HEALTH CARE SERVICE PROVIDER AGREEMENT (IPA)

THIS Agreement is made by and between _____ (hereinafter referred to as "Provider"), on behalf of its member providers (hereinafter referred to as Member Providers), a corporation composed of providers licensed to practice medicine and/or provide medical services in the state or states where services are provided, and USA MANAGED CARE ORGANIZATION, INC. A TEXAS CORPORATION, (hereinafter referred to as "USA").

WITNESSETH:

WHEREAS, USA is a Preferred Provider Organization (PPO) engaged in the business of administrating quality health care services at an affordable price through its products {USA H & W Network, a group health and wellness program, USA Workers' Injury Network (USA WIN), USA Medicare Select, HMO}, and Provider desires to provide services for the members (hereinafter referred to as "INSUREDS") of various group accident/health plans, work related injury/illness plans, motorist medical plans, Medicare Select plans, Health Maintenance Organization plans, and self-insured employers, and foreign nationals (including citizens, employees, and embassy officials) with state governments which have entered into agreements with USA, (hereinafter referred to collectively as "INSURERS"); and

WHEREAS, USA has a network of contracted facilities, physicians, providers and other ancillary service providers (hereinafter referred to along with Provider as "Providers") available for use by the eligible INSUREDS of various plans contracted with USA, thereby making available to INSUREDS such Providers for health and medical care needs; and

WHEREAS, Providers shall be made available by USA as a convenience to INSUREDS for the purpose of allowing INSUREDS access to health and medical care; and

WHEREAS, Provider desires to contract with USA and its affiliates to provide services to INSUREDS and to accept as payment in full for such services the amounts set forth in the attached Exhibit B; and

WHEREAS, Member Providers agree to conduct themselves ethically and in a manner that shall preserve and maintain the human dignity and integrity of all patients, and by their attitude and manner shall convey to the patient compassion and concern for the patient's problems. Member Providers shall dedicate themselves to alleviating those problems and providing comfort and care to those in need.

NOW, THEREFORE, in consideration of the mutual covenants herein contained and for good and valuable consideration, the legal adequacy of which is hereby acknowledged, the parties hereby agree as follows:

1. **Services to be provided.**
   a) USA does hereby agree to add Member Providers to its network of Providers in accordance with the Declaration of Standards for Participation, and Member Providers do hereby agree to comply with USA policies for Member Provider participation and to provide INSUREDS with medical/surgical care in their medical specialty(ies) and exercise their best medical judgment in the treatment of the eligible INSUREDS. With respect to such services, Member Providers agree to accept the rates set forth in Exhibit B of this Agreement, as full compensation for such services. Member Providers agree to provide 24 hours per day, 7 days per week call coverage. Member Providers must maintain active clinical privileges with at least one USA paneled facility in accordance with the Declaration of Standards for Participation. Attachment A sets out the specific provisions for USA Worker's Injury Network and Provider and Member Providers agree to comply with the terms, provisions and conditions of the applicable Attachment. Attachment B sets out the specific provisions for Lonestar Athletic Network and Provider agrees to comply with the terms, provisions and conditions of the applicable Attachment. Attachment C sets out the specific provisions for Alter-Net and Member Provider agrees to comply with the terms, provisions and conditions of the applicable Attachment.

   b) **HOSPITALIZATION-REFERRALS:** Member Providers agree that when hospitalization is necessary, they will arrange for hospitalizing INSUREDS in participating USA facilities when consistent with good medical practice. A toll-free number will be provided on INSURED'S I.D. card to obtain the names and locations of such participating USA facilities.

   c) **SPECIALIST-REFERRALS:** Member Providers agree to refer INSUREDS to a USA contracted participating specialist when necessary, and when consistent with good medical practice. Member Providers further agree to use the services of other USA contracted ancillary service providers when necessary and when consistent with good medical practice. A toll-free number will be provided on INSURED'S I.D. card to obtain the names and locations of such specialists participating with USA.

2. **Rates to be Paid to Provider.**

a) Member Providers, billing under their name and under the tax I.D. number provided to USA by Provider and/or Member Provider, are to be paid by INSURER according to the rates established in Exhibit B not to exceed billed charges. The negotiated rates in the Exhibit B represent the total amount to be received by Member Providers including any co-payments, co-insurance and/or deductibles paid by INSUREDS. INSURER shall pay the amount due to Member Providers for services rendered to INSURED, based on the provisions of the applicable plan and Member Providers agree to look to INSURER for the payment of such covered services except for any amounts required to be paid by INSURED pursuant to Subparagraph 2(c). Payments will be made to Member Providers for medical services actually rendered and only after submission of a claim.

b) Member Providers agree to provide services under this Agreement for the treatment and care of illnesses, injuries or conditions of INSUREDS. In the event a third party other than INSURER should have primary responsibility for payment of services provided an INSURED, Member Providers agree to collect payment from such other source prior to requesting payment from INSURER. Any payment made by INSURER to Member Providers for obligations which are the primary responsibility of a third party shall be refunded to INSURER by Member Providers. By executing this Agreement, Provider and/or Member Providers waive all rights to collect, and/or pursue collection of any amounts in excess of the reimbursement listed in Exhibit B from any INSURERS who may have secondary responsibility.

c) Services rendered or items furnished INSUREDS by Member Providers which are not covered as a benefit under the applicable plan and all co-payments, co-insurances and/or deductibles, are to be paid by INSURED and Member Providers are responsible for collection of such payments.

d) Member Providers agree and acknowledge that USA is administrating health care services on behalf of INSURERS under this Agreement. USA will not be responsible or liable for the cost of any services provided to INSUREDS by Member Providers or for the payment of any claim to Member Providers.

e) Member Providers agree to participate in the Cost Containment Guidelines as set forth in Exhibit A.

3. **Payment of Claim.**

Payment of claims is subject to the terms and conditions of INSURED'S insurance plan. Payment by INSURER shall be limited to services provided to INSURED for which INSURED is eligible. Payment by INSURER shall be reduced by co-payments, co-insurance and/or deductibles. Member Providers agree to bill at their usual and customary rate and further agree not to bill for the difference between Member Providers' usual and customary rates and the rates set forth in Exhibit B. INSURER shall make payments within thirty (30) days of receipt of claims, unless written notice of dispute or discrepancy is mailed to Member Providers within thirty (30) days. If claim is not paid within thirty (30) days on undisputed claims and ninety (90) days on disputed claims, Member Providers shall have the right to deny the negotiated rates set forth in Exhibit B and seek full billed charges.

4. **Hold Harmless.**

a) **PPO INSUREDS**

Member Providers agree that INSURER is responsible for payment of Member Providers' compensation pursuant to this Agreement. Member Providers shall not request payment from any INSURED for any treatment or services provided to INSURED pursuant to the terms of the Agreement except as otherwise provided herein. Member Providers agree to release and hold harmless INSURED, provided INSURER makes payment pursuant to the terms of this Agreement. Notwithstanding the foregoing, in the event INSURER fails to make payment within ninety (90) days of receipt of claim or if INSURER is declared insolvent or otherwise unable to make payment, Member Providers may bill INSURED for services rendered.

b) **HMO INSUREDS**

Member Providers hereby agree that in no event, including but not limited to non-payment by INSURER, INSURER insolvency, or breach of this Agreement, shall Member Providers bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against INSURED, or persons other than INSURER acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges (non-covered services) or co-payments on INSURER'S behalf made in accordance with the terms of the applicable plan between INSURER and INSURED.

Member Providers further agree that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of INSURED, and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Member Providers and INSURED or

persons acting on their behalf. Any modifications, additions or deletions to the provisions of this clause shall be effective on a date no earlier than fifteen (15) days after the Commissioner of Insurance has approved such changes.

5. Medical Records.

a) With the proper patient consent and in accordance with all local, state and federal laws governing confidentiality, Member Providers shall make available to USA, INSURER, or as applicable all federal, state and local agents, copies of all medical records for the purpose of maintaining a quality assurance program required by USA or INSURER for a period of the greater of five (5) years from the date of treatment or consultation or the number of years that medical records are required to be kept under applicable governing laws.

b) Member Providers shall furnish, upon request and without charge, all information reasonably required by USA to verify and substantiate its provision of medical services, the charges for such services, and the medical necessity for such services.

6. Pre-Certification and Certification.

It is the responsibility of Member Providers to verify with INSURER prior to the delivery of medical services in non-emergent situations and within forty-eight (48) hours or the next business day in emergency situations that any patient is an INSURED in good standing under the applicable plan and eligible for benefits, as well as to obtain information as to the extent and nature of INSURED'S benefits. Member Providers understand that it is their responsibility to verify eligibility and benefits allowing Member Provider to determine if/when pre-certification (pre-authorization) and certification (authorization) is required by the plan. Member Providers understand that an INSURED'S membership identification card is not a guarantee that the cardholder is an INSURED in good standing. INSURED'S I.D. card will display appropriate telephone numbers for benefit/eligibility verification.

Member Providers agree and acknowledge that USA has contracted with various INSURERS. INSURERS have elected at their discretion to secure services {pre-certification (pre-authorization), certification (authorization), case management and utilization management} from the vendor of their choice. While the requirements of the plan, as well as each vendor may vary, Member Providers agree, at a minimum to comply, free of charge, with the following:

Non-emergent and/or post-stabilization facility admissions after the provision of emergency care may require pre-certification/certification to be eligible for full benefits. Member Providers agree to phone the appropriate number provided on INSURED'S identification card to determine whether pre-certification/certification is required. Member Providers agree to notify the appropriate party prior to the delivery of medical services in non-emergent situations and within forty-eight (48) hours or the next business day in post-stabilization emergent situations. Member Providers should be prepared to provide the following information:

a) Patient's name, sex, and date of birth
b) INSURED'S name, address, social security number, and group/policy number
c) Name of INSURER
d) Pre-admission diagnosis(es)
e) Name, address, and telephone number of the physician
f) Date of service (admission or procedure date)
g) Treatment and or surgical procedures

Member Providers further understand that pre-certification and certification are a determination of medical necessity. Pre-certification/certification shall be granted when the intensity level of the treatment and the level of care are appropriate with respect to the severity of the illness. Medical services will be pre-certified/certified based on the information provided to the appropriate party at the time of notification. Pre-certification and certification are not verification of eligibility and/or benefits. To verify eligibility and/or benefits, Member Providers must phone the appropriate number listed on INSURED'S identification card.

In the case of an admission, if the medical condition of INSURED is such that he/she cannot be discharged from the facility on the last day certified, Member Providers must call the appropriate telephone number on INSURED'S identification card on or before the last day certified to determine whether additional days may be certified. Benefits may be reduced for additional days which are not certified.

In the case of an admission, where INSURED'S illness, injury or condition (e.g. coma) prohibits INSURED from cooperating with Member Providers to identify himself/herself as an INSURED having access to USA's network, Member Providers agree to notify the appropriate party as soon as Member Providers are able to identify INSURED.

Emergent admissions may be payable if they **a)** are certified or **b)** meet the conditions of an emergency as defined below:

An emergency is:

1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
   (i) 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; or
   (ii) serious impairment to bodily functions; or
   (iii) serious dysfunction of any bodily organ or part; or
   (iv) a "mental health" emergency consisting of a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

2) With respect to a pregnant woman who is having contractions:
   (i) that there is inadequate time to effect a safe transfer to another hospital before delivery; or
   (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

7. Change in Terms and Benefits.
It is agreed by the parties hereto that the benefits, terms and conditions of the various agreements between INSURER and INSURED of any plan may be changed during the term of this Agreement without notice. However, such changes will not affect this Agreement unless agreed to by Provider and USA.

8. Termination of Coverage of INSUREDS.
Coverage for each INSURED may be terminated by INSURED or INSURER. When an INSURED whose coverage has terminated receives services from a Member Provider, Member Providers agree to bill INSURED directly. INSURER shall not be liable to Member Providers for any bills incurred by an INSURED whose coverage has been terminated.

9. Duration.
The initial term of this Agreement shall be a period of one (1) year from the date of execution of this Agreement by USA. During that time, Provider agrees that the reimbursement listed in Exhibit B will not be subject to increase. This Agreement shall automatically renew for successive one (1) year terms on the anniversary date of this Agreement and shall remain in force until termination as provided for in Section 10 (Termination) of this Agreement.

10. Termination.
Either party to this Agreement may elect to terminate this Agreement, without cause, at any time by giving one hundred eighty (180) days prior written notice to the other party. Said notice shall clearly explain the reason giving rise to termination to be considered in compliance with this Section.

USA may terminate this Agreement at any time for immediate cause, which includes, but is not limited to:

a) The conviction of Provider of a felony.

b) Unprofessional conduct by or on behalf of Provider as defined by the laws of the state where services are rendered.

c) Provider's filing of bankruptcy (whether voluntary or involuntary), declaration of insolvency, or the appointment of a receiver or conservator of its assets.

USA may terminate a Member Provider's participation for immediate cause, without terminating this Agreement as a whole which includes, but is not limited to:

a) The failure of a Member Provider to maintain or obtain a license to practice medicine in the state where services are provided.

b) The failure of a Member Provider to obtain and/or maintain hospital privileges at a hospital or ambulatory health care facility contracted with USA.

c) The cancellation of a Member Provider's coverage or insurability under his/her professional liability insurance.

d) The conviction of a Member Provider of a felony.

e) Death of a Member Provider.

f) Unprofessional conduct by or on behalf of a Member Provider as defined by the laws of the state where services are rendered.

g) Member Provider's filing of bankruptcy (whether voluntary or involuntary), declaration of insolvency, or the appointment of a receiver or conservator of his/her assets.

In the event this Agreement, or a Member Provider is terminated for immediate cause, termination shall be effective upon receipt of written notification.

USA may also terminate this Agreement or a Member Provider for reasons other than immediate cause. Those reasons may include, but are not limited to, a breach of any provision contained in this Agreement, habitual neglect, or the continued failure of Provider and/or a Member Provider to perform his/her professional duties. If termination is for reasons other than immediate cause, USA will notify Provider and/or Member Provider in writing, stating the reason for termination, and giving Provider and/or Member Provider sixty (60) days in which to cure.

If Provider and/or a Member Provider has failed to effect a satisfactory cure within the sixty (60) day cure period, of all reasons stated in the notice of termination, termination shall be effective on the tenth (10th) day following the expiration of the sixty (60) day cure period.

11. Notice to INSURER of Termination of Agreement.

In the event this Agreement is terminated by either party in accordance with the procedure set forth herein, USA will notify INSURER. Provider agrees to notify Member Providers and Member Providers will notify INSUREDS, prior to giving service, that this Agreement is no longer in effect.

12. Accuracy of Information.

Provider represents and warrants that all information provided to USA is true and accurate in all respects and acknowledges that USA is relying on the accuracy of such information in entering into and continuing the term of this Agreement. Provider shall promptly notify USA, without request, of any change in the information provided.

13. Independent Contractor.

a) In entering into and complying with this Agreement, USA is at all times performing as an independent contractor. Nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee, principal and agent, partnership, joint venture, or any relationship other than that of independent parties contracting with each other solely to carry out the provisions of this Agreement for the purposes recited herein.

b) Member Providers shall be responsible for the treatment and medical care provided to each INSURED that Member Providers treat.

14. Confidentiality.

Each party may, in the course of the relationship established by this Agreement, disclose to the other party in confidence non-public information concerning such party's earnings, volume of business, methods, systems, practices, plans, purchaser discounts and contract terms, or other confidential or commercially valuable proprietary information (collectively referred to as "Confidential Information"). Each party acknowledges that the disclosing party shall at all times be and remain the owner of all Confidential Information disclosed by such party, and that the party to whom Confidential Information is disclosed may use such Confidential Information only in furtherance of the purposes and obligations of this Agreement. The party to whom any Confidential Information is disclosed shall use its best efforts, consistent with the manner in which it protects its own Confidential Information, to preserve the confidentiality of any such Confidential Information which such party knows or reasonably should know that the other party deems to be Confidential Information.

The party to whom Confidential Information is disclosed shall not use said information to the disadvantage of or in competition against the disclosing party. It is understood by each party that any Confidential Information disclosed is non-public information which is of great value to the disclosing party and that a breach of the foregoing confidentiality provision would cause irreparable damage. In the event of such a breach, the injured party shall have the right to seek and obtain in any court of competent jurisdiction an injunction to restrain a violation or alleged violation by the other party of this covenant together with any damages that the party may suffer in the event of such a breach.

15. Disputes.

USA agrees to attempt resolution of any dispute that may arise between Member Provider and INSURER from services delivered by Member Provider to an INSURED of INSURER. USA will act as a mediator between Member Provider and INSURER to resolve the dispute. Member Provider agrees to cooperate with USA acting as mediator, and INSURER in resolving the dispute. Cooperation includes providing any documentation requested by USA. If the mediation does not result in the resolution of the dispute, USA agrees to notify the parties in writing, and the parties may then seek any other means of resolution of the dispute.

If there is a dispute between the parties concerning the interpretation, performance or lack of performance of any term, condition or provision of this Agreement, the parties agree that they will submit the dispute to mediation with a third party neutral prior to filing a lawsuit. If the mediation does not result in a resolution of the dispute, then the parties may file suit to resolve the dispute. The parties agree that jurisdiction for any lawsuit filed by either party to enforce or interpret any provision, term or condition of this Agreement shall be brought in a court of competent jurisdiction in the State of Texas, and that venue for that suit shall be in Travis County, Texas. The prevailing party in any lawsuit brought pursuant to this paragraph shall be entitled to recover its reasonable attorney's fees and costs from the non-prevailing party.

16. Responsibility of the Parties.
Each party agrees it shall not be responsible for any claims, losses, damages, liabilities, costs, expenses or obligations arising out of or resulting from the negligent or willful misconduct of the other party, its officers, employees or agents in the performance of services pursuant to this Agreement.

17. Notices.
All notices, requests, or correspondence required under this Agreement shall be in writing, and delivered by United States mail to:

a) If to USA:

USA MANAGED CARE ORGANIZATION, INC.
4609 Bee Caves Rd, Suite 200
Austin, Texas 78746
Attention: Provider Relations
E-mail Address: info@usamco.com

b) If to Provider:

_____
_____
_____
Attention: _____
E-mail Address: _____

Either party may change the address to which communications are to be sent by giving written notice. All communications will be directed to Provider at the most current address on file with USA.

18. Attorney's Fees.
If it shall become necessary for either USA, Provider and/or Member Providers to employ an attorney to enforce or defend its rights under this Agreement, the non-prevailing party in any arbitration, legal action, or proceeding shall reimburse the prevailing party for its reasonable attorney's fees and costs of suit in addition to any other relief to which such party is entitled.

19. Partial Invalidity.
If any part, clause or provision of this Agreement is held to be void by a court of competent jurisdiction, the remaining provisions of this Agreement shall not be affected and shall be given such construction, if possible, as to permit those remaining provisions to comply with the minimum requirements of any applicable law and the intent of the parties hereto.

20. Waiver.
A party's waiver of a breach of any term of this Agreement shall not constitute a waiver of any subsequent breach of the same or another term contained in the Agreement. A party's subsequent acceptance of performance by the other party shall not be construed as a waiver of a preceding breach of this Agreement other than failure to perform the particular duties so accepted.

21. Controlling Law.
This Agreement and all questions relating to its validity, interpretation, performance and enforcement shall be governed by and construed in accordance with the laws of the state where services are being provided.

22. Conformity with Federal and State Statutes.
The Parties intend that the terms, conditions and provisions of this Agreement be and remain in compliance with the Medicare laws of the United States and any rules and regulations promulgated pursuant to that law or the laws of any state of the United States that are applicable to this Agreement. Therefore, if any term, provision or condition contained in this Agreement, is in conflict with the Medicare laws, rules and regulations, or any state laws, rules or regulations that are applicable to this Agreement, the conflicting term, provision or condition is modified, added, changed or amended without further action of the Parties so that this entire Agreement is consistent with and complies with Medicare laws, rules and regulations, and applicable state laws, rules and regulations. USA agrees to give Provider notice in writing of any change, modification, addition or deletion to this Agreement that is necessary for this Agreement to comply with applicable laws, rules and regulations. The Parties agree that notice of a change constitutes an amendment to this Agreement without the necessity of signatures of the parties, and is effective on the date of the notice.

23. Entire Agreement.
This Agreement, Attachment A, B, C, Exhibits A, B, and C, and Declaration of Standards for Participation contain the entire understanding between the parties hereto with respect to the subject matter hereof and supersedes all prior Agreements and understandings, expressed or implied, oral or written. Any material change to this Agreement's language or rates must be in writing and signed by duly authorized officers or representatives of Provider and USA. Non-material changes can be communicated via notifications. If neither party disapproves of a notification in writing within thirty (30) days, such notice will be considered accepted and binding. No other third party, including but not limited to any INSUREDS and INSURERS, shall be required to consent or receive notice of any such amendment or notice in order for the amendment or notice to be effective and binding upon the parties to this Agreement.

24. Title Not to Affect Interpretation.
The paragraph and subparagraph headings in this Agreement are for convenience only and they form no part of this Agreement and shall not affect its interpretation.

25. Execution in Counterparts.
This Agreement may be executed in any number of counterparts including facsimiles. Each counterpart shall be deemed to be an original against any part whose signature appears thereon, and all of which shall together constitute one and the same instrument.

26. Force Majeure.
Neither party shall be liable nor deemed to be in default for any delay or failure in performance under this Agreement or other interruption in the discharge of its responsibility, either directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, machinery or supplies, vandalism, strikes or other work interruptions by employees, or any similar or dissimilar cause beyond the reasonable control of either party.

27. Survival.
In the event this Agreement is terminated as set forth herein, Sections 4, 14, 16, 18, 21, 27, 28 and 34 shall survive the termination of this Agreement.

28. Termination Responsibilities.
In accordance with Section 10 (Termination) or any termination of this Agreement, or any product herein said termination shall have no effect upon the rights or obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. Member Providers agree to accept, as payment in full, the rates in Exhibit B for services rendered to an INSURED who is inpatient upon the effective date of such termination or undergoing a course of treatment, until INSURED is discharged or safely transferred to a participating USA facility, or completes said course of treatment.

29. Discrimination.
Member Providers agree to provide services for INSUREDS within the normal scope of Member Provider's medical practice. These services shall be accessible to INSUREDS, and made available to them, without limitation or discrimination, to the same extent as they are made available to other patients of Member Providers, and in accordance with accepted medical and professional practices and standards applicable to Member Provider's other patients.

30. Network Recognition.

USA maintains a current contracted carrier/payor (INSURER) list indicating clients who have directly contracted with USA for use of USA's network and services. INSURERS shall identify USA's network with USA's name or logo on the INSURED's identification card or explanation of benefits.

31. Updates.

In accordance with Exhibit C, Provider agrees to the Original Roster and Subsequent Update Requirements. Provider understands, with respect to any additions, deletions or changes to Member Providers information, the effective date of such information shall be no earlier than the date received by USA. USA shall accept no retroactive notifications, unless specifically agreed to by USA in writing. Provider shall be responsible for all discounts applied which are related to the untimely notification. Provider may not bill INSUREDS for such discounts. Provider and Member Providers agree to provide a timely response to all inquires by USA relative to the administration of this Agreement.

32. Insurance.

Member Providers shall, throughout the duration of this Agreement, maintain malpractice insurance, professional liability insurance, a program of self-insurance, an escrow account or other equivalent means to demonstrate Member Providers' ability to insure against, protect, or pay malpractice claims in an amount which is the greater of that which is required by the state in which services are rendered, that amount which is required by Facility to maintain active clinical privileges or $100,000 (one hundred thousand dollars) per occurrence and $300,000 (three hundred thousand dollars) in the aggregate.

Provider agrees to keep in full force and effect during the term of this Agreement and provide USA with evidence of, insurance policies of malpractice, professional liability and general liability in amounts as required by statute in those state(s) in which Provider is licensed to provide services and conduct business.

33. Licensure.

Member Providers shall, throughout the duration of this Agreement, be required to maintain any and all licenses and certificates as may be required by the state in which Provider provides services.

34. Warranty of Authority by Attorney-in-fact.

Provider hereby warrants to USA that it is duly authorized and appointed by Member Providers, as identified in accordance with Exhibit C, to enter into this Agreement on Member Provider's behalf. Provider further warrants that it is duly authorized to bind Member Providers to the terms and conditions contained herein and that such grant of authority has not been revoked, but remains in full force and effect as of the date of execution of this Agreement.

35. Claim Disputes.

Member Provider may, for a period of 90 (ninety) days from the receipt of payment of a claim, review the payment and provide to INSURER written notice of any perceived underpayment. INSURER shall reimburse Member Provider the amount of the underpayment within 30 (thirty) days provided documentation substantiates the payment error. After the 90 (ninety) day period has expired, payment of that claim is final and may not be disputed for any reason.

36. HIPAA Compliance

USA and Provider agree to comply with the requirements of 45 CFR § 164.504(e) as such may apply to USA as a business associate and Provider as a covered entity.

Signature on the next page

This Agreement is effective upon the date of execution by USA.

For and on behalf of:	**For and on behalf of:**
USA MANAGED CARE ORGANIZATION, INC. **4609 Bee Caves Rd, Suite 200** **Austin, Texas 78746**	_____ _____ _____ _____
_____ **Date**	_____ **Date**
_____ **Signature**	_____ **Signature**
_____ **Printed Name**	_____ **Printed Name**
_____ **Title**	_____ **Title**

ATTACHMENT A

USA MANAGED CARE ORGANIZATION, INC.
POLICIES FOR PROVIDER PARTICIPATION
USA WORKER'S INJURY NETWORK
TEXAS SPECIFIC

Pursuant to the agreement of the parties set out in Section 1(a) of the Health Care Provider Agreement (IPA), USA Managed Care Organization, Inc. (USA) has adopted the following policies and procedures for Member Provider participation in the USA Worker's Injury Network that are applicable to those Member Providers organized in the State of Texas or providing services under the Worker's Compensation statutes of Texas.

1. Member Provider may not send an invoice to or attempt to collect any amounts of payment from an employee who is employed in the State of Texas and subject to the Texas Worker's Compensation laws for injuries that are compensable under those laws under any circumstances, including the insolvency of the INSURER of the employee or insolvency of USA.

2. Member Provider must follow treatment guidelines, return-to-work guidelines and individual treatment protocols adopted by USA and set out in Exhibit C, Cost Containment Guidelines, to the Health Care Provider Agreement (IPA).

3. Member Provider may not deny treatment for a compensable injury to an employee solely on the basis that the treatment is not specifically addressed by the treatment guidelines used by USA or an INSURER.

4. USA may not refuse to renew a contract with a Member Provider because the Member Provider has, on behalf of an employee, filed a complaint against an INSURER that is a client of USA or appealed a decision or requested reconsideration or independent review of the decision of an INSURER.

5. If the Health Care Provider Agreement (IPA) with a Provider is terminated for any reason, at Provider's request, Member Provider will continue to be paid or reimbursed (as applicable) the agreed upon rates (as set out in Exhibit B to the Health Care Provider Agreement (IPA)) for care of an employee with a life-threatening condition or an acute condition for which disruption of care will harm the employee for a period of ninety (90) days from the termination date. If there is a dispute regarding the continuity of care for an employee being provided services by a Provider whose contract with USA has terminated, the parties must resolve the dispute through the complaint resolution process set out in Texas Insurance Code §§1305.401-1305.405 and Texas Administrative Code Title 28, Chapter 10, Subchapter G.

6. If the Health Care Provider Agreement (IPA) is terminated for any reason other than its expiration:

   a. USA agrees to give the Provider notice of termination at least ninety (90) days prior to the effective date of termination that it intends to terminate the Agreement;

   b. The Provider, on receipt of the termination notice may request a review of the termination by USA's advisory panel within thirty (30) days from the date the notice is received.

   c. For purpose of the review of Provider contract termination, USA will set up an advisory review panel that consists of three providers with the same licensure and the same or similar specialty as that of the terminated Provider with the authority to review the termination of Provider.

   d. The USA advisory panel will be provided with the documentation necessary to review the termination and the advisory panel must complete its review prior to the effective date of the termination.

   e. USA may not notify any patient of the Member Provider that the Provider is no longer a part of the USA WIN Network until the earlier of (i) the effective date of the termination or (ii) the date the advisory review panel makes a formal recommendation (assuming that the report of the advisory review panel confirms the termination).

   f. If there is potential of imminent injury or harm to the health of an employee who is the patient of the Member Provider that is being terminated for suspension or termination of an applicable license to practice, or a fraudulent act, USA may terminate the Member Provider immediately and will immediately notify the employees (if any) receiving medical services from the Member Provider that the Member Provider has been terminated.

g. If a Member Provider terminates its contract with USA, USA will notify employees of the clients of USA who are receiving medical care from the terminating Member Provider as soon as practicable and no later than the termination date that the Provider is terminating its agreement with USA.

7. Member Provider must post a notice to employees containing information required by Texas Insurance Code §1305.405 on the process for resolving workers' compensation health care network complaints in the office of the Member Provider. The notice must include the Texas Department of Insurance toll free telephone number for filing a complaint and must list all workers' compensation health care networks with which the Member Provider contracts.

8. USA will furnish Member Provider a list of any treatments that require pre-certification or pre-authorization and the procedures to obtain that certification or authorization.

9. The Health Care Provider Agreement (IPA) may not be interpreted in a manner that would allow the transfer of risk to an employee, as the transfer of risk is defined in Texas Insurance Code §1305.004(a)(26).

10. Provider and any subcontracting Member Provider must comply with all applicable statutory and regulatory requirements under both the laws of the State of Texas and the United States of America.

11. Exhibit B to the Health Care Provider Agreement (IPA) sets out the rates for medical services that are applicable to the Health Care Provider Agreement (IPA) with USA.

12. A Member Provider whose specialty has been designated by USA as treating Member Provider is a network treating Member Provider and agrees to any applicable provision as a treating Member Provider.

13. Billing by Member Provider and payment to Member Provider will be made in the manner and process set out in Texas Labor Code §408.027 and applicable rules.

14. Member Provider must provide treatment to injured employees who are presented to Provider through USA WIN Network and contracted INSURERS of the USA WIN Network.

15. USA will require contracted INSURERS to not use financial incentives or make payment to Member Provider that acts directly or indirectly as an inducement to limit medically necessary services.

16. Provider and Member Providers agree to allow INSURER to effect a contingency plan in the event that INSURER is required to reassume functions from USA WIN as contemplated under Texas Insurance Code §1305.155.

ATTACHMENT B

USA MANAGED CARE ORGANIZATION, INC.
POLICIES FOR PROVIDER PARTICIPATION
LONESTAR ATHLETIC INJURY NETWORK®
TEXAS SPECIFIC

Pursuant to the agreement of the parties set out in Section 1(a) of the Health Care Provider Agreement, USA Managed Care Organization, Inc. (USA) has adopted the following policies and procedures for Provider participation in the Lonestar Athletic Injury Network® that are applicable to those Providers organized in the State of Texas.

Provider has elected to participate in the Lonestar Athletic Injury Network® (Lonestar), a network of medical providers across Texas who have agreed to offer medical services to injured Texas students and athletes participating in U.I.L. – related activities.

Provider acknowledges that various plans are available for the funding of medical care and that plan selection resides with purchaser of coverage. Purchaser may be listed as either a Texas School District or as an individual electing to purchase Voluntary Coverage. Lonestar shall furnish copies of the plans available, upon request.

Provider agrees that reimbursement will be based on USA MCO contracted rates, subject to the provisions of the plans described above. Payments made represent the Full and Final reimbursement, and provider hereby agrees to forego balance billing of insured students and does hereby accept plan payments as Full Assignment. In instances wherein an injured student may be listed as a beneficiary of other coverage, the plans represented by Lonestar will become secondary and payments made will be in addition to those made by the primary insurance carrier.

Either party may terminate this agreement with the provision of a 180 day written notice.

All covered school districts will be notified of the provisions of this agreement as well as the participation status of contracted medical care providers in their communities.

Provider authorizes USA Managed Care Organization to consult with hospital administrators, members of medical staff, malpractice carriers and other persons to obtain and verify Provider's credentials and qualifications. Provider releases USA and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information.

ATTACHMENT C

USA MANAGED CARE ORGANIZATION, INC.
POLICIES FOR PROVIDER PARTICIPATION
ALTERNET MEDICAL SERVICES, INC.

Pursuant to the agreement of the parties set out in Section 1(a) of the Health Care Provider Agreement (IPA), USA Managed Care Organization, Inc. (USA) has adopted the following policies and procedures for Member Provider participation in Alter-Net Medical Services, Inc. (Alter-Net).

For and in consideration of the mutual promises and the agreement to provide the services as stated below, Provider and Alter-Net agree as follows:

1. Member Provider agrees to become a member of the Alter-Net Network and to deliver and perform all health care services that are authorized by Member Provider's state license to offer the public of that state to the Insureds that are referred to Member Provider by Alter-Net or the Insurer.

2. Alter-Net agrees to identify Insureds to Member Provider by causing the Insurer to identify Alter-Net on explanation of benefits (EOB) and/or electronic remittance advice (ERA).

3. Member Provider agrees that any Practitioner whose bills are submitted with the Member Provider's tax identification number(s) are subject to the terms of this Agreement.

4. Member Provider agrees to accept as payment in full for services provided to an Insured a sum of money equal to one hundred and ten (110%) percent of the initial publication of the current year's Medicare rate(s) for the state and locality of Member Provider's primary directory address for the services delivered to the Insured. Member Provider agrees to accept as payment in full for Anesthesia services the sum of $37.00 per unit based on the American Society of Anesthesiologist 15-minute increments. Payment for anesthesiologist billing with codes listed in the Relative Value Guide as published by ASA, will be determined by adding a Basic Value, which is related to the complexity of the service, plus Modifying Units (if any) plus Time Units, if applicable. The sum of which will then be multiplied by the anesthesia unit value listed above.

By accepting the sum stated above as payment in full for all health care services rendered to and delivered to an Insured, Member Provider agrees that it will not attempt to collect the difference between the gross amount billed to an Insurer or Insured for the healthcare services provided to the Insured and the amount accepted as payment in full from an Insurer or Insured. In other words, Member Provider agrees that it will not "balance bill" any Insured for health care services rendered and delivered by Member Provider or Member Provider's employees or practitioners to an Insured.

5. Member Provider agrees that Alter-Net is not assuming any liability for the quality of care delivered by Member Provider or Member Provider's employees or practitioners. Member Provider agrees to indemnify Alter-Net and hold Alter-Net harmless from any claim asserted by any Insured against Alter-Net arising out of any health care service provided by Member Provider or Member Provider's employees or practitioners to an Insured.

6. If the health care service delivered to an Insured by Member Provider arises out of a work-related injury or illness, Member Provider agrees to accept as payment in full for those services a sum of money equal to the lesser of eighty percent (80%) of the state's allowable fees for work-related injuries or illnesses, the rates outlined in Section 4 of this Agreement, or billed charges.

7. This Agreement is made and is enforceable under the laws of the State of Texas. Jurisdiction for any dispute over the terms of this Agreement, the enforcement of this Agreement or payment provided in this Attachment lies in a court of competent jurisdiction in the State of Texas.

EXHIBIT A
COST CONTAINMENT GUIDELINES

1. Member Providers agree to provide health care service in conformity with accepted prevailing medical, surgical, chiropractic, physical therapy and mental health/substance abuse practices in the community in which Member Providers practice.

2. Member Providers agree to utilize participating facilities, providers, and ancillary services (i.e., laboratory, x-ray, ultrasound, Hubbard Tank, isokinetic equipment, etc.) when not available in Member Providers' offices, and when consistent with good medical practice.

3. Member Providers agree to perform pre-admission testing whenever INSURED is to be hospitalized.

4. Member Providers agree to encourage the use of generic drugs, whenever medically possible, and when in the best interest of the patient.

5. Member Providers agree not to bill separately for components of a procedure to increase reimbursement.

6. While Utilization Management is primarily conducted by telephone, certain situations may require an on-site visit. Should this occur, Member Providers agree to accept Utilization Review Representatives on Member Providers' office setting for the purpose of reviewing medical records pertinent to continued stay or retrospective review of INSURED. Utilization Review Representatives agree to conduct reviews in accordance with Member Provider's policies.

7. Member Providers agree to promote and implement the aggressive treatment of an INSURED that will encourage the timely return to a quality standard of life as well as employment.

8. Member Providers agree to follow treatment guidelines equivalent to those required by the state in which Member Providers provide services or as outlined by Member Provider's specialty.

9. Member Providers agree to ONLY provide those services actually necessary to effectively treat an INSURED and ONLY provide treatment that does not constitute "maintenance care". Maintenance care is defined as treatment that has no definable condition and the treatment goal is only to maintain INSURED'S condition of health. Member Providers agree to ONLY perform those tests which are needed to properly diagnose and treat INSURED.

Current INSURED medical records shall immediately be made available by Member Providers, upon request, with proper patient authorization, for the purpose of concurrent review and retrospective review.

In addition to the above, when Member Providers are treating a work-related illness/injury;

1. Member Providers agree to provide INSURED with a return to work agenda, treatment plan and Member Provider's expectations of functional capacity concurrent with treatment. Member Providers agree, with the proper patient consent, to share this information with case managers assigned to the claim, adjusters, employers and other health care professionals who may be involved with the claim.

2. Member Providers agree when performing and/or assisting in the assessment of INSURED for the purpose of establishing Impairment Ratings and Disability Ratings, to utilize AMA Guidelines to Physical Impairment or those guidelines that may be required by the state in which Member Providers provide services.

EXHIBIT B

NOT VALID WITHOUT SIGNED
EXHIBIT B PPO
Payment Schedule

Please contact USA MCO's Network Development at
1-800-872-0820 ext. 4887
or
providermarketinginfo@usamco.com

for full Payment Schedule and Signature Page.

EXHIBIT C
ORIGINAL ROSTER AND SUBSEQUENT UPDATE REQUIREMENTS

Provider agrees to supply to USA the following information in electronic format for each Member Provider participating under this Agreement. All subsequent updates provided to USA shall be submitted electronically and consist only of additions/deletions/changes to the information supplied upon inception. Such additions shall include only those Member Providers who meet the requirements set forth in the Declaration of Standards for Participation.

1) Name (Last, First, MI, Suffix)
2) Degree (M.D., D.O., D.P.M., etc.)
3) Date of Birth
4) Gender (M/F)
5) Specialty(ies)

   **Your selection must be consistent with Member Provider's licensure, board specialties and sub-specialties.*
6) Social Security Number
7) Tax Identification Number that is registered to: (Group name/Corporation Name)
8) Physical Address(es) (At which Member Provider will be providing services under this Agreement and if Member Provider is "not" accepting new patients at any location)
9) Billing Address (If different than physical address)
10) Provider E-mail address
11) Telephone Number including area code
12) Fax Number including area code
13) All active, unrestricted hospital(s) staff privileges and ambulatory surgery center(s) privileges
14) State license(s) (state, license number, effective date, expiration date)
15) Medicaid Number
16) Medicare Number
17) NPI Number
18) CLIA Certification (state, certification number, effective date, expiration date)
19) Federal DEA Certificate (registration number, date issued, expiration date) OR
20) CDS Certificate (registration number, effective date, expiration date)
21) Does Member Provider participate in Workers Compensation? ☐Yes ☐No

   a) If Yes, does Member Provider provide:

Maximum Medical Improvement Ratings (MMI)?	☐Yes	☐No
Impairment Rating (IR) Services?	☐Yes	☐No
Independent/Required Medical Examinations (RME)?	☐Yes	☐No
Second Opinions?	☐Yes	☐No

   b) If Yes, has Member Provider filed financial disclosure in accordance with Texas Labor Code §408.023 and §413.041?

   ☐Yes ☐No

Provider hereby acknowledges that all Member Providers shall be considered participants of all products included in the Agreement, unless expressly indicated in the box provided below or in subsequent updates supplied to USA by the Provider.

Provider is participating in the following:	**Yes**	**No**	**VBP**
Group/Accident Health [USA Health & Wellness Network (USA H & W Network)]	☐	☐	☐
Work Related Injury/Illness [USA Workers' Injury Network (USA WIN)]	☐	☐	☐
Motorist Medical	☐	☐	☐
HMO	☐	☐	☐
Medicare Select (USA Medicare Select)	☐	☐	☐
Mental Health	☐	☐	☐

VBP: Varies By Physician

Contact Sheet
For

_____

(Group Name)

The following person(s) will be the USA's contact(s) for the above named physician group (IPA).

CONTRACTING:

Name: _____ Title: _____

E-mail Address: _____

Telephone Number: (__) _____ Fax Number: (__) _____

PROVIDER UPDATES:

Name: _____ Title: _____

E-mail Address: _____

Telephone Number: (__) _____ Fax Number: (__) _____

CEO / PRESIDENT / DIRECTOR

Name: _____ Title: _____

E-mail Address: _____

Telephone Number: (__) _____ Fax Number: (__) _____

This information shall remain valid until USA is notified, in writing, by the above mentioned physician group of any changes.

DECLARATION OF STANDARDS FOR PARTICIPATION

THIS Declaration is made by and between _____ (hereinafter referred to as Provider) and USA Managed Care Organization, Inc. a Texas Corporation (hereinafter referred to as USA).

For the purposes of this document, Member Providers shall refer to only those members of Provider who meet the Minimum Standards for Member Provider Credentialing and Re-credentialing. Only those Member Providers who meet the Minimum Standards for Member Provider Credentialing and Re-credentialing are eligible to participate under the Health Care Service Provider Agreement (IPA).

THIS Declaration shall serve to acknowledge the understanding of all parties with respect to USA's Declaration of Standards for Participation.

Provider acknowledges that USA is committed to the maintenance and assessment of the credentials of Member Providers within the network. Provider represents warrants and certifies and USA is entitled to rely thereon, that Provider performs credentialing and re-credentialing procedures in accordance with its written policies and procedures. Provider credentialing policies and procedures includes, but is not limited to, (i) Provider completing the initial credentialing (processing Member Provider application, verification of information, and performing a site visit [if applicable]), before the effective date of the initial contract with Member Provider, (ii) Provider notifying Member Provider applicants no later than sixty (60) calendar days after Provider's decision, (iii) written policies and procedures for suspending or terminating affiliation with a Member Provider, (iv) procedure for monitoring Member Providers between periods of re-credentialing and will take action when needed for identifying instances of poor quality, (vi) a process to ensure Member Provider selection and retention criteria do not discriminate against Member Providers who serve high-risk populations, (vii) procedures that credentialing and re-credentialing decisions are not based on a Member Provider applicant's race, ethnic/national identity, gender, age, or sexual orientation, (viii) process for notifying licensing or other appropriate authorizes, including Workers' Compensation Divisions, when a Member Provider's affiliation is suspended or terminated due to quality of care concerns and Provider will maintain evidence of notification, and (ix) performing primary source verification and acceptance of a Member Provider application within 180 calendar days prior to Provider's decision to deem Member Provider eligible for participation.

Provider represents warrants and certifies and USA is entitled to rely thereon, that Member Providers meet or exceed USA's Minimum Standards for Member Provider Credentialing and Re-credentialing (identified in the attachment) at the time of execution of a Health Care Service Provider Agreement (IPA) and compliance with these standards shall continue throughout the term of the Agreement. Non-compliance shall result in immediate termination of the Agreement, in whole or in part, pursuant to the termination provision of said Agreement.

Credentialing/recredentialing may be fully or partially delegated to Provider and/or its delegates if their policies and procedures meet or exceed USA's standards, policies and procedures. Provider, on behalf of itself and/or its delegates, further represents, warrants and certifies and USA is entitled to rely thereon, that the Provider has developed, implemented and completed a process to gather, verify and report Member Provider credentials. Delineated credentialing and recredentialing policies and procedures designed to confirm information reported to and used by the Provider to support the selection and evaluation of Member Providers is current, accurate, comprehensive and meet or exceed the processes outlined in the attached Minimum Standards for Member Provider Credentialing and Re-credentialing. Re-credentialing processes must be performed every three (3) years and include a method of collection and verification of any Member Provider status information subject to change (i.e., licenses, insurance status, hospital privileges, etc.).

USA reserves the right to ensure Provider compliance and request verification of the Minimum Standards for Member Providers as contained herein and verify the Provider's credentialing and recredentialing procedures. USA may, at any time, require Provider to supply within 15 (fifteen) business days any and all personal Member Provider information, copies of any and all licenses, registrations, certifications, or insurance certificates, or in the case of a periodic audit, all of the information required in the Minimum Standards for Member Provider Credentialing and Re-Credentialing for a percentage of Provider's Member Providers. It is the responsibility of Provider to maintain/obtain any release required in the furtherance of providing such information to USA. This information may be requested in writing by USA during the term of any Health Care Service Provider Agreement (IPA) executed by and between USA and Provider, and for a period of 5 (five) years after the termination of such Agreement.

MINIMUM STANDARDS FOR MEMBER PROVIDER CREDENTIALING AND RE-CREDENTIALING

- **All Member Providers must complete an application to provide the necessary confirmations and attestations of at least the following;**
  - -Current unrestricted license to practice medicine;
  - -Clinical privileges in good standing with at least one USA paneled facility designated by the Member Provider as the primary admitting facility (see clinical privileges exception);
  - -Valid DEA or CDS certificate (if practice allows prescribing);
  - -Graduation from medical school (MD's and DO's);
  - -Completion of an approved residency program (MD's and DO's);
  - -Graduation from Post Graduate Program (Allied Health Professionals);
  - -Current, adequate malpractice insurance; and
  - -5 years work history;
  - -5 years professional liability claims history including out of court settlements or dropped/closed cases;
  - -History of loss of license and/or felony convictions;
  - -History of loss or limitations of privileges or disciplinary activity, including, but not limited to, letters of concern, admonition, or censure;
  - -History of voluntary or involuntary termination of medical staff membership;
  - -History of voluntary or involuntary limitation, reduction, or loss of clinical privileges at a facility or setting or network;
  - -Willingness to provide immediate notice to Provider of any license restrictions, probations, suspensions or revocations;
  - -Attestation to the correctness and completeness of the application;
  - -Attestation to Member Provider's physical and mental health status and;
  - -Attestation to the lack of impairment due to chemical dependency/substance abuse; and
  - -Confirmation Member Provider accepts new patients.

  Additional information may be obtained from recognized monitoring organizations. This may include, but is not limited to, the National Practitioner Data Bank (NPDB).

- **Member Providers (physicians) must maintain active, unrestricted clinical privileges with at least one USA paneled facility;**

  Exception: Non-medical allied health providers may not hold facility privileges. Provider must perform primary source verifications with the following supporting documentation:

  Two letters of recommendation must be provided from peers or physicians in same or similar specialty, not associated in the same group, preferably from an in-network provider, personally acquainted with the applicant's professional and clinical performance either in a teaching facility or in other healthcare settings. These letters must address the length of professional acquaintance, clinical competence, moral and ethical behavior of the applicant.

  Exception: Member Providers (medical providers) without clinical privileges based on the outcome of the primary source verification with the following supporting documentation:

  Two letters must be obtained from physicians (MD or DO), who are Board Certified or Board Qualified and who are members in good standing in the medical community. Letters must be from a physician in the same or similar specialty, not associated in the same group, preferably from an in-network provider. These letters must address the length of professional acquaintance, clinical competence, moral and ethical behavior of the Member Provider, and;

  A statement from the Member Provider explaining the reason for the lack of hospital privileges.

Exception: Member Providers (medical providers) having privileges at a non-USA JCAHO accredited Non-USA Medicare certified facility will be limited to participation in USA's Workers' Injury Network

Exceptions to the standard (as identified) must be reviewed and approved by the Provider's Medical Director and or Credentials Committee.

When hospitalization is necessary, Member Provider will refer the INSURED to a USA participating provider with admitting privileges at a USA participating facility.

•All Member Providers must maintain a current, unrestricted license and practice within the scope of their licensure;

Member Providers (physicians) with a history of license restrictions, modifications, revocations and/or probation may be considered with the following supporting documentation;

Narrative statements from the Member Provider addressing previous license restrictions, probation, suspensions, modifications and/or revocations, together with any other documentation as may be requested by the Provider's Medical Director and/or Credentials Committee for review and approval.

Provider must perform primary source verifications with the applicable state licensing boards. Should derogatory information be obtained, Provider may obtain additional information from the State Board of Medical Examiners or Department of Regulation.

•All Member Providers prescribing medications must maintain a valid DEA or CDS certificate and Provider must perform primary source verification;

•Member Providers must not possess a history of chemical dependency or substance abuse, physical or mental illness that has the potential to affect the Member Provider's ability to function as a physician, or history of unprofessional conduct.

Exceptions to the standard (as identified) should only be considered with appropriate supporting documentation, including narrative statements from the Member Provider addressing the condition(s) and must be reviewed and approved by the Provider's Medical Director and or Credentials Committee.

•All Medical Member Providers engaged in medical specialties recognized by the American Board of Medical Specialties or the Osteopathic Board of Medical Specialties, must be graduates of an approved medical school, have completed an approved residency program and be board certified or board qualified;

For clarification purposes, USA Managed Care Organization, Inc. defines the term "board qualified physician" as follows: A physician who has initiated the certification process with a Member Board of the American Board of Medical Specialties or the Osteopathic Board of Medical Specialties and is still within the prescribed time frame for certification completion. Physicians, who are not BC/BQ submitting applications after May 1996, may be considered with the following supporting documentation:

Letter of recommendation from the chairman of the department of chief of staff to which the physician is assigned. This letter must address the length of professional acquaintance, clinical competence, moral and ethical behavior of the applicant; and

Letter of recommendation from a physician (MD or DO) who is Board Certified or Board Qualified and is a member in good standing in the medical community. Letter must be from physician in same or similar specialty, not associated in the same group, preferably from an in-network provider. This letter must address the length of professional acquaintance, clinical competence, moral and ethical behavior of the applicant.

Provider must primary source verify board certification or eligibility of Member Providers. The application must require Member Providers to furnish all applicable educational and medical background information for Provider to perform primary source verification.

•All Member Providers must maintain current, adequate malpractice insurance and Provider will perform primary source verification;

Member Providers shall, throughout the duration of this Agreement, maintain malpractice insurance, professional liability insurance, a program of self-insurance, an escrow account or other equivalent means to demonstrate Member Providers' ability to insure against, protect, or pay malpractice claims in an amount which is the greater of that which is required by the state in which services are rendered, that amount which is required by Facility to maintain active clinical privileges or $100,000 (one hundred thousand dollars) per occurrence and $300,000 (three hundred thousand dollars) in the aggregate. Provider may verify malpractice coverage with the insurance carrier for those non-medical allied health professionals without active clinical privileges at a JCAHO accredited or Medicare certified facility. The information may include status of coverage and may include claims history. If information received contradicts statements on the Member Provider's application or NPDB Report, the Member Provider must be contacted for confirmation and clarification.

Member Providers with a history of malpractice/negligence settlements or judgments may be considered for participation with the following supporting documentation:

Narrative statements from the Member Provider addressing the settlement and/or judgment issues and any other documentation as may be requested by the Provider's Medical Director and/or Credentials Committee for review and approval.

•Member Provider additional education/training/certification requirements;

Mental Health/Substance Abuse Clinicians, Speech/Language Pathologists and Audiologists must have completed a minimum of a Master's level degree. Speech/Language Pathologists must have a Certificate of Clinical Competence (CCC) established by ASLHA. Member Providers requiring certification by State Workers' Compensation Boards must maintain current, adequate certification. Podiatrists must be certified by the American Board of Podiatric Orthopedics/Primary Podiatric Medicine or American Board of Podiatric Surgery. Provider verification sources include letters from professional schools, residency/postdoctoral programs, etc. Participation is determined in whole or in part based on the outcome of primary source verifications. All Physician Assistants must have completed the NCCPA, National Commission on Certification of Physician Assistants, Examination. Certified Registered Nurse First Assistant must be certified by CCI formally known as CBPN and must have an Authorizing Physician who is a participating USA network provider.

•Member Provider site visit requirements;

Provider must perform an initial site visit at application and subsequent site visits at recredentialing. The visit results must be documented and structured to include a review of the site and medical record keeping practices. In the absence of documented site visits, Provider must require Member Providers to complete a Practitioner Site Questionnaire and provide sample medical records (properly blinded) for review and retention by Provider. The Practitioner Site Questionnaire and medical record criteria can be obtained from an authorized representative of USA Managed Care Organization.

•Provider must verify all Member Provider applicants are free of Medicare and Medicaid Sanction activity;

•Ongoing Member Provider Monitoring;

Provider must monitor the performance of Member Providers between re-credentialing which includes periodic review of: (i) Medicare and Medicaid sanctions, (ii) information from state licensing boards regarding sanctions or licensure limitations, (iii) complaints, (iv) and information from Workers' Compensation Divisions regarding sanctions or practice limitations.

•Member Provider rights;

Provider will inform Member Providers of their rights to: (i) review information submitted to support the credentialing application, (ii) right to correct erroneous information, (iii) right, upon request, to be informed of the status of the credentialing or re-credentialing application, and (iv) the right to be notified of these rights.

For and on behalf of:

_____

_____

_____

_____

Date

_____

Signature

_____

Printed Name

_____

Title