and (c) is not intended to give any third-parties any right of subrogation or action over against any party to this Agreement.

ARTICLE 3

REPRESENTATIONS AND WARRANTIES

3.1 Representations and Warranties of QualCare. During the Term (hereinafter defined) of this Agreement, QualCare represents and warrants that it is duly formed as a New Jersey for-profit business corporation, is validly existing and operating, and is in good standing under the laws of the State of the New Jersey. QualCare shall provide notice of any change in any of the foregoing during the Term of this Agreement.

3.2 Representations and Warranties of Physician. During the Term of this Agreement, Participating Provider represents and warrants that he/she:

3.2.1 is duly licensed, certified, or authorized to practice his/her profession without restriction or limitation within the applicable jurisdiction where Covered Services will be furnished hereunder; and

3.2.2 is board certified or board eligible in his/her specialty area(s) of practice; and

3.2.3 is a member in good standing of the medical staff of at least one Participating Hospital and has privileges at such Participating Hospital within his/her specialty area(s) of practice, as may be required; and

3.2.4 has the necessary professional competence, educational training, and skills necessary to provide Covered Services; and

3.2.5 has in effect a currently valid policy of general and professional liability insurance in accordance with this Agreement; and

3.2.6 is in compliance with all applicable federal, state and local laws, rules, and regulations related to the practice of his/her profession or the provision of health care services, as well as with QualCare's Provider Manual (the "**Provider Manual**"), a copy of which has been provided and is incorporated herein; and

3.2.7 is in good standing and is eligible to participate in various programs as well as is in compliance with all standards for credentialing, re-credentialing, and privileges, as set forth in the Provider Manual; and

3.2.8 has not had his/her license, certification, or authorization to practice his/her profession, his/her membership, his/her clinical privileges, or his/her ability to participate in Medicare, Medicaid, or any other federal, state, or local government program suspended, terminated, revoked, not renewed, or otherwise limited; and

3.2.9 acknowledges and agrees that QualCare may negotiate with Payors and enter into additional Payor Agreements for the provision of Covered Services to applicable Members in accordance with this Agreement; and

3.2.10 acknowledges that QualCare does not provide, directly or indirectly, any health care services and that QualCare only arranges for the provision of health care services specified in this Agreement; and

3.2.11 acknowledges and agrees that QualCare shall not be obligated to perform or be liable for the performance of any Covered Services required to be performed by Participating Provider pursuant to any Payor Agreement; and

3.2.12 has identified on the signature page all tax identification number(s) under which Physician will submit claims for Covered Services rendered on behalf of Members hereunder.

Participating Provider shall provide QualCare with at least five (5) business days', or such other period as may be required by applicable law, rule, or regulation, prior written notice of any change in any of the foregoing during the Term. Moreover, upon request, Participating Provider shall provide QualCare with evidence of such licenses, certifications, or authorizations or any other documentation verifying his/her compliance with any of the foregoing. Any untrue representation or warranty or any default, breach, or other failure of any representation or warranty hereunder shall constitute a material breach of this Agreement.

ARTICLE 4

DUTIES AND OBLIGATIONS OF QUALCARE

4.1 Provider Network. QualCare shall maintain an organized delivery system comprised of hospitals, physicians, health care professionals, and other providers for the purpose of coordinating and arranging for the delivery, through such Network, health care services to Members. QualCare shall have the authority to enter into contractual arrangements with Payors for the purpose of making available, through such Network, Participating Provider's delivery of Covered Services to Members.

4.2 Payor Agreements. QualCare shall assist Participating Provider and Participating Provider's office staff in being informed of Participating Provider's duties and obligations under any applicable agreement between QualCare and any Payor.

4.3 Policies and Procedures; Provider Manual. QualCare and/or the applicable Payor shall establish policies and procedures, including but not limited to, UM and QM programs, credentialing, re-credentialing, and privileges standards, grievance and appeals procedures, and administrative procedures, as may be set forth in QualCare's Provider Manual, as may be amended from time to time. To the extent that QualCare is responsible for providing UM or QM programs, QualCare shall establish appropriate medical committees to assure effective utilization and quality of care for Members. Such medical committees will assist QualCare in the development, implementation, and administration of QualCare's UM and QM programs.

4.4 Provider Listing. Upon receipt of the necessary information from Participating Provider, QualCare shall ensure that Participating Provider's name and address are included in the listing of participating providers with the applicable Payor and shall make available lists of participating providers to Members of the applicable Payor's Health Benefits Plan.

4.5 Member Identification Cards; Verification. QualCare shall assist Payor in providing each of its Members with an identification card that indicates his/her enrollment in Payor's Health Benefits Plan. This identification card shall include the QualCare logo, a description of the network to be accessed, the applicable telephone number(s) for eligibility, benefits and UM questions, the Payor identification number, and other information as may be required by the applicable Payor.

4.6 Delegation. In accordance with applicable law, rule, or regulation, QualCare may delegate some or all of its rights, duties, and obligations hereunder to any third-party.

4.7 No Liability for Covered Services. QualCare shall not be obligated to perform or be liable for the performance of any Covered Services required to be performed by Participating Provider Physician pursuant to any Payor Agreement. QualCare shall not be liable for any payment of any claims for furnishing Covered Services to Members, and QualCare shall not be an insurer, guarantor, or underwriter of the responsibility or liability of any Payor to provide benefits pursuant to any Health Benefits Plan.

ARTICLE 5

DUTIES AND OBLIGATIONS OF PARTICIPATING PROVIDER

5.1 Patient-Provider Relationship. Participating Provider shall be solely responsible for all decisions regarding medical care provided to Members, and the traditional relationship between Provider and patient shall in no way be affected by any of the terms and conditions of this Agreement, including without limitation Provider's acting as an advocate for the patient in seeking appropriate and Medically Necessary health care services. Participating Provider shall have the right to communicate openly with Members with respect to all appropriate diagnostic and treatment options, including without limitation alternative medications, regardless of coverage limitations.

5.2 Non-Recourse. This Agreement shall not be terminated and Participating Provider shall not be penalized solely for: (a) acting as an advocate for a Member seeking appropriate Medically Necessary health care services under the Member's Health Benefits Plan; (b) communicating with

Members with respect to all appropriate diagnostic and treatment options, including without limitation alternative medications, regardless of coverage limitations; (c) exercising Participating Provider's right to file a complaint or appeal, in accordance with the procedures set forth in this Agreement or the Provider Manual; or (d) participating in a hearing relative to a Member's termination or a Member's health care services.

5.3 Non-Discrimination. Participating Provider shall not differentiate or discriminate in the provision of Covered Services to Members because of race, color, national origin, ancestry, religion, sex, marital status, age, sexual orientation, genetic or hereditary information, or on the basis that Members are enrolled in a Payor's Health Benefits Plan, and agrees to render Covered Services in the same manner, in accordance with the same standards, and within the same availability as offered to Participating Provider's other patients.

5.4 Enrollment Verification. Participating Provider shall be responsible for verifying an individual's enrollment under the applicable Health Benefits Plan. An individual's possession or presentment of an identification card does not guarantee such individual's enrollment in an applicable Plan. Moreover, Participating Provider's verification of such enrollment shall not necessarily indicate that any health services being provided by Participating Provider are Medically Necessary or are Covered Services.

5.5 Provision of Covered Services. Participating Provider agrees to and shall participate in all Health Benefits Plans as may be required by QualCare hereunder. Participating Provider agrees to and shall provide, and arrange for the provision of, Covered Services, including without limitation Emergency services and Urgently Needed Services, as applicable, to Members pursuant to such Plans, pursuant to such Payor Agreements entered into between QualCare and the applicable Payors, pursuant to this Agreement, and pursuant to the Provider Manual, and shall comply with, and shall arrange for compliance with, all of the terms and conditions of each Payor Agreement, this Agreement, and the Provider Manual; provided, however, that the Payor Agreement, this Agreement, or the Provider Manual shall not require Participating Provider to provide services, charge a fee, or engage in activities that would cause Participating Provider to be in violation of any applicable law, rule, or regulation. Such Covered Services shall be within the Participating Provider's license, certification, and authorization as well as scope of service or specialty, consistent with standards prevailing in the community at the time the Covered Services are rendered.

5.6 No Financial Incentives. No financial incentives are being provided or received for the withholding of Medically Necessary Covered Services..

5.7 Records, Personnel, Equipment, and Facilities. Participating Provider shall maintain adequate and appropriate records, personnel, equipment, and facilities to enable Participating Provider to provide care recognized as being generally acceptable within the Participating Provider's scope of services or specialty and meeting the requirements under this Agreement. Participating Provider's personnel, equipment, and facilities shall be licensed, certified, or authorized to the extent required by law, rule, or regulation.

5.8 Inspections. Participating Provider shall permit (a) QualCare, the applicable Payor, and their representatives upon reasonable notice and during regular business hours, as well as (b) any

applicable federal, state, or local governmental agency, including without limitation the United States Department of Health and Human Services, the New Jersey Department of Banking and Insurance, and the New Jersey Department of Health and Senior Services, to monitor, inspect, and otherwise evaluate Participating Provider's health care services, records, personnel, equipment, and facilities and to review the scope of services provided to Members, subject to any applicable restrictions under applicable law, rule, or regulation. If conducted by QualCare, the applicable Payor, or their representatives, such monitoring, inspection, or evaluation shall not unreasonably interfere with the Participating Provider's ordinary course of business. To the extent such monitoring, inspection, or evaluation is performed by any applicable federal, state, or local governmental agency, Participating Provider shall provide QualCare with notice or copies of any communications received from or provided to such governmental agency.

5.9 Communications. Participating Provider shall engage in timely, good faith, and appropriate communications with, and make available such documents and information to, QualCare and Payor, as applicable, so that each may perform its duties and responsibilities efficiently and effectively for the benefit of Members under the applicable Health Benefits Plan.

5.10 Compliance and Cooperation:

5.10.1 Participating Provider shall comply and cooperate with all of policies and procedures set forth in this Agreement and the Provider Manual, as may be amended from time to time, including without limitation the UM and QM programs, credentialing, re-credentialing, and privileges standards, grievance and appeals procedures, and administrative procedures, all of which are incorporated herein by reference.

5.10.2 Participating Provider shall comply and cooperate with QualCare or the applicable Payor to resolve complaints, grievances, or claims of Members. Such compliance and cooperation shall include without limitation the prompt and accurate reporting to QualCare or to the applicable Payor of any complaints, grievances, or claims registered against Participating Provider by Member and assisting QualCare or the applicable Payor in its investigation of any such complaints, grievances or claims.

5.10.3 Participating Provider shall comply and cooperate with QualCare in the performance of any activities required by any public or private accrediting body for the accreditation or certification of QualCare. Such compliance and cooperation shall include without limitation completing provider applications and providing documents and information required by such accrediting body for the accrediting of QualCare.

5.11 Notice of Changes. Participating Provider shall provide QualCare with at least thirty (30) days advanced written notice, or otherwise use its/his/her best efforts to provide such written notice, in the event of any change in the Participating Provider's status, including without limitation changes to Participating Provider's tax identification number(s), and/or changes or limitations on new patients, office hours, office locations, and scope of services.

5.12 Coverage. Participating Provider shall provide or arrange for twenty-four (24) hour per day/seven (7) days per week Emergency and Urgently Needed Services to Members. Participating Provider shall maintain a minimum of ten (10) office hours per week, per office, and shall ensure

that all requests for routine appointments are honored within two (2) weeks, physical examinations are honored within four (4) months, and Urgently Needed Services are honored within twenty-four (24) hours of a Member's request for same. If Participating Provider arranges for coverage with a non-Participating Provider, such arrangements shall provide that the covering provider shall bill the Member's Health Benefits Plan directly and that the covering provider shall accept payments made in accordance with this Agreement as payment in full for Covered Services and otherwise abide by the terms and conditions of this Agreement, as applicable.

5.13 Non-Participating Providers. Participating Provider acknowledges and agrees that a Member may not receive the maximum benefits under his/her Health Benefits Plan if he/she is referred or admitted to a non-Participating Provider. When a Referral is required:

5.13.1 Participating Provider shall refer Member to other Participating Providers unless such Participating Provider determines it would be medically inappropriate to do so or in the event the required medical services are not available through other Participating Providers. In the event Participating Provider engages in a pattern of referring Members to out-of-network or non-participating Providers, QualCare may terminate this Agreement in accordance with **Article 10**.

5.13.2 Participating Provider shall admit Member requiring Hospital Services to Participating Hospitals unless the necessary Hospital Services are not available at a Participating Hospital or in the case of an Emergency. Participating Provider shall obtain an appropriate Authorization prior to admitting any Member to a hospital, except in the case of an Emergency. In cases where an Emergency admission is required, Participating Provider shall notify QualCare or its designee of such Emergency admission within forty-eight (48) hours of such Emergency admission or the next business day, whichever is later.

ARTICLE 6

UTILIZATION MANAGEMENT AND QUALITY MANAGEMENT

6.1 Establishment. QualCare or Payor, as applicable, or its representative shall establish UM and QM programs to review and monitor the quality, Medical Necessity, and appropriateness of Covered Services furnished by Participating Provider on an inpatient and outpatient basis. To the extent that QualCare is responsible for establishing UM or QM programs, QualCare shall establish appropriate medical committees to assure effective utilization and quality of care for Members and a multidisciplinary committee for continuous quality improvement (CQI) to monitor the quality of the UM program. Such committees will assist QualCare in the development, implementation, administration, and monitoring of QualCare's UM and QM programs, as applicable.

6.2 On-Site and Peer Review Activities. Upon reasonable notice and during regular business hours, Participating Provider shall allow QualCare or Payor, as applicable, to conduct on-site UM or QM activities as well as allow access to medical records of the Members in connection thereto. Such activities shall not unreasonably interfere with the Participating Provider's ordinary course of business. Participating Provider agrees to use its/his/her best efforts in implementing peer review and in complying, and ensuring and causing compliance, with all credentialing, re-credentialing, and privileges requirements for providing Covered Services to Members.

Participating Provider further agrees to cooperate in QualCare's or Payor's, as applicable, credentialing, re-credentialing, and privileges programs.

6.3 Participation and Compliance:

6.3.1 Participating Provider shall, in good faith: (a) participate in UM and QM programs established by QualCare or Payor, as applicable; (b) submit and participate in performance reviews by QualCare or Payor, as applicable; and (c) provide access to all pertinent documents and information necessary for QualCare or Payor, as applicable, to perform its UM and QM programs and administrative functions.

6.3.2 Participating Provider shall be bound by, comply with, and perform under, subject to Participating Provider's right of complaint and appeal hereunder, the UM and QM programs established by QualCare or Payor, as applicable. Participating Provider acknowledges and agrees that:

a. Adverse Benefit Determinations of the UM and QM committee may be used to deny or reduce payment for those Covered Services provided to Members. A Member may not be billed for the amount of any such payment that is so denied. Reimbursement will not be denied retroactively for a Covered Service provided to a Member where Participating Provider relied upon the written or oral Authorization of QualCare or Payor, as applicable, prior to providing services to the Member, except in cases of misrepresentation or fraud, or in cases of Member ineligibility under the applicable Plan.

b. Adverse Benefit Determinations made under the UM and QM programs are for purposes of determining whether services are Covered Services under the terms and conditions of the applicable Health Benefits Plan and the extent to which benefit payments will be made. Unless otherwise expressly set forth below, Adverse Benefit Determinations shall be made as required by the exigencies of the situation – within seventy two (72) hours of receipt of a claim for Urgently Needed Services, within fifteen (15) days of receipt of a claim for all other non-Urgently Needed Services, such as pre-authorizations, and within thirty (30) days of receipt of a post-service claim. Adverse Benefit Determinations shall be provided within two (2) business days. Such Adverse Benefit Determinations shall in no way affect the responsibility of Participating Provider to provide appropriate services to Members.

c. Failure to comply with any requirements of the UM or QM programs may be deemed by QualCare to be a material breach of this Agreement and may constitute additional grounds for termination of this Agreement.

6.4 Internal and External Appeals Under Applicable Carrier's Health Benefits Plan. The following provision shall apply only to applicable Carriers in accordance with the terms, conditions, policies, and procedures of such Carrier's Health Benefits Plan, as may be required by applicable law, rule, or regulation.

6.4.1 Participating Provider, acting on behalf of the Member with the Member's consent, may appeal any Adverse Benefit Determination resulting in a denial, termination, or

limitation of services or the payment of benefits therefor under the applicable internal appeal processes of Carrier.

a. For group and individual Plans, under a stage 1 internal appeal, Participating Provider, acting on behalf of the Member with the Member's consent, shall have the right to speak, regarding an Adverse Benefit Determination, with the Carrier's medical director, or the medical director's designee who rendered the Adverse Benefit Determination. Stage 1 appeals shall be concluded as required by the exigencies of the situation – within seventy-two (72) hours of receipt of the stage 1 appeal for any Urgently Needed Services, Emergency services, admissions, availability of care, continued stay and health care services for which the Member received Emergency services but has not been discharged from a facility, or within ten (10) calendar days in the case of all other stage 1 appeals. As applicable, at the conclusion of a stage 1 internal appeal, Carrier shall include a written explanation of the right to a further internal or external appeal, including the applicable time limits, if any, for making the appeal, and to whom the appeal should be addressed.

b. For group Plans, under a stage 2 internal appeal, Participating Provider, acting on behalf of the Member with the Member's consent, shall have the right to pursue his/her/its appeal before a panel of physicians and/or other providers selected by Carrier who have not been involved in Adverse Benefit Determination at issue. Stage 2 appeals shall be concluded as required by the exigencies of the situation – within seventy-two (72) hours of receipt of the stage 2 appeal for any Urgently Needed Services, Emergency services, admissions, availability of care, continued stay and health care services for which the Member received Emergency services but has not been discharged from a facility, or within twenty (20) business days in the case of all other stage 2 appeals. As applicable, at the conclusion of a stage 2 internal appeal, Carrier shall include a written explanation of the right to a further external appeal, including the applicable time limits, if any, for making the appeal, and to whom the appeal should be addressed.

6.4.2 External Appeals. Participating Provider acting on behalf of a Member with the Member's consent, may appeal a final internal Adverse Benefit Determination, except where the final internal Adverse Benefit Determination was based on eligibility, including rescission, or the application of a contract exclusion or limitation not related to Medical Necessity, through the Independent Health Care Appeals Program to an independent utilization review organization ("**IURO**"). Any stage 3 external appeal through the Independent Health Care Appeals Program must be filed within four (4) months of receipt of the final internal Adverse Benefit Determination. The external appeal request shall be filed on the forms provided in accordance with N.J.A.C. 11:24A-3.5(k)4 and mailed to the Department of Banking and Insurance, Consumer Protection Services, Office of Managed Care, P.O. Box 329, Trenton, New Jersey 08625-0329.

ARTICLE 7

CLAIMS PROCESSING, APPEALS AND REIMBURSEMENT

7.1 Payment for Covered Services. QualCare's Network fee schedule is attached hereto as **Exhibit A** and incorporated herein by this reference. Participating Provider agrees to bill the applicable Payor the usual and customary charges that such Participating Provider bills other

commercial third party payors and agrees to accept from the applicable Payor as payment in full for Covered Services rendered to Members the lesser of eighty percent (80%) of such Participating Provider's usual and customary billed charges or the fee listed on QualCare's Network fee schedule, less any applicable Co-Payments, Co-Insurance and Deductibles and less any amounts payable by another third party payor under the Coordination of Benefits provisions. Overpayments may be recovered by QualCare or the Payor, as applicable, in accordance with applicable federal and state laws, rules, and regulations, as well as with QualCare's and/or the Payor's policies and procedures, as applicable and as may be amended from time to time.

7.2 Submission of Claims. Participating Provider shall use standard claim forms adopted by DOBI to submit Clean Claims for Covered Services; except that, at the Member's option, the Member may file the Clean Claim on his/her behalf. In the event Member has assigned his/her benefits to the Participating Provider, the Participating Provider shall file the Clean Claim within one hundred eighty (180) days of the last date of service for a course of treatment. Any Clean Claim not filed within one hundred eighty (180) days of the last date of service for a course of treatment will not be eligible for payment. Participating Provider agrees that, consistent with accepted standards prevailing in the community, Payor shall have the right to determine the accuracy of all claims submitted, including without limitation verification of diagnostic codes, procedure codes, and other such elements of the submitted claim that affect the liability of Payor. Provider shall have the right to appeal such determination through the internal payment appeal and state sponsored binding arbitration appeal processes. Participating Provider agrees to look solely to Payor for payment of Covered Services provided by the Participating Provider to Members and further agrees not to bill Members for any amounts that are in dispute resulting from Payor's determination of its payment liability to Participating Provider, and Participating Provider shall be prohibited from seeking any payment directly from the Member for any amounts that may be in dispute.

7.3 Coordination of Benefits. Pursuant to N.J.A.C. 11:4-28 et seq., Participating Provider agrees to cooperate fully with and provide assistance to Payor for the purpose of Coordination of Benefits ("**COB**") with respect to other entities that are primary payors or otherwise have payment responsibility for services or supplies furnished to Members. COB payments shall be processed consistent with the following examples:

7.3.1 Where both the primary and secondary Plans pay Provider on the basis of contractual fee schedules and Provider furnishes services or supplies and is a participating provider of the primary and secondary Plans, the allowable expense shall be considered to be the contractual fee of the primary Plan. The primary Plan shall pay the benefit it would have paid without regard to the existence of other coverage, and the secondary Plan shall pay any deductible, coinsurance or co-payment for which the Member is liable up to the amount the secondary Plan would have been required to pay if primary and provided that the total amount received by the Provider from the primary Plan, the secondary Plan and the Member does not exceed the contractual fee of the primary Plan. In no event shall the Member be responsible for any payment in excess of the co-payment, coinsurance or deductible for the secondary Plan.

7.3.2 Where the primary Plan pays a benefit on the basis of the usual and customary rate ("**UCR**"), and the secondary Plan pays on the basis of a contractual fee schedule, and Provider furnishes services or supplies and is a participating provider of the secondary Plan, the primary

Plan shall pay the benefit it would have paid without regard to the existence of other coverage. The secondary Plan shall pay the difference between the Provider's billed charges and the benefit paid by the primary Plan up to the amount the secondary Plan would have paid if primary. The payment of the secondary Plan shall be applied first toward satisfaction of the Member's liability for any co-payment, coinsurance or deductible of the primary Plan. The Member shall only be liable for the co-payment, deductible and coinsurance under the secondary Plan if the Member has no liability for a co-payment, coinsurance or deductible under the primary Plan and the total payments by both the primary and secondary Plans are less than the Provider's billed charges. The Member shall not be liable for any billed charges in excess of the sum of the benefits paid by the primary Plan, the benefits paid by the secondary Plan, and the co-payment, deductible or coinsurance paid by the Member under either the primary or the secondary Plans. In no event shall Member be responsible for any payment in excess of the co-payment, coinsurance or deductible of the secondary Plan.

7.3.3 Where the primary Plan pays Provider on the basis of a contractual fee schedule, and the secondary Plan pays for the particular benefit on the basis of the UCR, and Provider furnishes services or supplies and is a participating provider of the primary Plan, the allowable expense considered by the secondary Plan shall be the contractual fee of the primary Plan. The secondary Plan shall pay any co-payment, coinsurance or deductible for which the Member is liable under the terms and conditions of the primary Plan up to the amount that the secondary Plan would have been required to pay if primary.

7.4 Payment:

7.4.1 The Carrier shall remit payment for every Clean Claim received for a Covered Service under the applicable Health Benefits Plan no later than the thirtieth (30th) day following receipt of the claim by Carrier or no later than the time limit established for the payment of claims under the federal Medicare Program, whichever is earlier, if the claim is submitted by electronic means, and no later than the fortieth (40th) day following receipt of the claim by Carrier if the claim is submitted by other than electronic means.

7.4.2 If all or a portion of the claim submitted is not paid within the time frames provided in **Article 7.4.1**, Carrier shall notify the Participating Provider and Member of the reason or reasons for the non-payment of the claim, including without limitation:

a. the claim is incomplete with a statement as to what information is required for adjudication of the claim;

b. the claim contains incorrect information with a statement as to what information must be corrected for adjudication of the claim;

c. Carrier disputes the amount claimed in whole or in part with a statement as to the basis of that dispute; or

d. Carrier believes there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with its fraud prevention plan established in accordance with applicable law, rule, or regulation, or referred the claim, together with supporting

documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

7.4.3 An overdue payment shall bear simple interest when required by law. The Carrier shall pay interest, to the extent required by applicable law, at the time the overdue payment is made. If Carrier fails to make payment to Participating Provider in the manner, amount, or time provided for pursuant to law, rule, or regulation, in accordance with the Agreement, or otherwise fails to discharge its obligations to Participating Provider, QualCare may, in its sole discretion, use whatever contractual remedies QualCare possesses against Carrier to remedy the defaults. QualCare shall exercise its remedies in the manner it determines is reasonable. QualCare has no other obligations to Participating Provider under this Agreement with respect to any claim, liability, damage or expense that Participating Provider may incur as a result of the failure of Carrier to discharge its obligations under this Agreement or any agreement between QualCare and Carrier or Payor, as applicable. In the event of such default, nothing in this Agreement shall be construed to limit Participating Providers ability to seek from such Carrier or Payor, as applicable, such legal remedies as may be available to Participating Provider and which Participating Provider may deem appropriate.

7.5 Overpayment:

7.5.1 With the exception of claims that were submitted fraudulently or submitted by Participating Provider that have a pattern of inappropriate billing or claims that were subject to COB, no Payor shall seek reimbursement for overpayment of a claim previously paid pursuant to this **Article 7** later than eighteen (18) months after the date the first payment on the claim was made. Payor shall not seek more than one (1) reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to the Participating Provider, Payor shall provide written documentation that identifies the error in the processing or payment of the claim that justifies the reimbursement request. Payor shall not base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

a. in judicial or quasi-judicial proceedings, including arbitration;

b. in administrative proceedings;

c. in which relevant records required to be maintained by the Participating Provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or

d. in which there is clear evidence of fraud by the Participating Provider and Payor has investigated the claim in accordance with its fraud prevention plan established in accordance with applicable law, rule, or regulation, and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

7.5.2 In seeking reimbursement for the overpayment from the Participating Provider, except as provided for in **Article 7.5.3**, Payor shall not collect or attempt to collect:

a. the funds for the reimbursement on or before the forty-fifth (45th) day following the submission of the reimbursement request to the Participating Provider;

b. the funds for the reimbursement if the Participating Provider disputes the request and initiates an appeal on or before the forty-fifth (45th) day following the submission of the reimbursement request to the Participating Provider and until the Participating Provider's rights to appeal hereunder, if applicable, are exhausted; or

c. a monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee.

Payor may collect the funds for the reimbursement request by assessing them against payment of any future claims submitted by the Participating Provider after the forty-fifth (45th) day following the submission of the reimbursement request to the Participating Provider or after the Participating Provider's rights to appeal hereunder, if applicable, have been exhausted if Payor submits an explanation in writing to the Participating Provider in sufficient detail so that the Participating Provider can reconcile each Member's bill.

7.5.3 If Payor has determined that the overpayment to the Participating Provider is a result of fraud committed by the Participating Provider, and Payor has conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, Payor may collect an overpayment by assessing it against payment of any future claim submitted by the Participating Provider.

7.6 Grievances, Internal Appeals, and Arbitration Under Applicable Carrier's Health Benefits Plan. The following provision shall apply only to applicable Carriers in accordance with the terms, conditions, policies, and procedures of such Carrier's Health Benefits Plan, as may be required by applicable law, rule, or regulation.

7.6.1 Participating Provider may initiate an internal appeal for any claim disputes through Carrier within ninety (90) days of receipt of the applicable claims determination. Carrier shall process the appeal and notify the Participating Provider of its determination within thirty (30) days. If Participating Provider is not notified of the determination of the appeal in a timely manner, Participating Provider may refer the dispute to arbitration.

a. If the determination is in favor of the Participating Provider, Carrier shall comply with the provisions of this **Article 7** and pay the amount of money in dispute on or before the thirtieth (30th) day following the notification of the determination on the appeal.

b. If the determination is against the Participating Provider, the notice of the determination on the appeal shall include written instructions for referring the dispute to arbitration.

7.6.2 Any dispute regarding the determination of an internal appeal conducted pursuant to **Article 7.6.1** may be referred to arbitration as approved and sponsored by DOBI. Any party may initiate an arbitration proceeding on or before the ninetieth (90th) day following the receipt of the determination which is the basis of the appeal, on a form prescribed by DOBI. The arbitrator

shall conduct the arbitration proceedings pursuant to the rules of the arbitration entity, including rules of discovery subject to confidentiality requirements established by state or federal law. An arbitrator's determination shall be: (a) signed by the arbitrator; (b) issued in writing, in a form prescribed by DOBI; and (c) issued on or before the thirtieth (30th) day following the receipt of the required documentation. The arbitration shall be non-appealable and binding on all parties to the dispute.

7.6.3 Participating Provider may also submit and seek resolution of a complaint or grievance not otherwise expressly set forth hereunder to Carrier for review and resolution. Such resolution shall not exceed thirty (30) days following receipt of the complaint or grievance. In the event Participating Provider is not satisfied with the resolution of the complaint or grievance, Participating Provider may submit the complaint or grievance to the New Jersey Department of Banking and Insurance or the New Jersey Department of Human Services, as may be applicable.

7.7 Hold Harmless; Deductibles, Co-Payments and Co-Insurance:

7.7.1 Participating Provider shall seek payment for Covered Services provided to Members only from the applicable Payor hereunder. Under no circumstances, including without limitation the termination of this Agreement, the non-payment by Payor, or the insolvency of Payor, shall Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against any Member or any person acting on his/her behalf, for Covered Services provided pursuant to this Agreement. Moreover, Participating Provider shall neither seek nor require Member to tender a deposit or similar payment during the Member's course of treatment with respect to Covered Services rendered pursuant to this Agreement. This provision shall not prohibit the collection of Deductible amounts, Co-Payments or Co-Insurance in accordance with the terms and conditions of the applicable agreement between the Payor and the Member or the Health Benefits Plan.

7.7.2 Participating Provider agrees that this provision shall survive the termination of this Agreement for Covered Services rendered prior to the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member. This provision is not intended to apply to services provided after this Agreement has been terminated. Participating Provider agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Participating Provider and any Member, or person acting on his/her behalf.

7.7.3 Notwithstanding the foregoing, under the following circumstances and in accordance with the following terms, Participating Provider shall be entitled to bill and collect from Members:

a. Any applicable Co-Payments, Co-Insurance amounts, or Deductibles for Covered Services according to the terms and conditions of the Health Benefits Plan applicable to such Members.

b. Full charges for services provided which are not Covered Services under Payor's Health Benefits Plan, provided that Participating Provider has informed the Member prior to rendering the service that such service is not a Covered Service and that the Member will be

responsible for payment, and the Member nonetheless requests the service be rendered and provides written consent thereto.

c. Covered Services rendered in which the benefits as set forth in the Plan have been exhausted.

d. Payment as a result of a Payor, other than a Carrier, defaulting on payment of a claim.

ARTICLE 8

INSURANCE AND INDEMNIFICATION

8.1 Insurance Coverage. Participating Provider shall purchase and maintain for the duration of this Agreement, at its/his/her cost and expense, policies of comprehensive general liability insurance, professional liability insurance with minimum coverage of $1,000,000 per occurrence and $3,000,000 in the annual aggregate, worker's compensation insurance, and other insurance or equivalent protection as required by QualCare or as shall be necessary to protect Participating Provider against the risks of the conduct of its/his/her business, including without limitation claims for damages arising by reason of personal injury or death of a Member or other risks associated with the conduct of Participating Provider under this Agreement. Participating Provider shall provide QualCare with evidence of such coverage. Participating Provider shall authorize insurance carriers to issue to QualCare a memorandum certificate of insurance policies of Participating Provider promptly following execution of this Agreement, and ten (10) days prior to any renewal, cancellation, termination or material alteration of any such insurance policies. Prior to the expiration and/or cancellation of any such policy, Participating Provider shall secure replacement of such insurance coverage and furnish QualCare with a memorandum certificate as heretofore described.

8.2 Indemnification

8.2.1 Participating Provider shall indemnify and hold harmless QualCare, its directors, officers, shareholders, trustees, employees, and contractors (collectively, the "**Indemnified Party**"), from any and all liability, damages, costs, claims, demands, expenses of any kind (including attorney's fees), and governmental fines, resulting to the Indemnified Party to the extent that they arise out of the negligence of Participating Provider or, where applicable, any of its directors, officers, shareholders, trustees, employees, or contractors related to services provided in the discharge of its/his/her responsibilities under this Agreement, or to the extent that they arise out of any dishonest, fraudulent, or criminal act of Participating Provider or, where applicable, any of its directors, officers, shareholders, trustees, employees, or contractors in the performance or omission of any act or responsibility pursuant to this Agreement. In no event shall Participating Provider be required to indemnify QualCare in the event that QualCare or the applicable Payor is held liable under N.J.S.A. 2A:53A-33.

8.2.2 QualCare shall indemnify and hold harmless Participating Provider and, where applicable, its directors, officers, shareholders, trustees, employees, and contractors (collectively, the "**Indemnified Party**"), from any and all liability, damages, costs, claims, demands, expenses

of any kind (including attorney's fees), and governmental fines, resulting to the Indemnified Party to the extent that they arise out of the negligence of QualCare or, where applicable, any of its directors, officers, shareholders, trustees, employees, or contractors related to services provided in the discharge of its responsibilities under this Agreement, or to the extent that they arise out of any dishonest, fraudulent, or criminal act of QualCare or, where applicable, any of its directors, officers, shareholders, trustees, employees, or contractors in the performance or omission of any act or responsibility pursuant to this Agreement.

ARTICLE 9

RECORDS AND INFORMATION

9.1 Maintenance of Records. Participating Provider shall maintain and retain complete and accurate medical records for Members in such form as required by law and in accordance with generally accepted medical records documentation and storage practices. Participating Provider shall retain such medical records as may be required by applicable law, rule, or regulation. Participating Provider shall treat such records as confidential in compliance with applicable law, rule, and regulation.

9.2 Privacy of Member's Records and Information. Any records or information regarding the identity, diagnosis, health or treatment of a Member, or payment therefor, shall be treated as confidential in accordance with applicable law, rule, or regulation. Each party and Participating Provider shall be responsible for ensuring that performance of its/his/her duties and obligations and the exercise of its/his/her rights under this Agreement complies with all applicable Privacy Laws (hereinafter defined). In the event that this Agreement or any practices which could be, or are, employed in the performance of this Agreement are inconsistent with or do not satisfy the requirements of any Privacy Laws, each party and Participating Provider shall agree in good faith upon an appropriate amendment to this Agreement to comply with such laws, rules, and regulations and to execute and deliver any documents required to comply with such Privacy Laws, including without limitation any business associate agreement pursuant to the Health Insurance Portability and Accountability Act ("**HIPAA**"). For purposes of this Agreement, "**Privacy Laws**" means all present and future laws and regulations relating to the privacy and security of individually identifiable medical, financial, or other information, including, without limitation regulations implementing HIPAA (Sections 1171 through 1179 of the Social Security Act as amended and Section 284 of Pub. L. 104-191).

9.3 Access to Records and Information:

9.3.1 All records and information developed or maintained in connection with the provision of Covered Services or in connection with participation in QualCare's Network are subject to review and audit at any reasonable time by QualCare or Payor, as applicable, and shall be made available to QualCare or Payor, as applicable, as may be requested and as permitted by law, rule, or regulation.

9.3.2 Medical records shall be provided to QualCare or Payor, as applicable, at no cost and in a timely manner pursuant to applicable law, rule, or regulation, or with the Member's consent.

9.3.3 If a Member is transferred or disenrolls, upon request, Participating Provider shall arrange for a copy of the Member's medical records to be provided without charge within seven (7) days of the date of such transfer or disenrollment or as otherwise may be required by law, rule, or regulation. Participating Provider shall obtain the Member's written consent if necessary for any release of such medical records.

ARTICLE 10

TERM AND TERMINATION

10.1 Term. This Agreement shall commence as of the Effective Date and shall continue for a period of three (3) year thereafter ("**Initial Term**"), unless either party shall give written notice to the other party within ninety (90) days prior to the end of the Initial Term, or the Agreement is earlier terminated as provided herein. Thereafter, this Agreement shall automatically renew for successive one (1) year periods (each a "**Renewal Term**"), unless either party shall give written notice to the other party within ninety (90) days prior to the end of any Renewal Term, or the Agreement is earlier terminated as provided herein (the Initial Term and all Renewal Terms, collectively, the "**Term**").

10.2 Termination. This Agreement may be terminated as follows:

10.2.1 At any time by voluntary, mutual agreement of the parties hereto.

10.2.2 By either party at any time after the Initial Term, without cause, by providing ninety (90) days prior written notice to the other party, subject to Participating Provider's right to notice and a hearing as set forth hereunder.] [By QualCare at any time by providing ninety (90) days prior written notice to Provider, subject to Provider's right to notice and a hearing as set forth hereunder.]

a. Where applicable, such written notice shall contain a statement indicating the right to obtain a reason for the termination in writing, if the reason is not otherwise stated in the notice, the right to request a hearing, and any exceptions thereto, and the procedures for exercising such rights.

b. Except for non-renewals under **Article 10.1**, for breaches or non-performance under **Article 10.2.3**, and any Serious Breach under **Article 10.2.4**, believed fraud, imminent danger of Member, or to protect the health, safety and welfare of the public under **Article 10.2.5**, QualCare shall provide written notice of the reasons for termination (the "**Termination Notice**"). Within ten (10) days of receipt of the Termination Notice, Participating Provider shall have the opportunity to request in writing a hearing with respect to such termination (a "**Hearing Request**"). Within thirty (30) days of receipt of a Hearing Request, QualCare shall hold a hearing before a panel appointed by QualCare in accordance with applicable New Jersey law, rule, and regulation. The panel shall render a decision in writing within thirty (30) days of the close of the hearing, unless within such thirty (30) day period the panel provides notice to both QualCare and Participating Provider of a need for an extension for rendering its decision.

10.2.3 At the election of the non-breaching party if a material breach or failure to perform under the Agreement, other than a Serious Breach (hereinafter defined), remains uncured after the non-breaching party has given the breaching party at least thirty (30) days prior written notice of, and an opportunity to cure, such breach.

10.2.4 At the election of QualCare, automatically, immediately, and without notice, upon the occurrence of any of the following events (each a "**Serious Breach**"):

a. Participating Provider becomes incapable of rendering services;

b. Participating Provider's license, certification, authorization to operate or provide services or Participating Provider's ability to participate in Medicare, Medicaid, or any other federal, state, or local government program is suspended, terminated, revoked, not renewed, or otherwise limited in any way;

c. Participating Provider is placed on probation, reprimanded, disciplined, or fined, has any accreditation suspended, terminated, revoked, not renewed, or otherwise limited in any way, or has any privileges suspended, terminated, revoked, not renewed, or otherwise limited in any way by any federal or state agency or board;

d. Participating Provider fails to maintain insurance coverage as required by this Agreement; provided that, if the loss of insurance is solely due to a curable clerical or recordkeeping error, a Serious Breach shall not exist unless such error is not cured within twenty (20) days of such loss of insurance; or

e. Participating Provider is convicted of a felony or any other crime.

10.2.5 Immediately by QualCare where termination is necessary due to believed fraud, imminent danger to Members, or to protect the health, safety and welfare of the public.

10.2.6 Upon written notice by QualCare if Participating Provider is determined, by QualCare or Payor, to have engaged in a pattern of referring Members to out-of-network or non-participating Providers.

10.3 Procedure Upon Termination. In the event of the termination of this Agreement, the following procedures upon termination shall apply:

10.3.1 Payment. The payment provisions set forth in this Agreement shall continue to apply to all claims for Covered Services provided on dates prior to the effective date of the termination.

10.3.2 Obligations Under Payor Agreements. The parties shall continue to fulfill all of its/his/her duties and obligations under each Payor Agreement issued prior to the effective termination date, to which it/he/she shall be bound under this Agreement as it relates to each such Payor Agreement, until the termination of each such Payor Agreement.

10.4 Continuation of Services. Termination hereunder shall result in immediate cessation of the Agreement on the effective date of such termination; provided, however, that (except where this

Agreement was terminated for a Serious Breach or pursuant to Section 10.2.5), Participating Provider and QualCare shall continue to abide by the terms and conditions of the Agreement, as may be amended from time to time, and Provider shall:

10.4.1 in cases where it is Medically Necessary for the Member to continue treatment with Participating Provider, continue to provide Covered Services for up to four (4) months following the effective date of such termination;

10.4.2 in the case of a pregnancy of a Member, continue to provide Covered Services through postpartum evaluation of the Member for up to six (6) weeks after delivery;

10.4.3 in the case of post-operative care of a Member, continue to provide Covered Services for up to six (6) months following the effective date of the termination;

10.4.4 in the case of oncological treatment of a Member, continue to provide Covered Services for up to one (1) year following the effective date of the termination; or

10.4.5 in the case of psychiatric treatment of a Member, continue to provide Covered Services for up to one (1) year following the effective date of termination.

Notwithstanding Sections 10.4.1 through 10.4.5, when termination is by the Participating Provider, the Participating Provider shall continue to provide services pursuant to the terms and conditions of the Agreement, as may be amended from time to time, to Members who are patients of the Participating Provider immediately prior to the date of termination for thirty (30) days following the date of termination, but for the remainder of the four (4) month period only in cases where it is medically necessary for the Member to continue treatment with the Participating Provider, except as Sections 10.4.1 through 10.4.5 may apply.

10.5 Patient Transfers. As may be required by law, rule, or regulation, Carrier shall, within thirty (30) days following termination, initiate procedures to notify Members of termination and to facilitate the transfer of Members' care to other Participating Providers. The parties agree to facilitate in a timely manner any transfer of the Members' care necessitated by termination of this Agreement and to do so in a manner that ensures patient confidentiality and continuation of appropriate care consistent with generally accepted medical standards in effect at the time of the termination.

ARTICLE 11

GENERAL PROVISIONS

11.1 Amendment. This Agreement may be amended at any time by mutual consent of the parties. QualCare may amend this Agreement, the Provider Manual or the Payor's or QualCare's policies and procedures, as applicable, upon ninety (90) days advance written notice if the amendment results in a Material Change, or upon thirty (30) days advance written notice for all other amendments. If an amendment results in a Material Change, Physician may terminate this Agreement only by providing QualCare with notice of its/his/her intent to terminate this Agreement within thirty (30) days of delivery of the notice of amendment, in which event this

Agreement shall terminate on the effective date provided in the notice of amendment. Notwithstanding the foregoing, such notice shall not be required in the event the amendment is required due to a change in the applicable federal or state laws, rules, or regulations.

11.2 Notices. Except as otherwise expressly required under this Agreement or by applicable law, rule, or regulation, notices or other written communications required or permitted hereunder may be effectuated if sent by letter, facsimile, electronic mail, or other generally accepted media. Notices required under Article 10 shall be made by either overnight mail, and shall be effective on the date of receipt or one (1) business day from such overnight mailing, whichever is earlier, or by certified mail, return receipt requested, and shall be effective on the date of receipt or three (3) business days from such mailing, whichever is earlier.

11.3 Assignment. No Provider, including without limitation Physician, shall have any right to assign, or otherwise delegate, in whole or in part, its/his/her rights, duties, and obligations under, this Agreement. Any such assignment or delegation, or attempt at assignment or delegation, shall be null and void and without full force and effect. Notwithstanding the foregoing, upon reasonable notice, QualCare shall have the right to assign, or otherwise delegate, in whole or in part, any or all of its rights, duties, and obligations under this Agreement to any related entity of QualCare.

11.4 Benefits. This Agreement shall be binding upon, and shall inure to the benefit of, the parties hereto and their respective heirs, personal representatives, executors, administrators, successors and assigns.

11.5 Construction. Every term, condition, representation, warranty, covenant, agreement and section of this Agreement shall be construed simply according to its fair meaning and not strictly for or against any party.

11.6 Gender and Number. The use of the masculine, feminine or neuter gender and the use of the singular and plural shall not be given the effect of any exclusion or limitation herein; and the use of the word "person" or "party" shall mean and include any individual, trust, corporation, partnership or other entity.

11.7 Headings. The subject headings of the articles and paragraphs of this Agreement are included for purposes of convenience and shall not affect the construction or interpretation of any of its provisions.

11.8 Severability. In the event that any provision of this Agreement shall be determined to be invalid or unenforceable by any court of law for any reason, such provision shall be deemed modified to the extent necessary to make it enforceable and the remainder of this Agreement shall be unaffected thereby and shall remain in full force and effect.

11.9 Waiver. The failure to insist upon strict adherence to any term or condition of this Agreement on any occasion shall not be considered a waiver or relinquishment of any right to insist upon strict performance of that term or condition, or any other term or condition, of this Agreement at any time thereafter.

11.10 Use of Name and Likeness. None of the parties shall use the name and likeness of any other party for promotional purposes without the prior written consent, which shall not unreasonably be withheld, of the party whose name or likeness is proposed to be used. In all respects, each party reserves the right to use its/his/her name and all symbols, trademarks, or service marks.

11.11 Confidentiality:

a. During the Term, QualCare may disclose to the other party (the "**Receiving Party**") highly sensitive, confidential, or proprietary information, which QualCare has developed, including without limitation this Agreement, the Provider Manual, the Network, QualCare's policies, procedures, and guidelines, QualCare's products, services, designs, plans, flow charts, marketing and pricing plans, financial information, costs and pricing information, databases, files, reports, and other technical or business information, in whatever form (collectively, the "**Proprietary Information**"). All Proprietary Information, whether transmitted by oral, written, electronic or any other means, shall be protected under this Agreement.

11.11.2 During the Term and for a period of one (1) year thereafter, the Receiving Party: (a) shall treat such Proprietary Information as confidential and a trade secret of QualCare; (b) shall use such Proprietary Information only for the purposes permitted under this Agreement; and (c) and shall not disclose to unauthorized third-parties such Proprietary Information without the prior written consent of QualCare. If the Receiving Party is requested or required (by oral questions, interrogatories, requests for information or documents, subpoena or similar process) to disclose any Proprietary Information, the Receiving Party, to the extent possible, shall cooperate with QualCare and provide QualCare with prompt notice of such request(s) so that QualCare may seek an appropriate protective order and/or waive compliance by the Receiving Party with the provisions of this Agreement.

11.11.3 Upon termination, at QualCare's request, Receiving Party shall return all Proprietary Information and all copies thereof.

11.11.4 This **Article 11.11** shall survive the termination or expiration of this Agreement.

11.12 Non-Solicitation: During the Term and for a period of one (1) year thereafter, Participating Provider shall not solicit Members, directly or indirectly, to enroll in any other health benefits plan, insurance, health coverage, or alternative health care delivery system. This provision shall survive the termination or expiration hereof.

11.13 Dispute Resolution. To the extent that there are any disputes or controversies not otherwise governed by the internal, external, or other appeals processes expressly set forth hereunder or as required by law, rule, or regulation, the parties shall attempt to resolve any such dispute or controversy between them. If such dispute or controversy cannot be resolved, the parties agree to settle such dispute or controversy by arbitration in accordance with the rules of the American Arbitration Association then in effect, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction.

11.14 Governing Law. The validity, enforceability and interpretation of any of the clauses of this Agreement shall be determined and governed by the laws of the State of New Jersey.

11.15 Inconsistency With Laws. Any portion of this Agreement that conflicts with applicable state or federal law, rule, or regulation is effectively amended to conform to any such applicable requirements.

11.16 Changes in Laws. In the event there are changes to any federal, state or local laws, rules, regulations, or general instructions, or the application thereof, or the interpretation of existing provisions or the adoption of new legislation, any of which would in the reasonable opinion of counsel to either party affect the legality of this Agreement, the parties agree to examine the Agreement and to re-negotiate those provisions which are required to be revised in order to accommodate such changes.

11.17 Force Majeure. Notwithstanding any other provisions contained herein, no party shall be liable to the other party, and no party shall be deemed to be in default hereunder, for any delay or failure in performance or interruption of service under this Agreement resulting from, without limitation: (1) acts of God, fire, flood, earthquake, storm, hurricane, or other natural disaster; (2) war, invasion, act of foreign enemies, hostilities (whether war is declared or not), civil war, rebellion, revolution, insurrection, military or usurped power or confiscation, terrorist activities, nationalization, government sanction, blockage, embargo, labor dispute, strike, lockout, or civil commotion; (3) shortages of, or inability to obtain, labor, materials, equipment, or supplies, (4) interruption or failure of electrical, telephone, facsimile, network, or computer systems or equipment; or (5) any other cause beyond the reasonable control of that party.

11.18 Entire Agreement. This Agreement, including all exhibits, attachments, addendums, schedules, and riders thereto, forms the entire understanding and agreement between the applicable parties and supersedes any prior understanding or agreement to the contrary, whether written or oral. This Agreement sets forth and merges the entire agreement and understanding of the applicable parties. This Agreement cannot and shall not be changed, modified, amended or supplemented except by another written agreement that is executed by the applicable parties.

[REMAINDER OF THE PAGE INTENTIONALLY LEFT BLANK]

[SIGNATURE PAGE FOLLOWS]

ARTICLE 12

SIGNATURE PAGE

IN WITNESS WHEREOF, this Agreement is hereby entered into by and between the undersigned to be effective as of the Effective Date stated above.

QUALCARE, INC.
30 Knightsbridge Road
Piscataway, NJ 08854

By: _____

Title: _____

Dated: _____, 20___

PROVIDER: _____
Address: _____
_____
_____
Telephone: _____
Facsimile: _____

Provider
Signature: _____
Print Name: _____
Title: _____

Dated: _____, 20___

Tax ID Number(s):_____
_____
_____
_____

ACKNOWLEDGEMENT

By signing this signature page, the parties acknowledge and agree that Plan(s) identified below are incorporated into this Agreement, that Provider agrees to participate in such Plan(s) in accordance with this Agreement, including without limitation any addendum(s) attached hereto, and that Provider has received copies of all applicable addendum(s) applicable to such Plan(s).

Plans subject to this Agreement (initial all that apply):	**Applicable Addendums:**
[ ] PPO Plans	None
[ ] HMO/POS Plans	See Exhibit B
[ ] WCMCO Plans	See Exhibit B

EXHIBIT A
TO THE
QUALCARE PROVIDER NETWORK PARTICIPATION AGREEMENT

Fee Schedule(s)

QualCare Standard Rates Apply

EXHIBIT B
TO THE
QUALCARE PROVIDER NETWORK PARTICIPATION AGREEMENT

Product Addendum(s)

- HMO/POS ADDENDUM
- WC PRODUCT ADDENDUM