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PARTICIPATING PROVIDER AGREEMENT
by and between
CONSUMER HEALTH NETWORK PLUS, LLC
a division of Medlogix, LLC

and

NAME OF PROVIDER

PARTICIPATING PROVIDER AGREEMENT

This PARTICIPATING PROVIDER AGREEMENT ("Agreement") is made and entered into as of the Effective Date set forth on the signature page of this Agreement, by and between CONSUMER HEALTH NETWORK PLUS, LLC, d/b/a CHN PPO, a New Jersey limited liability company ("CHN"), and the person or entity whose name is listed under the heading "Provider" on the signature page of this Agreement ("Provider").

WITNESSETH:

WHEREAS, Provider is either (i) an individual health care provider duly licensed, certified, accredited or otherwise duly authorized to practice in the states of practice; or (ii) a partnership, professional service corporation or other entity duly organized and existing under and pursuant to the laws of the states of practice, the partners, shareholders, members and professional provider employees of which (together the "Provider") are all duly authorized to practice in the states of practice; and

WHEREAS, CHN desires to obtain quality, cost efficient health care services from selected health care providers and to negotiate agreements with purchasers of such services; and

WHEREAS, CHN desires to engage Provider to furnish such services and Provider desires to furnish such services.

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

- 1 **Preamble and Recitals** The preamble and recitals hereinabove set forth are hereby incorporated into and made part of this Agreement.
- 2 **Definitions**
 - 2.1 **Plan** "Plan" means an arrangement under which a Payor is obligated to pay, directly or indirectly, a provider of health care services, in connection with the provider's rendering Covered Services to Eligible Members.
 - 2.2 **Eligible Persons** "Eligible Persons" means the persons entitled to receive the Covered Services pursuant to a Plan.
 - 2.3 **Covered Services** "Covered Services" means the health care services provided pursuant to a Plan.
 - 2.4 **Participating Provider** "Participating Provider" means those health care providers who (i) have directly entered into an agreement with CHN to perform the Covered Services (ii) have indirectly through CHN agreements with IPAs, PHOs or other organizations agreed to provide Covered Services to Eligible Persons or (iii) have indirectly through CHN agreements with other networks ("Leased Networks") agreed to provide Covered Services to Eligible Persons.
 - 2.5 **Payor** "Payor" means the party responsible for the actual payment for Covered Services rendered to Eligible Persons that has, directly or indirectly, entered into a Payor Agreement with CHN. Payors may include health insurance carriers, auto insurance carriers, workers compensation carriers, workers compensation managed care organizations, health maintenance organizations, self-funded employee benefit plans, and the like. Payors "indirectly" entering into Payor Agreements with CHN assume the obligation to pay claims pursuant to arrangements with Network Lessees, as defined below, and do not include "Carriers" as that term is defined in N.J.A.C. 11:24B-1.2.
 - 2.6 **Network Lessee** "Network Lessee" means a party to an agreement with CHN under which CHN provides access to its Participating Providers.
 - 2.7 **Payor Agreement** "Payor Agreement" means an agreement with a Payor directly, or indirectly with a Network Lessee or other entity, pursuant to which Participating Providers shall provide the Covered Services for Eligible Persons.
 - 2.8 **Standard Terms** "Standard Terms" means the terms set forth in EXHIBIT 2.8.
 - 2.9 **Fee Schedule** "Fee Schedule" means a schedule of maximum reimbursement amounts pursuant to which a Payor shall pay Participating Providers to provide Covered Services. The description of the Fee Schedule applicable to Provider is set forth in EXHIBIT 2.9.
 - 2.10 **Provider/Facility Manual** "Provider/Facility Manual" means the manual of rules, regulations, policies and procedures of CHN as provided to Provider.
 - 2.11 **Utilization Management Program** "Utilization Management Program" means either the utilization management program established, administered or subcontracted by CHN or the utilization management program required by a Payor in a Payor Agreement or required by an entity pursuant to an Agreement with CHN. A summary of the Utilization Management program is set forth in the Provider/Facility Manual.
 - 2.12 **Credentialing Criteria** "Credentialing Criteria" means the criteria established by CHN for the initial credentialing and re-credentialing (every 3 years) of Participating Providers, which may be amended from time to time by CHN in its sole discretion. The Credentialing Criteria pertaining to Provider are set forth in EXHIBIT 2.12. All Providers must pass the CHN credentialing process prior to participation in any Plan of CHN PPO.
 - 2.13 **Medically Appropriate** "Medically Appropriate" or "Medical Appropriateness" means services or supplies which, under the provisions of this Agreement, are determined to be: (i) appropriate and necessary for the symptoms, diagnosis or treatment of the injury or disease; (ii) provided for the diagnosis or direct care and treatment of the injury or disease; (iii) preventative services as provided in a Plan; (iv) in accordance with commonly recognized and accepted medical standards; (v) not primarily for the convenience of the Eligible Person or of any provider providing Covered Services to the Eligible Person; (vi) an appropriate supply or level of care; (vii) within the scope of the medical specialty education and training of a provider; and (viii) provided in a setting consistent with the required level of care.
 - 2.13.1 Under a particular Plan, Covered Services may not include all services which are Medically Appropriate.

2.14 **Review Procedure** "Review Procedure" means the procedure whereby a provider or Participating Provider may request a reconsideration of various actions of CHN. The Review Procedure may be modified from time to time by CHN, within its sole discretion and is included in the Provider/Facility Manual.

2.15 **Carrier** is given the meaning set forth in N.J.A.C. 11:24B-1.2.

3 **Terms and Fee Schedules**

3.1 **Standard Terms and Fee Schedule**

3.1.1 Provider accepts and is hereby bound by the Standard Terms and the Fee Schedule of this Agreement.

3.1.2 Provider shall provide Medically Appropriate Covered Services to Eligible Persons of each Payor executing a Payor Agreement with CHN or revising an existing Payor Agreement if the terms are substantially similar to the Standard Terms.

3.1.3 Upon written request from a Participating Provider, CHN shall provide within 45 days: (i) The list of clients or other Payors that are entitled to any contracted rate under CHN's contract with the Participating Provider; and (ii) The identity of the specific client or other Payor by whom a contracted rate was applied to a particular claim under CHN's contract with the Participating Provider.

3.2 **Modification of Standard Terms and Fee Schedule**

3.2.1 During the term of this Agreement and subject to Provider's right to reject as set forth below, CHN may (i) modify or create new Standard Terms and/or the Fee Schedule; or (ii) create separate terms for various CHN programs.

3.2.2 CHN may submit the proposed modified terms, ("Modifications") to Provider. Provider shall have the right to reject the Modifications by serving written notice of such rejection upon CHN within thirty (30) days of the effective date of the notice from CHN.

3.2.3 Failure to provide notice of rejection within such thirty (30) day period shall constitute acceptance by Provider of the Modifications.

3.2.4 If Provider rejects the Modifications for a CHN program or Modifications which have been negotiated with an individual Payor, Provider shall not be required to provide Covered Services to Eligible Persons in such CHN program or for such Payor, as applicable.

3.2.5 If Provider rejects the Modifications, CHN shall have the option to (i) implement the Modifications without inclusion of Provider; or (ii) withdraw the Modifications; or (iii) terminate this Agreement in accordance with Section 7.2.3, in which case the Modifications shall not apply.

4 **Obligations of CHN**

4.1 **Administration** CHN shall administer and, in its sole discretion, determine the composition of the network of Participating Providers of CHN.

4.2 **Marketing and Promotion** CHN shall, within its discretion:

4.2.1 market, advertise and actively promote CHN; and

4.2.2 solicit Payor Agreements from Payors offering Plans that may, but shall not be required to, include financial incentives or other programs to encourage Eligible Persons to use Participating Providers.

4.3 **Assistance** To permit CHN to perform its obligations pursuant to this Agreement, Provider shall reasonably assist CHN in marketing, advertising and promotion. CHN shall use its best efforts to furnish Provider with appropriate materials to support such efforts.

4.4 **Information** CHN shall use reasonable efforts to obtain information from each Payor with regard to the identity of Payors and disseminate such information to the Participating Providers of CHN as CHN shall, in its sole discretion, deem appropriate to keep each Participating Provider reasonably informed as to the identity of Payors.

4.5 **Liability for Claims, Decisions and Fees**

4.5.1 Payors shall be liable for claims decisions and for the payment of a Payor's portion of claims pursuant to a Plan.

4.5.2 CHN shall not be responsible or liable for any claims decisions or for the payment of any claims submitted by Provider for furnishing Covered Services or non-Covered Services to Eligible Persons. CHN shall not be an insurer, guarantor or underwriter of the responsibility or liability of any Payor to provide benefits pursuant to any Plan.

4.5.3 Provider hereby acknowledges that payment for Covered Services furnished to Eligible Persons shall be due solely from a Payor and such Eligible Persons

4.5.4 CHN is not involved in and shall not be responsible or liable for plan design or benefit determinations of Payors.

4.6 **Use of Credentialing Forms** CHN shall accept the New Jersey Universal Physician Application, referenced in N.J.A.C. 11:42C-1.3(a) with respect to Providers who are physicians, and hereby gives notice that a downloadable version of such application is available through the website of the New Jersey Department of Banking and Insurance (<http://www.state.nj.us/dobi/mccred.htm>) and, upon written request, CHN shall provide a hardcopy of such application form to Provider.

5 **Obligations of Provider**

5.1 **Provider Standards** Provider hereby warrants and represents that:

5.1.1 Provider is and, at all times during this Agreement, shall be in compliance with the Credentialing Criteria; and

5.1.2 the information contained in the application of Provider for membership in CHN is true and correct in all respects and does not fail to state a material fact that would make it otherwise misleading.

5.2 **Provider Services and Obligations** Provider shall:

5.2.1 provide Medically Appropriate Covered Services to Eligible Persons for which Provider is qualified and which Provider customarily furnishes to the general public from the office locations indicated on the signature page of the CHN Application submitted by Provider ("Provider's Offices"). Services rendered by Provider under tax identification numbers not listed on the signature page (whether as a partner, shareholder, member or professional provider employee), and/or from sites or office locations not listed as Provider's Offices shall be considered rendered by Provider pursuant to this Agreement; and

- 5.2.2 perform the Covered Services pursuant to the requirements of state licensure, applicable state and federal certification, and applicable accreditation requirements and standards; and
- 5.2.3 treat Eligible Persons in all respects no less favorably than Provider treats all other patients, and determine whether or not to accept Eligible Persons for treatment or terminate the treatment of Eligible Persons only on the basis of the same criteria employed by Provider to make such determinations in connection with all other patients; and
- 5.2.4 obtain from Eligible Persons a written assignment of benefits and an authorization to release medical records and cooperate and comply with the billing and other procedures established by CHN or a Payor and set forth in the Provider/Facility Manual or in other written communications from CHN; and
- 5.2.5 submit all claims for Covered Services as provided in the Provider/Facility Manual and pursuant to the Standard Terms. Provider shall accept as full payment from each Payor for the Covered Services deemed Medically Appropriate pursuant to the Utilization Management Program the lesser of charges customarily charged to other patients or the consideration provided in the Fee Schedule. Provider hereby waives any amounts from any Payor and any Eligible Person (i) in excess of the fees customarily charged to other patients or the amounts provided in the Fee Schedule; and (ii) after Provider has appealed the UM determination and the outcome remains not to be Medically Appropriate, any amount from any Payor or Eligible Person for services performed which have been deemed not to be Medically Appropriate by the Utilization Management Program. Provider hereby acknowledges that payment for Covered Services furnished to Eligible Persons shall be due solely from a Payor and such Eligible Persons; and
- 5.2.6 subject to Section 6.3, provide any party operating the Utilization Management Program with access, upon reasonable notice during normal business hours, to the appropriate records and information regarding Covered Services rendered to Eligible Persons for inspection and copying in such a manner as may be reasonably requested to permit the party operating the Utilization Management Program to implement the Utilization Management Program and perform its administrative obligations set forth herein and to verify claims for Covered Services submitted by Provider; and
- 5.2.7 comply with the rules, regulations, policies and procedures as enacted by CHN from time to time and summarized in the Provider/Facility Manual, comply with the Utilization Management Program, participate in and observe the protocols of the Utilization Management Program, submit to performance reviews in conjunction therewith; and
- 5.2.8 within ten (10) days of occurrence, notify CHN and provide CHN with all information with respect to any disciplinary action against Provider or any malpractice actions, judgments or settlements of Provider. Provider hereby authorizes any hospital, any governmental agency or professional licensing, accrediting or certifying agency, or any other person or entity to release to CHN any information pertaining to any such matters and pertaining to the Credentialing Criteria; and
- 5.2.9 consent to the inspection by CHN, Network Lessees, independent credentialing entities, independent accreditation entities, their agents and their representatives of the contents of the credentialing file of Provider and all documents that may be material to an evaluation of qualifications and competence of Provider and consent to the release of such information to such parties. Provider hereby releases from liability CHN, Network Lessees, their respective officers, directors, employees and agents from their acts performed and statements made, in good faith and without malice, in connection with evaluating the credentials and qualifications of Provider. Provider hereby releases from liability CHN, Network Lessees and any and all individuals who provide information to CHN, Network Lessees, their medical directors and their representatives and agents, in good faith and without malice, concerning the Credentialing Criteria, Provider's disciplinary actions, professional competence, background, experience, ethics, character, utilization practice patterns, health status and other qualifications to be a Participating Provider; and
- 5.2.10 give prior written notice to CHN within ten (10) days if the practice of Provider shall add a partner, shareholder, member or professional provider employee, if Provider shall cease to fulfill the Credentialing Criteria or if the health status of a Provider shall effect patient care.
- 5.2.11 give prior written notice to CHN within ten (10) days if the Provider will begin to provide Services under tax identification numbers not listed on the signature page (whether as a partner, shareholder, member or professional provider employee), and/or from sites or office locations not listed as Provider's Offices. If Provider fails to notify CHN, the new or additional tax identification number(s) and/or new additional locations(s) shall be included in the capitalized term "Provider" for purposes of this Agreement.
- 5.2.12 have the right and obligation to communicate openly with Eligible Persons regarding diagnostic tests and treatment options.

6 Confidential Information

- 6.1 **Legal Restrictions** Neither party hereto shall be in default for failure to supply information which such party, in good faith, believes cannot be supplied due to prevailing law/regulatory agencies, or for supplying information which such party, in good faith, believes is required to be supplied due to prevailing law/regulatory agencies. In a manner consistent with the preceding sentence, either party may disclose Confidential Information as necessary to investigate and/or resolve a dispute between Provider and a Payor or Eligible Person or CHN.
- 6.2 **Non-Disclosure of Confidential Information**
 - 6.2.1 Provider (and the respective officers, directors, employees, agents, successors and assigns of Provider) shall hold any and all Confidential Information in the strictest confidence as a fiduciary, and shall not, voluntarily or involuntarily, sell, transfer, publish, disclose, display or otherwise make available to others, except for governmental agencies, any portion of the Confidential Information without the express written consent of CHN. Provider shall use best efforts to protect the Confidential Information consistent with the manner in which Provider protects the confidential business information of Provider. Notwithstanding the foregoing, Confidential Information may be disclosed to federal or New Jersey governmental agencies to the extent such disclosure is required by law.
 - 6.2.2 "Confidential Information" shall mean information of CHN that shall be subject to patent, copyright, trademark, trade name or service mark protection, or described as confidential by CHN or a Payor, or not otherwise in the public domain and related to the business and operations of CHN, including, without limitation, this Agreement and the exhibits hereto, lists of Payors, Network Lessees and Participating Providers and information related thereto, eligibility data, information relating to earnings, volume of business, methods, systems, practices or plans of CHN and its Payors, and all similar information of any kind or nature whatsoever which is known only to persons having a fiduciary or confidential relationship with CHN and its Payors.
- 6.3 **Medical Records**
 - 6.3.1 The parties hereto shall maintain the confidentiality of any and all medical records which shall be in their possession and control, and such information shall only be released or disseminated pursuant to the valid authorization of the patient whose medical condition is reflected in such medical records or as shall be otherwise permitted under applicable law.
 - 6.3.2 Medical records shall be maintained in accordance with the provisions of applicable law and in accordance with the standards of American Accreditation Healthcare Commission / ("URAC") and JCAHO.
 - 6.3.3 CHN shall have the right to conduct an annual review of the medical records of Eligible Persons in the possession of Provider to determine compliance with the quality management policies and procedures of CHN.

- 6.4 **Trademarks and Copyrights** Each party acknowledges each other party's sole and exclusive ownership of its respective trade names, commercial symbols, trademarks and service marks, whether presently existing or later established (collectively "Marks"). No party shall use the other party's Marks in advertising or promotional materials or otherwise without the owner's prior written consent; PROVIDED, HOWEVER, that CHN, Payors, Network Lessees and other entities with agreements with CHN may, but shall not be required to, list Provider in the CHN Participating Provider directory or otherwise publicize the status of Provider as a Participating Provider.

7 **Term and Termination**

7.1 **Term and Voluntary Termination**

- 7.1.1 The initial term of this Agreement ("Initial Term") shall commence on the Effective Date of this Agreement and shall continue for one (1) year. This Agreement shall be automatically renewed for additional periods of one (1) year (each a "Renewal Term") unless either party shall give at least four (4) months prior written notice via certified mail, return receipt requested of non-renewal or termination to the other party.
- 7.1.2 If Provider shall begin to provide Services under tax identification numbers not listed on the signature page (whether as a partner, shareholder, member or professional provider employee) or relocate any of the Provider's Offices, within ten (10) days of such change, Provider shall provide notice to CHN and CHN shall have the option, for four (4) months from the effective date of the notice, to terminate this Agreement.

7.2 **Termination of Agreement**

- 7.2.1 Except as otherwise specifically provided herein, either party may terminate this Agreement for cause upon the breach of this Agreement by the other party not remedied within thirty (30) days after receipt by such other party of notice thereof from the terminating party.
- 7.2.2 Anything elsewhere in this Agreement to the contrary notwithstanding, CHN shall have the option to terminate this Agreement at any time upon written notice if CHN reasonably concludes that: (A) Provider has engaged in fraud; or (B) the continuation of this Agreement may result in imminent danger to Covered Persons or the public health, safety or welfare; or (C) Provider has breached this Agreement. The following shall be deemed to be a breach of this Agreement: (i) failure to satisfy the Credentialing Criteria; (ii) failure to purchase or maintain policies of insurance as required in the Credentialing Criteria; (iii) disqualification or suspension from practice or a reasonable threat of disqualification or suspension in any state, or if Provider has any other license, certification or authorization required to perform any duties hereunder restricted, suspended or terminated; (iv) Provider is disciplined or threatened with disciplinary action by any governmental authority or agency, managed care organization, hospital or other facility; (v) Provider is no longer a member in good standing of the medical or professional staff of any hospital of which Provider was a member as of the Effective Date, or if any such hospital restricts in any way or terminates any privileges granted to Provider; (vi) Provider commits professional misconduct, violates the principles of professional ethics; (vii) in the sole determination of CHN, there are an excessive number of professional liability claims filed or resolved against Provider; or (viii) Provider is subject to an indictment or information for a felony.
- 7.2.3 If CHN exercises its option to terminate pursuant to Section 3.2.5, this Agreement shall terminate 90 days following CHN's notice of Provider's rejection.
- 7.2.4 If CHN terminates this Agreement, Provider shall receive a written statement setting forth the reason(s) for the termination. CHN's obligation to provide such written notice is more fully set forth in the Provider/Facility Manual. Provider shall have a right to a hearing in connection with the termination of this Agreement under certain circumstances, more fully set forth in the Provider Review Procedure which is included in the Provider/Facility Manual.
- 7.3 **Procedure Upon Termination** Upon the termination of this Agreement by either party for any reason, whether for cause or not for cause, whether voluntary or involuntary, all rights and obligations hereunder shall cease, except (i) those rights and obligations provided in Section 6 and this Section 7.3; and (ii) those rights and obligations which shall have accrued as a result of the operation of this Agreement. Upon termination Provider shall:
- 7.3.1 continue to provide Covered Services pursuant to this Agreement (i) until either the termination of each Payor Agreement in force on the date of termination or twelve (12) months, whichever is earlier; and (ii) thereafter, to Eligible Persons who shall be receiving care from Provider until the earlier of the conclusion of any treatment for a specific condition existing as of such termination or the discharge or transfer of such Eligible Person; and
- 7.3.2 immediately discontinue use of any and all signs, plaques, letterheads, forms or other materials identifying Provider as a Participating Provider of CHN and as a participant in the Plans of each Payor; and
- 7.3.3 immediately disclose to each Eligible Person in Provider's care, in the form prescribed by CHN or by a Payor, the possible adverse economic consequences to such Eligible Persons of Provider's termination.

- 7.4 **Termination and Eligible Persons** In the event of notice of termination of this Agreement and upon actual termination of this Agreement, CHN may (i) inform Eligible Persons of such termination; (ii) inform Eligible Persons of the economic effect of using Provider as a non-Participating Provider; and (iii) recommend that Eligible Persons engage other Participating Providers.
- 7.5 **Prohibited Terminations (and Penalties)** CHN shall not terminate this Agreement or otherwise penalize Provider because Provider: (a) submits its own complaints; (b) submits complaints on behalf of an Eligible Person; (c) acts as an advocate for an Eligible Person in seeking Medically Necessary Covered Services under the Eligible Person's Plan.
- 7.6 **Suspension Pending Investigation** CHN shall have the right to suspend Provider's status as a Participating Provider upon written notice if CHN reasonably concludes that Provider may constitute an imminent danger to Eligible Persons. Suspensions initiated under this provision shall be governed by the Provider Review Policy set forth in the Provider/Facility Manual.

8 **Miscellaneous Provisions**

- 8.1 **Provider-Patient Relationship** Nothing contained in this Agreement shall interfere with or in any way alter any provider-patient relationship and Provider shall have the sole responsibility for the care and treatment of Eligible Persons under Provider's care. Nothing contained herein shall grant CHN or any party performing utilization management the right to govern the level of care of a patient. Utilization management decisions shall only effect reimbursement of Provider for services rendered and shall not limit the performance of the services of Provider or effect Provider's professional judgment.
- 8.2 **Non-Exclusivity** Nothing in this Agreement shall be intended or construed to prevent either party from entering into substantially similar agreements with other entities similar to the other party.
- 8.3 **Remedies** Remedies at law may be inadequate and the parties shall be entitled to equitable relief, including without limitation, injunctive relief, specific performance or other equitable remedies in addition to all other remedies provided hereunder or available to the parties at law or equity. No remedy made available by any of the provisions of this Agreement is intended to be exclusive of any other remedy.
- 8.4 **Independent Contractors** Each party, its officers, agents and employees are at all times independent contractors to the other party. Nothing in this Agreement shall be construed to make or render either party or any of its officers, agents, or employees an agent, servant, or employee of, or joint venture of or with, the other.

- 8.5 **Notices** Notices shall be written and personally delivered or by fax, effective on delivery, or sent by United States mail, postage prepaid, effective on the third (3rd) day following the date deposited in the mail, addressed to the parties as set forth below, or to any other address specified in writing by such party except as otherwise specifically provided herein.
- 8.6 **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 word "person" or "party" shall mean and include any individual, trust, corporation, partnership or other entity.
- 8.7 **Amendment** Except as otherwise specifically provided herein, no amendment to this agreement shall be effective against a party to this Agreement unless such amendment is in writing, signed by such party, PROVIDED HOWEVER, the Provider/Facility Manual may be amended from time to time in the sole discretion of CHN
- 8.8 **Compliance with Terms** Failure to insist upon strict compliance with any of the terms herein (by way of waiver or breach) by either party hereto shall not be deemed to be a continuous waiver in the event of any future breach or waiver of any condition hereunder.
- 8.9 **Rights of Parties** Except for the right granted by CHN to certain Payors or Network Lessees to enforce this Agreement as a third party beneficiary, nothing in this Agreement, whether express or implied, is intended to confer any rights or remedies under or by reason of this agreement on any persons other than the parties to this Agreement and their respective successors and assigns.
- 8.10 **Assignment** This Agreement may not be assigned by Provider without the express written consent of CHN. CHN may assign this Agreement, upon notice to Provider, to any other entity.
- 8.11 **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.
- 8.12 **Severability** If any portions of this Agreement shall, for any reason, be invalid or unenforceable, such portions shall be ineffective only to the extent of such invalidity or unenforceability, and the remaining portion or portions shall nevertheless be valid, enforceable and of full force and effect.
- 8.13 **Multiple Counterparts** This Agreement may be executed in multiple counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute a single instrument.
- 8.14 **Conflict of Laws** This Agreement shall be governed by the laws of the State of New Jersey, without giving effect to its conflicts of law provisions.

IN WITNESS WHEREOF, the parties hereto have set their hands on the dates set forth below, as of the Effective Date set forth below.

PROVIDER:

CONSUMER HEALTH NETWORK PLUS, LLC
d/b/a CHN PPO
300 American Metro Blvd, Suite 220
Hamilton, NJ 08619

Date

Signature of Provider

By _____

Name of Provider

Name

Address

Title

City, State, Zip Code

NPI Number

Effective Date of Agreement

Federal Tax ID Number or Social Security Number

EXHIBIT 2.8

STANDARD TERMS

The following shall constitute the Standard Terms as defined in this Agreement. As part of a separate agreement between CHN and Payors, CHN shall use reasonable efforts to have Payors observe the Standard Terms.

- 1 **Covered Services** Participating Provider shall furnish to Eligible Persons those Medically Appropriate Covered Services customarily furnished by such Participating Provider in the same physical setting and in the same manner as such services are customarily provided to other similarly situated patients of Participating Provider.
- 2 **Payment to Participating Provider** Pursuant to the terms of the applicable Plan, Payor or its agent and the Eligible Person shall pay to Participating Provider the lesser of Participating Provider's charges customarily billed to other patients or the amounts set forth in the applicable Fee Schedule as full payment of any claim submitted by Participating Provider for Covered Services furnished to Eligible Persons pursuant to such Plan.
- 3 **Payment by Eligible Persons** Participating Provider and/or any provider on call for Provider shall: (i) bill Eligible Persons directly for, and use best efforts to collect, any deductible, co-payment or coinsurance for Covered Services specified in the applicable Plan, unless otherwise prohibited in such Plan, in amounts which, when added to Payors payments shall not exceed the lesser of charges customarily charged to other patients or the consideration provided in the applicable Fee Schedule; (ii) bill Eligible Persons directly for any services that are not Covered Services; and (iii) bill Eligible Persons directly for any Covered Services provided to Eligible Persons after the benefits set forth in a Plan to which the Eligible Person is entitled have been exhausted.
- 4 **Claims Submission** Each Participating Provider shall, as provided in the applicable Plan, submit claims to CHN, the agent of CHN, Payor or the agent of Payor, on a UB-04 form or CMS-1500 form, or successor forms, as applicable. Participating Providers shall use best efforts to submit claims within thirty (30) days after providing Covered Services. Payors shall have the right to deny payment of any claims, which have not been submitted by Participating Provider within six (6) months after providing Covered Services. CHN, CHN's agent, Payor or Payor's agent shall apply the applicable Fee Schedule, which was in effect on the date the Covered Services were provided to each Participating Provider's claim to determine the amount due such Participating Provider.
- 5 **Time for Payment**
 - 5.1 Except where coordination of benefits applies or when a claim is subject to audit, Payor or its paying agent shall use all reasonable efforts to make all payments due to Participating Provider within forty-five (45) days following receipt by Payor, or its paying agent, of a complete and proper claim form and other information required to determine that the claim is payable under the Plan; PROVIDED, HOWEVER, the timing of the payment of claims by government entity Payors shall be subject to adequate funding of such Payors.
 - 5.2 Payment by Payor of any claim shall be final ninety (90) days after payment and neither Payor nor Provider shall have further recourse. Provider may initiate an appeal on or before the 90th calendar day following receipt of payment.
- 6 **Verification of Eligible Persons** Participating Providers shall be notified of the eligibility of Eligible Persons in accordance with Payors' customary verification procedures.
- 7 **Exhaustion of Benefits** If an Eligible Person shall exhaust any benefits under any Plan, Participating Provider shall arrange for payment to be made by such Eligible Person directly to Participating Provider.
- 8 **Coordination of Benefits** If coordination of benefits is required with respect to a New Jersey issued group insured health plan, subject to New Jersey's regulations governing the coordination of benefits, such coordination of benefits shall be in accordance with N.J.A.C. 11:4-28.7(e). In all other instances the following (a) – (c) shall apply: (a) To the extent additional parties shall be liable, under coordination of benefits, for payment to Participating Providers for Covered Services rendered to Eligible Persons, such other party or parties shall not be entitled to the benefit of any rates set forth in the Fee Schedule if this Agreement is primary, regardless of any coordination of benefit provisions in such party's agreement with the Eligible Person or Participating Provider and regardless of whether such party is the primary or secondary insurer; (b) Secondary Payor shall be responsible for any copayments, deductibles or coinsurance for which Covered Person is liable up to the amount set forth in the Fee Schedule; and (c) When the amount due to the Participating Provider from the Eligible Person and the primary and/or secondary Payor is equal to or greater than the Fee Schedule under this Agreement, no payment shall be due under this Agreement
- 9 **Workers' Compensation, EPO, POS and Other Programs** The standard terms for workers' compensation, EPO, POS and other programs shall be set forth in the Provider/Facility Manual and subject to the applicable requirements of the laws of the appropriate state.
- 10 **Service**. Participating Provider shall establish procedures, including an appropriate call system, to provide that Covered Services are available to Eligible Persons twenty-four (24) hours per day, seven (7) days per week. Any provider with which Provider has an arrangement to provide coverage for Provider shall abide by all of the terms and conditions of this Agreement, including, without limitation, accepting the Fee Schedule as payment in full for Covered Services.
- 11 **Communication with Eligible Person** Participating Provider shall not be penalized and this Agreement shall not be terminated solely because Provider acts as an advocate for an Eligible Person in seeking Medically Appropriate Covered Services. Provider is encouraged to communicate all Medically Appropriate diagnostic testing and treatment options to Eligible Persons.
- 12 **Amendment of Standard Terms** The Standard Terms shall be automatically amended to include applicable statutory or regulatory requirements.
- 13 **Healthcare Quality Act (NJ Provider) Participating** Provider shall not be penalized and this Agreement shall not be terminated because Participating Provider acts as an advocate for an Eligible Person in seeking Medically Appropriate Covered Services. Participating Provider is encouraged to communicate all Medically Appropriate diagnostic testing and treatment options to Eligible Persons.
- 14 **Standard Terms Applicable to Carriers Only** The following terms apply only to Carriers. Accordingly, these terms are in addition to the other terms and conditions of this Agreement including the Standard Terms.
 - 14.1 **Carrier Insolvency**. Provider shall not have a right in any event, including but not limited to nonpayment by a Carrier of amounts due the Provider under this Agreement, insolvency of a Carrier or any breach of this Agreement by the Carrier, to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Eligible Person, persons acting on the Eligible Person's behalf (other than the Carrier), an employer or group contract holder for services provided pursuant to this Agreement except for the payment of applicable co-payments or deductibles for services covered by the Carrier or fees for services not covered by the Carrier. The requirements of this clause shall survive any termination of this Agreement for services rendered prior to such termination, regardless of the cause of such termination. The Carrier's Eligible Persons, the persons acting on the Carrier's Eligible Person's behalf (other than the Carrier) and the employer or group contract holder shall be third party beneficiaries of this section. This section supersedes any oral or written agreement now existing or hereafter entered into between Provider and the Eligible Person, persons acting on the Eligible Person's behalf (other than the Carrier) and the employer or group contract holder. This Section 14.1 shall be automatically amended to conform with any applicable statutory requirements of the state in which services are rendered by Provider.
 - 14.2 **Non-Limitation of Carrier** Nothing in this Agreement shall be construed to in any manner limit the authority or responsibility of a Carrier to comply with all regulatory requirements.

EXHIBIT 2.9

FEE SCHEDULE

- 1 **Fee Schedule** The schedule of maximum reimbursement amounts pursuant to which Payors shall pay Participating Providers to provide Medically Appropriate Covered Services shall be the lesser of the following:
 - 1.1. the then current Fee Schedule of CHN, samples of which may be provided from time to time or supplied upon request from Provider;
 - 1.2. any applicable state, federal or other mandated fee schedule; or
 - 1.3. the actual fees or charges of Provider.
- 2 **Amendment** This Fee Schedule shall remain in force until modified, in writing, pursuant to Section 3.2 of this Agreement.
- 3 **Entire Agreement** This Exhibit 2.9 represents the entire agreement of the parties with respect to the Fee Schedule and all prior and concurrent agreements, correspondence or oral negotiations citing sample fees or charges, understandings, representations, or warranties with respect to the Fee Schedule have been merged herein and superseded hereby.

CREDENTIALING CRITERIA**1 PROFESSIONAL CREDENTIALS**

- 1.1 Provider is either (i) a person with an unrestricted license or other authorization to practice in the state of location; or (ii) a partnership, professional service corporation or other entity, all of the partners, shareholders, members and provider employees of which have an unrestricted license or other necessary authorization to practice in the state of location. A copy of Provider's current valid license shall be provided with Provider's application to CHN ("Application").
- 1.2 Provider, where applicable, has active full and unrestricted clinical and admitting privileges in Provider's specialty at a minimum of one (1) Participating Provider facility ("Participating Facility") or if Provider is a member of a non-admitting specialty, maintain full and unrestricted privileges appropriate to such specialty at a Participating Facility. Provider shall maintain each Participating Facility and other hospital, medical or professional staff appointment and all clinical and admitting privileges granted in connection therewith that Provider possessed as of the Effective Date of Provider's Participating Provider Agreement. A letter from each Participating Facility stating the Provider has such clinical privileges shall be provided with the Application.
- 1.3 Provider shall, if permitted under Provider's license, have and maintain unrestricted prescribing privileges. A copy of Provider's current DEA certification and state drug registration ("DPS"), if applicable, shall be provided with the Application.
- 1.4 Provider, where applicable, has not and shall not (i) have any hospital appointment or privileges reduced, limited, suspended or terminated or been placed on probation by any hospital at which Provider has had a medical or professional staff appointment or privileges; (ii) been restricted from receiving payments from Medicare, Medicaid or any other third party reimbursement programs; (iii) been subject to disciplinary action by any state or local medical society, specialty society, state board of medical examiners or the Drug Enforcement Agency; or (iv) been subject to sanctions of any kind whatsoever by any person or entity for improper prescribing procedures or actions; PROVIDED, HOWEVER, that, in the discretion of CHN, the foregoing shall not apply to suspensions related to a reasonable delay in completing medical records. Any such actions shall be reported by Provider on the Application.
- 1.5 Provider has not and shall not have been disciplined, suspended or terminated from a PPO, HMO or other managed care organization.
- 1.6 Provider has not been convicted of a felony.
- 1.7 Provider is in good general health.
 - 1.7.1 Provider shall report on the Application any physical or mental problems that may affect Provider's ability to practice Provider's profession. If Provider has such disabilities the Provider shall provide, with the Application, a statement from Provider's personal physician stating that the disabilities shall not interfere with the Provider's ability to provide high quality medical care.
 - 1.7.2 Provider shall certify on the Application that Provider does not have a history of and is not presently abusing drugs or alcohol. A Provider with a history of drug or alcohol abuse may be considered for membership in CHN, within the sole discretion of CHN, if such Provider's personal physician provides a statement that Provider has been rehabilitated and is continuing with the rehabilitation program.
 - 1.7.3 Provider shall certify on the Application that Provider does not have any communicable and/or chronic infectious disease that may be potential danger to patients.
 - 1.7.4 CHN shall have sole discretion in the determination of the impact of the health status of Provider for purposes of credentialing.
- 1.8 Provider shall purchase and maintain, at the sole cost and expense of Provider, policies of professional liability insurance in amounts as required by CHN from time to time. At the present time such insurance shall be a minimum of ONE MILLION DOLLARS (\$1,000,000.00)/THREE MILLION DOLLARS (\$3,000,000.00). Provider shall authorize the insurance carrier to issue to CHN a certificate of insurance policies of Provider upon the request of CHN, and each such policy shall contain an endorsement requiring the insurer to give CHN not less than thirty (30) days prior written notice of any cancellation, termination or material alteration of such policy. Notwithstanding the foregoing, Provider shall provide CHN with notification within fifteen (15) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such policy, Provider shall secure replacement of such insurance coverage upon the same terms, and shall furnish CHN with a certificate and endorsement as described herein. A copy of the issuing section of the policy reflecting such insurance shall be provided with the Application.
- 1.9 Provider shall provide the following information on the Application:
 - 1.9.1 Details of any professional liability actions that have resulted in adverse judgments or any financial settlements.
 - 1.9.2 Details of any pending professional liability actions or claims or threatened claims with respect to professional liability.

This information shall be reviewed by CHN. The evaluation shall consider the frequency of such actions, the financial impact of such actions and the clinical circumstances surrounding the alleged acts of malpractice. CHN is fully cognizant of the current litigious conditions in the United States and its evaluation shall consider the litigious climate as part of the credentialing process. Providers shall not be automatically disqualified from participation in CHN due to a history of judgments and/or settlements. CHN shall have sole discretion in the determination of the impact of this information for purposes of credentialing.
- 1.10 Physician Providers (i) shall be board certified in a specialty recognized by the American Board of Medical Specialties ("ABMS") or other appropriate boards applicable to the specialty of Provider in the sole discretion of CHN; or (ii) shall have completed a fully-approved formal residency program that meets all of the educational requirements of the ABMS, American Osteopathic Association or the American Podiatric Association, as applicable. A copy of Provider's board certification or appropriate training shall accompany the application. Expiration or re-certification dates shall be indicated where applicable.
- 1.11 The Provider shall provide complete information with respect to professional training, which shall include, without limitation, the following:
 - 1.11.1 Undergraduate Education
 - 1.11.2 Medical and/or Professional Education
 - 1.11.3 Internship and Residency
 - 1.11.4 Fellowships
 - 1.11.5 Teaching/Faculty appointments
 - 1.11.6 Professional publications
 - 1.11.7 References where required on the Application
- 1.12 The credentials of Providers shall only be acceptable if the Provider's practice is limited to the specialty in which the Provider has received training and Provider has completed an acceptable residency program. CHN shall have the sole discretion with respect to the determination of the impact of this information for purposes of credentialing. CHN reserves the right to require specific formal training in new procedures and/or technologies prior to credentialing, Recredentialing or, if applicable, recommending payment for procedures.
- 1.13 Provider shall, in the sole discretion of CHN, demonstrate a commitment to continuing medical education. The attachment of a current Physician's Recognition Award from the American Medical Association shall satisfy this requirement. In the absence of this Award, Provider shall attach to the Application evidence of a minimum of fifty (50) hours of Category I CME Credits within the previous two (2) year period satisfactory to CHN.

- 1.14 Applicant shall maintain appropriate medical records and shall, subject to applicable law, provide such records to CHN as deemed necessary by CHN, in its sole discretion, for purposes of utilization management and/or quality assessment.
- 1.15 Applicant shall provide twenty-four (24) hour-a-day coverage, seven (7) days a week by other Participating Providers with training equivalent to the Provider. Individual exemptions of this requirement may be granted for Providers for which there are no local equivalently trained Providers. Determinations of equivalent training and the granting of any waiver of this requirement shall be in the sole discretion of CHN.
- 1.16 Provider shall: (i) properly maintain, calibrate and license all diagnostic equipment in Provider's offices; (ii) maintain a formal quality control program for all office diagnostic equipment; and (iii) allow diagnostic testing and procedures to be performed and interpreted only by persons with appropriate training and/or certification.
- 1.17 CHN reserves the right to require independent verification of any and all of the Credentialing Criteria and to perform site visits to the locations of Provider.

ADDENDUM TO PARTICIPATING PROVIDER AGREEMENT

The following applies to fully insured health benefits clients and supersedes any terms in the main body of the Agreement which are inconsistent with this addendum.

1 Definitions

- 1.1 **Medical Necessity** - means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease; not primarily for the convenience of the covered person or the health care 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 covered person's illness, injury or disease.

2 Amendments

- 2.1 This Agreement and any material amendments thereto are subject to prior approval of the NJ DOBI, and may not be effectuated without such approval. Any amendments that alter numbers, be they dollar amounts, enrollment amounts or the like, without altering methodologies from which the numbers were derived are not subject to prior approval of the NJ DOBI.
- 2.2 Any sections of the Agreement that conflict with State or Federal law are effectively amended to conform with the requirements of the State or Federal law.

3 Time for Payment

- 3.1 Provided the criteria set forth in (a) – (e) immediately below are met, the following time frames shall apply to the payment of claims submitted to Payors: For claims submitted electronically, Payor shall remit payment no later than the 30th calendar day following receipt of claim by Payor or no later than the limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. s. 1395u(c)(2)(B), whichever is earlier. If the claim is submitted by other than electronic means, Payor shall remit payment no later than the 40th calendar day following receipt of claim by Payor.

- (a) the health care provider is eligible at the date of service;
- (b) the person who received the health care service was covered on the date of service;
- (c) the claim is for 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 covered person; and
- (e) the Payor has no reason to believe that the claim has been submitted fraudulently.

4 Procedure Upon Termination – Upon the termination of this Agreement, whether for cause or not for cause, whether voluntary or involuntary, all rights and obligations hereunder shall cease except (i) those rights in this section 3; and (ii) those rights and obligations which shall have accrued as a result of the operation of this Agreement. Upon termination Provider shall:

- 4.1 continue to provide Covered Services pursuant to this Agreement (i) until either the termination of each Payor Agreement in force on the date of termination or twelve (12) months, whichever is earlier; and (ii) thereafter, to Eligible Persons who shall be receiving care from Provider until the earlier of the conclusion of any treatment for a specific condition existing as of such termination except in cases of pregnancy where covered services shall continue to the postpartum evaluation up to six weeks after delivery, post-operative care covered services shall continue for a period of up to six months, oncological treatment covered services shall continue for a period of up to one year and psychiatric treatment covered services shall continue for a period of up to one year or the discharge or transfer of such Eligible Person;

5 Fee Schedule – If required by New Jersey law, CHN, on behalf of Payor, shall provide fee schedule information to health care providers as follows:

CHN shall, upon request, furnish Provider with a written fee schedule, or in an electronic format if agreed upon by both parties, showing the fees for the 20 most common evaluation and management codes and the 20 most common office-based or hospital-based in-network services for Provider, to be provided by Provider under the applicable Payor Agreement to which the request applies. If CHN negotiates a fee schedule with Provider that is specific to Provider, CHN shall provide only the applicable fee schedule for Provider. CHN shall furnish the information requested under this Section 5 within 15 days of the request of Provider.

Provider agrees that information provided under this Section 5 is proprietary and shall be kept confidential by Provider. Unauthorized distribution of such information may result in the health care Provider's termination from the network.