Application Checklist

PracticeHealth
Independent Practice Resources

Documents Required per Provider

	Credentialing Fee of $300 - Please forward provider's name, title and start date for the Credentialing Fee e-invoice. - This payment MUST be received before any credentialing can begin.
	CAQH Management Form - MUST include CAQH ID# and provider's signature - **Directions for printing the Colorado Mandated Application below**
	Practice Health (formerly Rose Medical Group) Participation Agreement (Physicians or Advanced Practitioners ONLY)
	Colorado Medical License
	Colorado DEA - Address change submission receipt will work if address listed is out-of-state
	Professional Liability Insurance Facesheet
	Current Board Certificate
	Curriculum Vitae - Current (including NEW role; 5-year+ history & written explanation for all gaps >29 days
	Multiplan Designation of Tax ID Authorization Form - REQUIRED if provider is to be credentialed with Multiplan/PHCS and/or Beech St.
	Medicaid Enrollment/Revalidation Letter - REQUIRED if provider is to be credentialed with Colorado Access
	HealthONE Facility Admitting Privileges - REQUIRED for Specialists; PCPs must be affiliated with HealthONE

Documents Required per Practice

- If New/Initially Joining – please include all below documents with provider packets

	Practice Health Contract Selection Spreadsheet
	Messenger Model Minimum Fees & Policy Statement
	W9
	Practice Intake Form

Upon receipt of the $300 Credentialing Fee, all required documents, & signed Participation Agreement, Practice Health will build a provider's credentialing file to submit applications to the health plans selected by the practice. Please be aware the credentialing process typically takes 90-120 business days to complete and is required by all health plans before loading the credentialed provider to our contracts. Contract Configuration (loading a provider to a contract) usually adds an additional 45-90 business days. If the new provider is currently credentialed with the commercial payors in Colorado and is only changing contract affiliations, this process may take less time to complete.

To Print or Save a Copy of a Colorado Mandated Application:

1. Log in to CAQH (proview.caqh.org)
2. Click "Review & Attest" In the upper right corner beneath name
3. Click red "Attest" button
4. Click "Review & Attest" again
5. Click "Download Your State Application" on the lower right and select Colorado; check box to include all documents
6. Click red "Save" button and save to computer
7. Open file and SAVE
8. Please email the saved file along with the rest of the required documents to applicable Credentialer: Colleen.McMullen@healthonecares.com OR Chelsea.Parsons@healthonecares.com

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2018 Practice Health (formerly Rose Medical Group) Membership Dues & Policies

General Membership Dues Policy:

Annual Membership Dues will be invoiced at the start of each membership year. The membership year is on a calendar basis, January through December. Annual Membership Dues will be charged according to the membership levels noted below, and are due within 30 days of the invoice.

2018 Current Member Annual Dues Rates:

- Physician & Midlevel Providers: $528 per membership year
- Retired Physician: $50 per membership year (see requirements below)

2018 New Members:

- A one-time NON-REFUNDABLE and NON-TRANSFERABLE Credentialing Fee of $300, will be assessed per provider, regardless of provider level. The credentialing process will not begin until Practice Health receives a signed Practice Health Participation Agreement and the one time Credentialing Fee paid in full.
- Requests to refund Credentialing Fees will be honored under the following circumstances:
    - Notification to Practice Health to withdraw the membership application occurs within 30 days of payment.
    - AND Practice Health has not initiated credentialing with the health plans or CVO.
- Prorated Annual Membership Dues, at the rates as noted above for Current Members, will be invoiced either 90 days from the start date of the credentialing process OR on the date that the new member is sent on an update to any health plan to credential the member to a Practice Health contract, *whichever comes first*. Proration will be calculated based on the remaining full months in the membership year.
- In the event that a provider does not intend to participate in any Practice Health fee for service contracts, Prorated Annual Membership Dues will be invoiced at the date of joining and will calculated based on the remaining full months in the membership year.

Discounted Retired Physician Requirements:

- Retired Physicians may maintain a Retired Physician status, and continue to participate in Group Purchasing discounts and education events, when the physician meets all of the following requirements:
    - The physician is not credentialed to Practice Health fee for service agreements, and is no longer providing patient care
    - The physician has paid active Practice Health (RMG) membership dues for the 2 years preceding retirement
    - The physician requests Retired Membership status before the start of the membership year
        - Physicians that retire during a membership year will be provided the prorated membership fees as described in the Termination Policy below, and will be granted Retired Physician status for the remainder of the membership year as a courtesy.

Termination Policy:

- Practices may receive a prorated refund/credit of Annual Membership Dues for terminating Members. The prorated credit/refund will be calculated based on the remaining full months in the membership year using the following refund calculation dates:
    - To receive proration from the effective date of the member's actual termination with the practice, Practice Health must receive a written 30 day notification prior to the termination date. Example: Practice Health receives written notification from the practice on May 15 that Dr X will be terminating on June 15. The practice will receive a refund/credit for 6 months of dues for the remaining full months of the membership year, July through December.
    - Notification made less than 30 days prior to the actual effective date will receive proration based on 30 days from the date of notification to Practice Health. Example: Practice Health receives written notification from the practice on September 20 that Dr X terminated on June 15. The practice will receive a refund/credit based on a termination date 30 days from notification, or October 19, resulting in 2 months of dues credit/refund for the remaining full months of the membership year, November and December.

*** This policy has been approved by the Practice Health Board of Directors, and will be reviewed annually. ***

PracticeHealth
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CAQH ACCOUNT MANAGEMENT

More often than not, the commercial payers pull provider credentials and documentation directly from the CAQH ProView (proview.caqh.org) account for (re)credentialing purposes.

Due to the importance of the accuracy of this information, Practice Health does not create these profiles for providers.

If elected by the provider/practice, Parctice Health will maintain and reattest the profile once it is completed initially by the provider. The decision for Practice Health to manage the provider's account is entirely up to the practice, and should always be discussed with the provider first.

REQUIRED - CAQH ID#: _____

If Practice Health has permission to manage the account, we will ensure that re-attestation is completed every ninety days and that the account has only the most current information.

REQUIRED: **Please select one of the two options below:**

❑ **YES, I give permission for PH to maintain and attest my profile as needed.**

Username: _____

Password: _____

❑ **NO, I will maintain and reattest my own profile every 90 days.**

Also, make sure to include a completed Colorado Mandated Application in addition to the CAQH User ID # of the completed profile. (**REQUIRED**)

Printed Name: _____ Date: _____

Signature: _____

ROSE MEDICAL GROUP

PHYSICIAN PARTICIPATION AGREEMENT

THIS PHYSICIAN PARTICIPATION AGREEMENT ("Agreement") is made and entered into as of the Effective Date set forth on the signature page, by and between ROSE MEDICAL GROUP, INC., a Colorado non-profit corporation, (hereinafter referred to as "RMG"),and the physician identified on the signature page, a physician duly licensed to practice in the State of Colorado, (each hereinafter referred to as "Physician") (RMG and Physician, collectively the "parties").

RECITALS

WHEREAS, RMG has created a network of physicians in the greater Denver, Colorado area to contract with payors to provide medical care and services; and

WHEREAS, RMG desires to create and maintain contractual relationships with health plans and employer groups, and provide related contract management and maintenance services for its contracting providers; and

WHEREAS, Physician is licensed to practice medicine in the State of Colorado, is capable of providing medical services in the State of Colorado as represented in Physician's membership application, and desires to provide such services through participation as a provider in network; and

WHEREAS, Physician wishes to procure from RMG certain managed care contracting and other hereinafter described services; and

WHEREAS the parties wish to set forth the terms and conditions of their relationship and their respective rights and obligations.

NOW, THEREFORE, in consideration of the foregoing Recitals, which constitute a material part hereof, and the mutual covenants and agreements herein contained, RMG and Physician agree as follows:

ARTICLE I
Definitions

1.01 "Benefit Plan" A Benefit Plan is the plan, contract, agreement or other arrangement between a Covered Individual and a Payor that describes the Covered Services which the Covered Individual is entitled to receive, subject to any requirements, conditions, limitations, exclusions and other rights and obligations governing the arrangement, including, but not limited to, the obligation of the Payor to pay or reimburse for all or a portion of the cost of such Covered Services.

1.02 "Covered Individual" means any individual, or eligible dependent of such individual, whether referred to as an insured, subscriber, member, enrollee, employee or otherwise who is eligible to receive Covered Services pursuant to a Health Plan Agreement.

1.03 "Covered Services" means those Medically Necessary medical services eligible for payment under the terms of the applicable Health Plan Agreement and have been authorized pursuant to applicable utilization management requirements.

1.04 "Fee For Service Agreements" are agreements for which participating providers are paid on a fee for service basis for providing Covered Services to Covered Individuals.

1.05 "Health Plan Agreement" or "HPA" means the agreement between a Payor and RMG setting forth the terms and conditions under which RMG participating providers will provide Covered Services to Covered Individuals.

1.06 "Medical Necessity" or "Medically Necessary" means a service or supply ordered by a participating Physician which is commonly and customarily recognized as appropriate in the treatment of a Covered Individual's diagnosed illness or injury.

1.07 "Payor" means an insurance carrier, nonprofit hospital, medical-surgical or health service corporation, health care plan, health maintenance organization, employer, employee welfare benefit plan, multiple employer welfare arrangement, a state or federal governmental agency, or any other person or entity which has entered into a Health Plan Agreement with RMG to provide or arrange for the provision of Covered Services to Covered Individuals.

1.08 "Physician" means an individual physician licensed as an M.D., D.O. or D.P.M.

ARTICLE II
RMG Responsibilities

2.01 RMG shall identify and solicit non-risk managed care contracts ("Fee For Service Agreements") with Payors who seek to contract with RMG physicians and other providers of Covered Services for Covered Individuals. RMG will then seek to contract or facilitate the contracting for such contracts on a messenger model or other basis as may meet applicable legal requirements, and in accordance with the terms of this Agreement. RMG and Physician will strictly comply with all applicable policies and legal requirements relating to the process for facilitating Fee For Service Agreements.

2.02 RMG shall discuss and negotiate the terms and conditions of Fee For Service Agreements with Payors for and on behalf of RMG and physician providers, as applicable, contracting with and through RMG. Physician hereby authorizes and appoints RMG as Physician's attorney-in-fact to negotiate and execute binding Fee For Service Agreements with Payors under which Physician shall provide Covered Services consistent with this Agreement and pursuant to which Physician shall accept as payment in full the amounts to be negotiated by RMG, in addition to any amounts the Covered Individual is required to pay directly as a Covered Individual obligation, such as a co-payment or deductible.

2.03 If required by Payors, RMG shall design, develop and implement or contract for quality assurance and utilization review programs to assure Covered Services

provided or arranged for Covered Individuals by Physician and any other participating physicians are both appropriate and consistent with current standards of medical care and are in compliance with RMG's quality and utilization guidelines. Physician agrees that such programs may be incorporated by reference into this Agreement upon thirty (30) days' notice to Physician, on a Payor by Payor basis.

2.04 RMG may include in the HPAs utilization review programs mechanisms for pre-admission, concurrent and retrospective review of Covered Services which shall be binding upon Physician.

2.05 RMG shall promptly notify Physician of any material changes in the HPAs and quality and utilization review procedures and activities.

ARTICLE III
Physician Responsibilities

3.01 Physician shall fully comply with HPAs as they relate to Physician, as well as RMG utilization review mechanisms, RMG, medical and administrative guidelines, and other published policies of RMG. Physician agrees to participate in and cooperate with the utilization review and quality assurance programs established by RMG, Payor or any Medicare Advantage or Medicare Cost plan. Failure to cooperate may constitute a basis to deny payment for services rendered to Covered Individuals or to impose other economic sanctions on Physician. The policies by which the imposition of sanctions for noncompliance may be addressed shall be adopted by the Board of Directors of RMG, and will become a part of this Agreement. New policies and/or procedures may be implemented from time to time during the term of this Agreement. RMG shall notify Physician in writing of any new policy or procedure, which policy or procedure shall become effective upon transmittal of such notice or as otherwise stated in the notice, but not less than thirty (30) days following their adoption by the Board of Directors of RMG, unless otherwise required by applicable law.

3.02 Physician, at all times during the term of this Agreement shall: (a) be duly licensed to provide the services he/she will provide hereunder and is not subject to probation, suspension, conditions, limitations or any other restrictions of the ability to practice; (b) be qualified for and have been granted membership in good standing on the medical staff of an HCA HealthOne LLC hospitals or affiliated entities, to the extent applicable medical staff membership is necessary for the practice of the Physician's specialty; (c) have current controlled substances registrations issued by the federal Drug Enforcement Agency and any applicable state regulatory agency, which registrations have not been suspended, revoked or restricted in any manner; (d) provide services in accordance with applicable standards of care, within the scope of the Physician's license, training and expertise; (e) not be party to any agreement that precludes the Physician from satisfying any of the Physician's obligations hereunder; (f) be board-certified or board-eligible in his/her specialty by the applicable American board; if board eligible, a Physician must become board certified within the applicable eligibility period and no later than 5 years after successful completion of a residency approved by the Accreditation Council for Graduate Medical Education or Canadian equivalent; (g) be appropriately insured as set forth in Section 3.05, (h) meet all quality and performance metrics required by the RMG for participation in the network, and (i) not appear on the List of Excluded Individuals and Entities who are

excluded from participating in the Medicare or Medicaid program. Physician has disclosed, and will during the term of this Agreement disclose, to RMG the existence of all Claims and Disciplinary Actions against Physician. If Physician engages other persons to assist in performing services under this Agreement, Physician represents and warrants that each such person (i) is either employed by or under the direct supervision and control of Physician, (ii) is appropriately licensed/certified and has all other qualifications necessary to assist Physician, and (iii) and does not appear on the List of Excluded Individuals and Entities who are excluded from participating in the Medicare or Medicaid program. If Physician is requested by RMG to participate in any initiative to reduce costs through a vendor selection program, Physician will disclose in writing to RMG any financial relationship between the Physician (or an immediate family member) and any vendor that may be considered through the vendor selection program.

3.03 Physician shall provide Medically Necessary Covered Services to Covered Individuals in accordance with applicable HPAs.

3.04 Upon reasonable request of RMG, Physician shall serve on RMG committees which review all aspects of those Covered Services rendered to Covered Individuals pursuant to an HPA.

3.05 Physician shall, at his or her sole cost and expense, maintain professional liability insurance in an amount of One Million Dollars ($1,000,000) per claim and Three Million Dollars ($3,000,000) in the aggregate to insure Physician and Physician's employees, partners, agents or contractors against liability for damages directly or indirectly related to the performance of Physician or his or her activities hereunder. Said amount may be changed from time to time by RMG Board of Directors. If requested, Physician shall furnish evidence of such coverage to RMG. If Physician becomes uninsured at any time while this Agreement is in effect, Physician shall notify RMG in writing within five (5) days of the date Physician becomes aware of lapse in coverage or date insurance expires, whichever is earlier.

3.06 The Physician shall not differentiate or discriminate in any manner in accepting, or providing Covered Services, to Covered Individuals on the basis of race, age, color, sex, sexual orientation, ethnicity, nationality, religion, disability, place of residence, health or economic status or source of payment, except, in the latter instance, to the extent of differences in the scope of Covered Services or Covered Individual responsibilities under different Benefit Plans. Physician shall render Covered Services in the same manner, at the same standards and with the same availability as offered to other patients.

3.07 Physician agrees to accept the payment pursuant to agreed HPA fee schedules or reimbursement methodologies with respect to Fee For Service Agreements that have been entered by RMG on Physician's behalf under the terms and conditions of this Agreement.

3.08 If any Covered Individual requests or requires medical services which are not Covered Services, Physician shall be entitled to enter into agreements with such patients to provide such services to these patients on a fee for service basis.

3.09 Physician shall be entitled to bill and collect from a Covered Individual any applicable copayment, deductible or other amount specified in an HPA as the Covered Individual's financial responsibility. Physician agrees to give its permission and assistance to RMG and Payors upon request for purposes of coordinating benefits with other carriers or benefit plans. If, under applicable coordination of benefit rules, a Payor is the primary Payor, then Physician's compensation will be paid on the basis specified in the applicable HPA. If, under applicable coordination of benefit rules, a Payor is other than the primary Payor, and Physician's bill to the primary Payor was not computed on the basis specified in this Agreement, then any further reimbursement to Physician from Payor will not exceed either the amount equal to the patient's liability under the primary plan or an amount which, when added to amounts paid by the primary Payor, equals the amount specified in this Agreement.

3.10 Physician shall use claim forms approved, mandated or provided by Payor and submit them to Payor or no later than thirty (30) days following the date of encounter unless otherwise specified by the Payor.

3.11 Physician shall maintain, with respect to each patient receiving Covered Services in accordance with an applicable HPA, a standardized medical record in such form, containing such information, and preserved for such time period(s) as may be required by state and federal law.

3.12 The medical records referred to in paragraph 3.12 above shall be and remain the property of Physician and shall not be removed or transferred from Physician's premises except in accordance with applicable state and federal case law, statutes and regulations promulgated thereto. To the extent permitted by law, in accordance with procedures required by law, and upon receipt of twenty-four (24) hour prior written notice from RMG or Payor, Physician shall permit RMG or Payor to inspect and make copies of said records, and shall provide copies of such records to RMG or Payor upon request.

3.13 Physician shall cooperate with RMG in providing up-to-date information regarding the address, credentials and qualifications of the Physician for use in rosters, directories, and promotional materials of RMG, the Network or any Payor. Physician consents to the listing of Physician's name, business addresses and business telephones in rosters and marketing materials used by contracting Payors or RMG. Physician shall promptly notify RMG of any changes in such information as they may occur.

3.14 Physician hereby waives any claim against, and agrees to hold harmless any officer, director, employee, agent or member of RMG as a result of the termination of any Physician agreement or any other sanction imposed or action taken, guideline or policy adopted, or denial of payment or retroactive collection of payment by the RMG, its officers, directors, agents, employees or committee members towards Physician, if such action was taken not in bad faith, reasonable efforts were made to obtain the facts, and such action was based upon reasonable belief that it was warranted by the facts.

3.15 Physician shall notify RMG in writing within five (5) calendar days after one of the following events occur:

A. The Physician's Colorado medical license or ability to practice medicine in the State of Colorado or at any health care facility is suspended, revoked, terminated or subject to terms of probation or other restriction; or

B. The Physician becomes the subject of any disciplinary proceeding or action relating to participation in the Medicare or Medicaid programs; or

C. A civil action is brought against the Physician as a result of the alleged negligence or errors of Physician's employees, contractors, or agents; or

D. Criminal charges are filed against the Physician for any reason; or

E. There is a change in the Physician's business address; or

F. There is any problem or situation which materially affects the Physician's ability to perform the duties and obligations under this Agreement or an HPA.

3.16 In the event that Payor is a health maintenance organization Physician agrees that in the event that such Payor fails to pay for Covered Services rendered by Physician to a Covered Individual pursuant to an HPA, including Payor's insolvency or breach of the HPA, Physician shall not bill, charge, collect or otherwise seek compensation or reimbursement against the Covered Individual. This shall not prohibit the collection of applicable copayments, deductibles, coinsurance or other patient payments.

3.17 Physician shall not bill, charge, collect or otherwise seek compensation or reimbursement against the Covered Individual for Covered Services where payment for such services has been denied because Physician has failed to comply with the terms of this Agreement.

ARTICLE IV
Contracting

For Fee for Service agreements offered by Payors which RMG is required to facilitate on a messenger model or modified messenger model basis, RMG will facilitate a contracting process with the Payor in accordance with the following guidelines.

4.01 "Pure" Messenger Model Guidelines. If RMG determines that it will facilitate the Fee for Service Agreement on a "pure" messenger model basis on behalf of the Physician, RMG will act as a messenger to communicate to the Physician the offer received from the Payor, and to transmit proposals back and forth between the Payor and the Physician. Where the "pure" messenger model is used, the Physician will communicate the proposal to each of its Physician who will make a separate, independent and unilateral decision whether to accept or reject the Payor's offer or proposal. The Physician agrees not to discuss or seek to establish an understanding or agreement among other physician on prices or other competitive terms offered or proposed by the Payor. Nor will RMG, in its messenger role, inform the Physician of the view of any other RMG Physician, or of RMG's own view, of a given offer or proposal. In sum, under the "pure" messenger model, RMG will only facilitate the separate consideration of the Fee for Service Agreement proposal by each RMG Physician, and will not engage in any

negotiation of the Fee for Service Agreement collectively on behalf of RMG Physician as a whole, or of any subgroup of RMG Physicians, other than on behalf of RMG Physicians that are corporate Affiliates.

4.02 Modified Messenger Model Guidelines. For Fee for Service Agreements offered by Payors which RMG decides to facilitate on a modified messenger model basis on behalf of the Physician and its RMG Physicians, RMG will request the Physician to obtain from its RMG Physician and specify in advance particular contracting parameters, terms, rates, and/or methodologies which, if offered by a Payor, would be acceptable to such RMG Physicians ("Contract Parameters"). Contract Parameters shall be determined independently and unilaterally by RMG Physician. The Physician agrees not to discuss with or seek any agreement or understanding regarding Contract Parameters among its RMG Physician or with any other RMG Physician. Nor will RMG inform the Physician of the view of any other RMG Physician, or of RMG's own view, regarding appropriate Contract Parameters. The initial Contract Parameters shall be delivered by Physician in a confidential writing to RMG. The Physician may amend the Contract Parameters at the direction of its RMG Physician at any time by written notice to RMG, and such amended Contract Parameters will go into effect upon receipt, except to the extent that RMG has already have relied and made commitments on the basis of the prior Contract Parameters. Where an offer or proposal by a Payor for a Fee for Service Agreement meets or exceeds (is more favorable than) the Contract Parameters of certain RMG Physicians, the Physician agrees that RMG may accept and bind the Physician and those RMG Physician to the Fee for Service Agreement.

For Fee for Service Agreements offered by Payors which RMG decides to facilitate on a modified messenger model basis on behalf of the Physician and its RMG Physician, if the Payor's offer does not meet the Contract Parameters specified by RMG Physician, then RMG will forward a copy of the Payor's Fee for Service Agreement and fee schedule offer to the Physician to communicate to its RMG Physician for acceptance or rejection in accordance with the terms above. Within thirty (30) days of the Physician's receipt of such offer, or such lesser period as may be required by the Payor, the Physician shall notify RMG in writing, whether the Physician and its RMG Physician agree to accept and be bound by the terms of the Fee for Service Agreement and fee schedule. If RMG Physician do not opt out of the Fee for Service Agreement on the terms so offered in a timely manner or do not respond in a timely manner to the notice of the offer, then they will be deemed to have "opted-in" to such Fee for Service Agreement and will participate in such contract. Those RMG Physicians who reject the Fee for Service Agreement so offered will be deemed to have "opted-out" of the Fee for Service Agreement and will not participate in such contract.

ARTICLE V
Independent Contractor

In the performance of the work, duties, and obligations set forth in this Agreement, and in regard to any services rendered or performed on behalf of Covered Individuals by RMG or Physician, their agents, servants and employees such persons are at all times acting and performing as independent contractors with respect to each other. Nothing herein shall be construed to create between RMG and Physician the relationship of employer-employee, partner or joint venturer. PHYSICIAN ACKNOWLEDGES AND AGREES THAT

THE PHYSICIAN WILL NOT BE ENTITLED TO WORKERS' COMPENSATION OR UNEMPLOYMENT COMPENSATION BENEFITS AND THAT THE PHYSICIAN WILL BE OBLIGATED TO PAY FEDERAL AND STATE INCOME TAX ON THE AMOUNTS EARNED.

ARTICLE VI
Term And Termination

6.01 This Agreement shall remain in full force and effect until December 31, 2017 and shall automatically renew for successive annual terms, unless either party terminates this Agreement in accordance with this Article VI of the Agreement.

6.02 Notwithstanding any other provision in this Agreement, this Agreement may be terminated on the first to occur of the following:

A. RMG may terminate this Agreement pursuant to the provisions of its quality assurance and utilization review programs regarding sanctions which may be imposed upon participating physicians.

B. Either party to the Agreement shall have the right to terminate this Agreement upon providing thirty (30) days' written notice to the other party if the party to whom such notice is given is in breach of this Agreement. The party claiming the right to terminate hereunder shall set forth in the notice of intended termination required hereby the facts underlying its claim of the other party's breach of the Agreement. Remedy of such breach within twenty (20) days of the receipt of such notice shall revive this Agreement for the remaining term.

C. In cases where RMG determines in good faith that the health, safety or welfare of any Covered Individual is jeopardized by continuation of this Agreement, or if Physician furnished incomplete or inaccurate information on any application or statement, or if, in the judgment of RMG, the ability of the Physician to perform the services covered by this Agreement is otherwise impaired or adversely affected, RMG may terminate this Agreement immediately upon written notice to Physician.

D. Either party may terminate this Agreement, without cause, by giving ninety (90) days' prior written notice to the other of termination. During that ninety day notice period, Physician shall continue to provide services pursuant to the terms of this Agreement.

E. RMG may terminate this Agreement immediately and without notice should Physician's membership in RMG be terminated for any reason.

6.03 As of the date of termination and pursuant to any provision of this paragraph or of this Agreement, this Agreement shall be considered to be of no further force or effect whatsoever and each of the parties shall be relieved and discharged herefrom, except that each party to this Agreement shall remain liable for any obligations or liabilities arising from activities carried on by such party or its agents, servants, or employees during the period this Agreement shall have been in effect. The termination of this Agreement shall in no manner release or discharge Physician from any professional or legal obligation to continue to provide or

arrange for the provision of appropriate medical services to Covered Individuals as required by any HPA.

6.04 Upon the effective date of termination of this Agreement, Physician shall immediately and permanently discontinue the use of any marks, names or indicia which in the opinion of RMG may in any way indicate or tend to indicate that Physician or its Physicians are in any manner associated with RMG.

6.05 Notwithstanding the foregoing provisions, RMG shall not, on its own behalf or on behalf of a Payor, terminate this Agreement or the participation of Physician as a result of (i) Physician expressing disagreement with RMG or a Payor's decision to deny or limit benefits to a Covered Individual; (ii) Physician assisting a Covered Individual to seek reconsideration of such a decision by RMG or a Payor; (iii) Physician discussing with a Covered Individual (or former Covered Individual) any aspect of the Covered Individual's medical condition, any proposed treatments or treatment alternatives, whether or not covered by the applicable HPA; or (iv) Physician's personal recommendation regarding selection of a health plan based upon the Physician's personal knowledge of the health needs of such Covered Individual.

ARTICLE VII
Confidentiality

7.01 The Parties acknowledge that, as a result of this Agreement, each may have access to certain trade secrets and other confidential and proprietary information of the other as well as the terms of this Agreement and payment rates under RMG facilitated HPAs ("Confidential Information"). Each Party shall hold, and cause its employees and agents to hold, as confidential such Confidential Information, provided however, that nothing herein shall be interpreted to prevent the RMG from using alone, or in collaboration with third Parties, any information obtained or developed under this Agreement to study costs and utilization, evaluate treatment outcomes and Physician performance and develop statistical analyses, utilization management processes and other programs and products, and further, the provisions of this Section are subject to the provisions of Section 7.04(b). Notwithstanding the foregoing, nothing herein shall be construed to limit communications (i) necessary or appropriate for the delivery of Covered Services, (ii) to Covered Individuals regarding treatment alternatives or rights to appeal coverage determinations, and/or (iii) to Covered Individuals identifying the type of reimbursement arrangement (i.e., fee-for service, capitation) under which the Physician is compensated for Covered Services under this Agreement.

(a) RMG and Physician shall maintain the confidentiality of all documents, including quality assurance and utilization review records, in accordance with all applicable state and federal law, and implementing regulations, and shall inform all of their respective officers, agents and employees of the requirements of this paragraph and any special requirements as to particular classes of records.

7.02 Any and all Covered Individual records and charts produced by Physician as a result of services performed under an HPA and subject to this Agreement shall be and

remain the property of Physician. Both during and after the term of this Agreement, RMG or its agent shall be permitted to inspect and duplicate an individual chart or record to the extent necessary to perform utilization or quality assurance review. However, such inspection, duplication or review of confidential patient medical records shall be done in strict compliance with all case law, statutes and regulations imposing standards of privilege and confidentiality. RMG shall be solely responsible for maintaining patient confidentiality and privilege with respect to any information obtained by RMG pursuant to this paragraph.

7.03 HIPAA Compliance. RMG shall treat medical records and personal health information of Covered Individuals as confidential in compliance with all applicable federal and state laws, including the Health Insurance Portability and Accountability Act of 1996, and the privacy and security rules promulgated thereunder, the Health Information Technology for Economic and Clinical Health ("HITECH") Act (collectively, HIPAA"), and any applicable state law and the regulations promulgated thereunder. For purposes of this Agreement, "Protected Health Information" ("PHI") and Electronic Protected Health Information" ("ePHI") shall have the meaning ascribed to those terms under HIPAA. The parties agree to abide by the terms of the HIPAA Business Associate Exhibit attached hereto as **Exhibit** A and incorporated herein. Physician shall obtain from its patients, any necessary consents or authorizations to the release of medical records and personal health information to RMG and its representatives as the same may be required by applicable Federal or state law or regulation.

7.04 Proprietary Information. As used in Section 7.01, proprietary information includes:

i. fee schedules and payment criteria of HPA;

ii. clinical data and information collected by RMG;

iii. clinical protocols, guidelines, and care patterns;

iv. performance results regarding individual Physicians; and

v. business operations, practices and procedures of RMG or Physicians, including staffing, strategies and financial plans and budgets, contractual relationships or terms, practice management procedures, health information technology systems and/or systems or processes related to the specific operation of Physicians ("Confidential Information").

In addition, the parties will hold in strict confidence any information specified in writing by any party hereto as confidential information. The parties shall each exercise best efforts to prevent any of their respective agents, employees or independent contractors or any other person involved in doing business with or controlled by the recipient party from disclosing or transmitting to any third party any such Confidential Information obtained from the disclosing party; provided, however, that nothing herein shall prohibit a recipient party from disclosing or transmitting information to the extent necessary or appropriate under this Agreement or as required by law. Without limiting the foregoing;

A. Physician shall not disclose to any third party, including, without limitation, other Physicians, practices or groups, Confidential Information, unless such disclosure is reasonably needed to coordinate care, required by law or is authorized in writing by RMG.

B. Notwithstanding the foregoing, Physician may disclose HPA terms to Physician employees, agents, or attorneys with a need to know for purposes of administering the HPA, and who have undertaken a similar duty of nondisclosure. Upon the termination of this Agreement for any reason, Physician shall immediately return and/or destroy any Confidential Information obtained by or from RMG, including any originals or copies of policies, procedures, clinical data and information and performance results. The parties agree that failure to abide by this Section will cause irreparable injury and, therefore, agree that in the event of a breach of this Section, each party shall be entitled to enforce these covenants in equity by way of injunction to restrain the violation, threatened violation or continued violation thereof, without the requirement to post bond, and that such application for such an injunction shall be without prejudice to any other right of action that may accrue to such party by reason of the breach.

ARTICLE VIII
Governing Law

The validity, interpretation and performance of this Agreement shall be governed by and construed in accordance with the laws of the State of Colorado.

ARTICLE IX
Severability

The provisions of this Agreement shall be deemed severable and if any portion shall be held invalid, illegal or unenforceable for any reason, the remainder of this Agreement shall be effective and binding on the parties.

ARTICLE X
Waiver Of Provision

The failure by a Party at any time to require performance of any provision of this Agreement shall not constitute a waiver of such provision and shall not affect the right of such Party to require performance at a later time. Any waiver of the breach of any term or condition of this Agreement by either Party shall not be a continuing waiver and shall not operate to bar the waiving Party from claiming a breach of this Agreement for any subsequent breach hereunder.

ARTICLE XI
Entire Agreement

This Agreement, including any exhibits and attachments, constitutes and expresses the entire agreement and understanding between the Parties hereto in reference to all matters herein referred to, and supersedes all previous discussions, promises, representations, and understandings, whether oral or written, between the Parties.

ARTICLE XII
Notice

12.01 Any notice required or permitted to be given under this Agreement, except as otherwise specifically provided for herein, shall be in writing and may either be delivered personally or sent by certified U.S. mail, return receipt requested, postage prepaid:

A. Notice to RMG shall be addressed as follows:
Rose Medical Group
4900 S. Monaco St, Suite 240
Denver, Colorado 80237

B. Notice to Physician shall be addressed as indicated below Physician's signature.

12.02 A notice shall be deemed given three (3) days after the date on which it is deposited in the mail in accordance with the foregoing or upon delivery, if delivered personally. Either party may change the address at which to send notices by giving the other party ten (10) days' prior written notice of such change.

ARTICLE XIII
Non-Exclusivity Of Relationship

This Agreement in no manner precludes or prohibits Physician from negotiating or entering into similar and/or separate agreements with other managed care entities or networks or third party Payors, nor does it preclude RMG from negotiating or entering into similar and/or separate agreements with other similar providers.

Notwithstanding the foregoing, Physician grants RMG the right of first opportunity to seek to negotiate Fee For Service Agreements with designated payors ("Designated Payors"). Designated Payors will be those payors identified by the Board of Directors of RMG. This right of first opportunity means that for a period of 180 days following notice to Physicians, RMG will seek to negotiate a Fee For Service Agreement using a messenger or modified messenger model approach described in this Agreement. During this period, Physician will not approach a Designated Payor with respect to such a contract. If, however, a Designated Payor seeks to negotiate directly with any Physician, the restrictions set forth in this Article with respect to negotiations will be terminated and the Physician will be free to negotiate directly with any Designated Payor.

ARTICLE XIV
Assignment

Physician shall not assign or transfer his/her rights, duties or obligations under this Agreement without prior written consent of RMG. RMG may, without the consent of Physician assign, delegate or otherwise transfer any or all of its rights, duties or obligations under this Agreement.

ARTICLE XV
Dispute Resolution

Each Party hereto, in the event of a dispute related to the creation, implementation, termination or performance of either party under this Agreement, shall notify the other in writing of any dispute and seek in good faith resolution of such dispute. The written notice shall specify the basis of the dispute. Within thirty (30) days of receipt of the dispute notice or such other time as may be necessary to fully investigate such dispute, the party receiving the notice shall respond to the other, in writing or through a telephonic or personal contact, and the parties shall then schedule, within thirty (30) days of receiving a notice of the dispute, a personal meeting. A failure to cooperate to schedule the personal meeting shall result in an inability of that party to initiate the next phase, i.e. arbitration, of the dispute resolution process. If both parties are satisfied at the conclusion of this phase of the Dispute Resolution process, the matter is concluded. If one or both parties continue to believe that the matter is not resolved, then a party may submit the dispute to confidential binding arbitration as set forth in this Section. The arbitration shall be conducted in Colorado pursuant to the rules of the American Health Lawyers Association before a single arbitrator chosen by the parties, and if the parties cannot agree on an arbitrator, then the arbiter will be selected as set forth in such rules. The Decision of the Arbitrator shall be final and binding, and not subject to an appeal.

Costs of the arbitration, including reasonable attorneys' fees and arbitrator fees, shall be shared equally by the parties, unless the arbitrator concludes a different allocation of costs is appropriate based upon a determination by the arbiter with respect to the reasonableness and good faith of the positions taken by either of the parties.

ARTICLE XVI
Fees

The RMG, in its sole discretion, may establish a schedule of fees or dues to be paid by all participating physicians, including Physician, for application fees, fee for service, access fees or other such charges, and may from time to time amend or modify such fee schedules, as it deems appropriate. Physician agrees to pay RMG such fees as are allocable to and due from Physician in a timely manner. RMG's adjustment or modification of its fees and charges may be implemented without Physician's consent, it being understood that Physician shall retain termination without cause rights under Article VI 6.02 D.

ARTICLE XVII
Third Party Beneficiaries

The rights and obligations of each party to this Agreement shall inure solely to the benefit of the parties hereto, and no person or entity shall be a third-party beneficiary of this Agreement.

ARTICLE XVIII
Amendments

This Agreement may be amended by the RMG giving the Physician at least thirty (30) days prior written notice of such amendment. Such amendment shall become effective at the end of that thirty (30) day notice period, unless the Physician objects in writing to the RMG within that period. If the Physician objects in writing to the RMG in a timely manner, then representatives from each Party shall meet and attempt to resolve the dispute. If the dispute cannot be resolved within thirty (30) days following delivery of a timely notice, then the amendment will not go into effect with respect to the Physician, and the RMG may, at its option, terminate this Agreement upon thirty (30) days' notice. If the Physician agrees in writing to accept the amendment before the end of the thirty (30) day notice of termination period, then this Agreement, as so amended, shall remain in effect.

ARTICLE XIX
Access To Books And Records

Physician agrees that until the expiration of ten (10) years after the furnishing of services provided under this Agreement, Physician shall make available to the Secretary of the United States Department of Health and Human Services (the "Secretary") and the United States Comptroller General, and their duly authorized representatives, this Agreement and all books, documents and records necessary to verify the nature and extent of the costs claimed to Medicare for those services provided under this Agreement.

ARTICLE XX
Comply with Laws

Physician agrees to comply with all applicable state and Federal laws, rules and regulations, including Medicare laws, rules and regulations described in Exhibit B in the performance of Medicare services.

[SIGNATURES ON NEXT PAGE]

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of date set forth below.

PHYSICIAN

By: _____

_____
Print Name

Address:
_____
_____
_____

Accepted By:

ROSE MEDICAL GROUP

By:_____

Title:_____

Date:_____

Effective Date: _____

EXHIBIT A

BUSINESS ASSOCIATE EXHIBIT

This Business Associate Exhibit ("**Exhibit**") to the Group Physician Participation Agreement outlines the responsibilities of Rose Medical Group ("**Business Associate**") and the licensed physician identified on the signature page to the Agreement ("**Covered Entity**") each a "Party" and collectively, the "Parties."

RECITALS

WHEREAS, Covered Entity is, owns, operates, manages and/or is otherwise affiliated with one or more covered entities ("**Covered Entities**") as defined in the federal regulations at 45 C.F.R. Parts 160 and 164 (the "**Privacy Standards**") promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") and the Health Information Technology for Economic and Clinical Health Act of 2009 ("**HITECH**"), thereby resulting in Business Associate being considered a business associate of Covered Entity;

WHEREAS, pursuant to HIPAA and HITECH, the U.S. Department of Health & Human Services ("**HHS**") promulgated the Privacy Standards and the security standards at 45 C.F.R. Parts 160 and 164 (the "**Security Standards**") requiring certain individuals and entities subject to the Privacy Standards and/or the Security Standards to protect the privacy and security of certain individually identifiable health information ("**Protected Health Information**" or "**PHI**"), including electronic protected health information ("**EPHI**");

WHEREAS, the Parties wish to comply with Privacy Standard and Security Standards as amended by the HHS regulations promulgated on January 25, 2013, entitled the "Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act," as such may be revised or amended by HHS from time to time;

WHEREAS, Covered Entity and Business Associate have entered into a Clinically Integrated Participation Agreement (the "Service Agreement") pursuant to which Business Associate may provide services for Covered Entity that require Business Associate to access, create, use and disclose health information that is protected by federal law; and

WHEREAS, in order to protect the privacy and security of PHI, including EPHI, created or maintained by or on behalf of the Covered Entity, the Privacy Standards and Security Standards require a Covered Entity to enter into a "business associate agreement" with individuals and entities providing services for or on behalf of the Covered Entity if such services require the use or disclosure of PHI or EPHI; and

NOW, THEREFORE, in consideration of the mutual promises set forth in this Exhibit and the Service Agreement, and other good and valuable consideration, the sufficiency and receipt of which are hereby severally acknowledged, the Parties agree as follows:

1. **Scope of Exhibit**. All capitalized terms not otherwise defined in this Exhibit shall have the meanings set forth in the Privacy Standards and Security Standards (45 C.F.R. Parts 160 and 164), collectively referred to hereinafter as the "**Confidentiality Requirements**". Subcontractor acknowledges and agrees it meets the definition of a **"business associate"** at 45 C.F.R. §160.103. In accordance with this Exhibit and the Service Agreement, Business Associate may use, disclose, access, create, maintain, transmit and/or receive on behalf of Covered Entity, PHI and EPHI. All references to PHI herein shall be construed to include EPHI, and to be limited to that PHI used, disclosed, accessed, created, maintained, transmitted and/or received on behalf of Covered Entity by Business Associate pursuant to the Service Agreement. Business Associate agrees not to use or disclose (or permit the use or disclosure of) PHI in a manner that would violate the Confidentiality Requirements if the PHI were used or disclosed by Covered Entity in the same manner. To the extent the Business Associate is to carry out a Covered Entity's obligations under the Confidentiality Requirements, the Subcontractor shall comply with the provision(s) of the Confidentiality Requirements that would apply to the Covered Entity in the performance of such obligation(s).

2. **Use of PHI**. Except as otherwise permitted or Required By Law, Business Associate shall use PHI in compliance with 45 C.F.R. § 164.504(e). Furthermore, Business Associate shall use PHI (i) solely for Covered Entity's benefit and only for the purpose of performing services for Covered Entity as such services are defined in the Service Agreement, and (ii) as necessary for the proper management and administration of Business Associate or to carry out its legal responsibilities, provided that such uses are permitted by law. Business Associate may de-identify PHI in accordance with the Confidentiality Requirements.

3. **Disclosure of PHI.** To the extent permitted by law, Business Associate may disclose PHI to any third party as necessary to perform its obligations under the Service Agreement and as permitted or required by applicable law. Further, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that: (i) such disclosures are required by law, or (ii) Business Associate: (a) obtains reasonable assurances from any third party to whom the information is disclosed that it will be held confidential and further used and disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (b) requires the third party to agree to immediately notify Business Associate of any instances of which it is aware that PHI is being used or disclosed for a purpose that is not otherwise provided for in this Exhibit or for a purpose not expressly permitted by the Confidentiality Requirements. Business Associate shall comply with the minimum necessary standard in accordance with 45 C.F.R. §164.502(b).

a. Business Associate shall report to Covered Entity any use or disclosure of PHI not permitted by this Exhibit of which it becomes aware, such report to be made within thirty (30) business days of Business Associate becoming aware of such use or disclosure.

b. If Business Associate uses or contracts with any agent, including a subcontractor (collectively, "**Subcontractors**") that uses, discloses, creates, accesses, receives, maintains or transmits PHI on behalf of Business Associate, Business Associate shall require each Subcontractor to agree in writing to the same restrictions and conditions that apply to Business Associate under this Exhibit; specifically, Business

Associate agrees to enter into business associate agreements with its Subcontractors that meet the requirements of the Confidentiality Requirements.

c. Business Associate agrees to mitigate, to the extent practical, any harmful effect that is known to Business Associate and is the result of a use or disclosure of PHI by Business Associate or any of Business Associate's Subcontractors in violation of this Exhibit.

4. **Individual Rights Regarding Designated Record Sets.** If Business Associate maintains a Designated Record Set on behalf of Covered Entity, Business Associate shall (i) provide access to, and permit inspection and copying of, PHI by Covered Entity under conditions and limitations required under 45 C.F.R. §164.524, as it may be amended from time to time, and (ii) in accordance with 45 C.F.R. §164.526, amend or append PHI maintained by Business Associate as reasonably requested by Covered Entity. Business Associate shall respond to any request from Covered Entity for access pursuant to an Individual's request within twenty (20) days of the Covered Entity's request and shall make any amendment or append any PHI as requested by Covered Entity within thirty (30) days of such request. Any information requested from Business Associate under this **Section 4** shall be provided in the form or format requested, if it is readily and reasonably producible in such form or format. Business Associate may charge a reasonable fee based upon Business Associate's labor costs in responding to a request for electronic information (or a cost-based fee for the production of non-electronic media copies). Business Associate shall notify Covered Entity within five (5) business days of receipt of any written request for access or amendment by an Individual. Covered Entity shall determine whether to grant or deny any access or amendment requested by the Individual, and Covered Entity shall be responsible for all communications with requesting Individuals regarding such Individuals' rights under 45 C.F.R. §164.524 and/or 45 C.F.R. §164.526.

5. **Accounting of Disclosures.** Business Associate shall make available to Covered Entity in response to a request from an Individual the information required for an accounting of disclosures of PHI with respect to the Individual in accordance with 45 C.F.R. §164.528. Business Associate shall provide to Covered Entity such information necessary to provide an accounting within thirty (30) days of Covered Entity's request. Such accounting will be provided without cost if it is the first accounting requested by an Individual within any twelve (12) month period. For subsequent accountings within a twelve (12) month period, Business Associate may charge Covered Entity a reasonable fee based upon Business Associate's labor costs in responding to a request for electronic information (or a cost-based fee for the production of non-electronic media copies).

6. **HHS Audits.** Business Associate shall make available to HHS or its agents its internal practices, books, and records relating to the compliance of Business Associate and/or Covered Entity with the Confidentiality Requirements, such internal practices, books and records to be provided in the time and manner designated by HHS or its authorized agents.

7. **Implementation of Security Standards; Notice of Security Incidents.** In compliance with the applicable Confidentiality Requirements, Business Associate will use appropriate safeguards to prevent the use or disclosure of PHI other than as permitted under this Exhibit. Business Associate will implement administrative, physical and technical safeguards

that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI that it uses, discloses, creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate will promptly report to Covered Entity any Security Incident of which it becomes aware; provided, however, that Covered Entity acknowledges and shall be deemed to have received notice from Business Associate that there are routine occurrences of: (i) unsuccessful attempts to penetrate computer networks or services maintained by Business Associate; and (ii) immaterial incidents such as "pinging" or "denial of services" attacks.

8. **HIPAA Data Breach Notification**. Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any "breach" of "unsecured PHI" as those terms are defined by 45 C.F.R. §164.402 (hereinafter a "HIPAA Breach"). Business Associate will, following the discovery of a HIPAA Breach, notify Covered Entity promptly after Business Associate discovers such HIPAA Breach, unless Business Associate is prevented from doing so by 45 C.F.R. §164.412 concerning law enforcement investigations. No later than fifteen (15) business days following a HIPAA Breach, Business Associate shall notify Covered Entity in accordance with 45 C.F.R. §164.410.

9. **Term and Termination**.

a. The term of this is Exhibit shall commence on the Effective Date of the Service Agreement. This Exhibit shall remain in effect until terminated in accordance with the terms of this **Section 9**, provided, however, that termination shall not affect the respective obligations or rights of the Parties arising under this Exhibit prior to the effective date of termination, all of which shall continue in accordance with their terms.

b. Notwithstanding any termination provisions set forth in the Service Agreement, eeither Party may immediately terminate this Exhibit (the "Terminating Party") and shall have no further obligations to the other Party (the "Terminated Party") hereunder if the Terminated Party fails to observe or perform any material term contained in this Exhibit for thirty (30) days after written notice thereof has been given to the Terminated Party.

c. Upon the termination of the Service Agreement, either Party may terminate this Exhibit by providing written notice to the other Party.

d. Upon termination of this Exhibit for any reason, Business Associate agrees either to return to Covered Entity or to destroy all PHI received from or on behalf of Covered Entity that is in the possession or control of Business Associate. In the case of PHI which is not feasible to "return or destroy," Business Associate shall extend the protections of this Exhibit to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

10. **Obligations of Covered Entity.**

a. Consents. Covered Entity represents that it has received all consents, authorizations, and permissions necessary under federal and state law to permit Business Associate to perform its obligations and services under the Service Agreement.

b. Notice of Privacy Practices. Covered Entity shall promptly notify Business Associate in writing of any limitation(s) of which Covered Entity is aware regarding Covered Entity's notices of privacy practices to the extent that such limitation(s) may affect Business Associate's use or disclosure of PHI.

c. Revocation of Authorization or Consent. In the event Covered Entity is aware of any changes in, or revocation of, any authorization, consent or other permission by an Individual to use or disclose PHI that a reasonable and prudent person would expect to impact (adversely or otherwise) Business Associate's use, disclosure, access, creation, maintenance, transmission and/or receipt of PHI, Covered Entity shall promptly notify Business Associate in writing of such event.

d. Restrictions Regarding Uses/Disclosures. Covered Entity shall promptly notify Business Associate in writing of any restriction(s) of which Covered Entity is aware regarding any agreed-to restriction(s) concerning the use or disclosure of an Individual's PHI (e.g., restrictions agreed-to in accordance with 45 C.F.R. §164.522), if a reasonable and prudent person would expect such restriction(s) to impact (adversely or otherwise) Business Associate's use, disclosure, access, creation, maintenance, transmission and/or receipt of PHI.

11. **Ineligible Persons.** Covered Entity represents and warrants to Business Associate that Covered Entity and its directors, officers, and key employees: (i) are not currently excluded, debarred, or otherwise ineligible to participate in the federal health care programs as defined in 42 U.S.C. §1320a-7b(f) or any state healthcare program (collectively, the "**Healthcare Programs**"); (ii) have not been convicted of a criminal offense related to the provision of healthcare items or services but have not yet been excluded, debarred, or otherwise declared ineligible to participate in the Healthcare Programs; and (iii) are not under investigation or otherwise aware of any circumstances which may result in Subcontractor being excluded from participation in the Healthcare Programs (collectively, the "**Warranty of Non-exclusion**"). Covered Entity's representations and warranties underlying the Warranty of Non-exclusion shall be ongoing during the Term, and Covered Entity shall immediately notify Business Associate of any change in the status of the representations and warranties set forth in this Section 11. Any breach of this Section 11 shall give Business Associate the right to terminate this Exhibit immediately.

12. **Miscellaneous.**

a. **Notice.** All notices, requests, demands and other communications required or permitted to be given or made under this Exhibit shall be in writing, shall be effective upon receipt or attempted delivery, and shall be sent by (i) personal delivery; (ii) certified or registered United States mail, return receipt requested; (iii) overnight

delivery service with proof of delivery; or (iv) facsimile with return facsimile acknowledging receipt. Notices shall be sent to the addresses below. Neither party shall refuse delivery of any notice hereunder.

Business Associate: Rose Medical Group
4900 S. Monaco St, Suite 240
Denver, Colorado 80237

Covered Entity: Physician identified on the signature page of the Agreement

b. **Waiver.** No provision of this Exhibit or any breach thereof shall be deemed waived unless such waiver is in writing and signed by the Party claimed to have waived such provision or breach. No waiver of a breach shall constitute a waiver of or excuse any different or subsequent breach.

c. **Assignment.** Neither Party may assign (whether by operation of law or otherwise) any of its rights or delegate or subcontract any of its obligations under this Exhibit without the prior written consent of the other Party.

d. **Severability.** Any provision of this Exhibit that is determined to be invalid or unenforceable will be ineffective to the extent of such determination without invalidating the remaining provisions of this Exhibit or affecting the validity or enforceability of such remaining provisions.

e. **Entire Exhibit.** This Exhibit constitutes the complete agreement between Business Associate and Covered Entity relating to the matters specified in this Agreement, and supersedes all prior representations or agreements, whether oral or written, with respect to such matters. In the event of any conflict between the terms of this Agreement and the terms of any Service Agreement or any such later agreement(s), the terms of this Exhibit shall control unless the terms of such Service Agreements are more strict with respect to the protection of PHI, or the Parties specifically otherwise agree in writing. No oral modification or waiver of any of the provisions of this Exhibit shall be binding on either Party. No obligation on either Party to enter into any transaction is to be implied from the execution or delivery of this Exhibit. This Exhibit is for the benefit of, and shall be binding upon the Parties, their affiliates and respective successors and assigns. No third party shall be considered a third-party beneficiary under this Exhibit, nor shall any third party have any rights as a result of this Exhibit.

f. **Governing Law.** This Exhibit shall be governed by and interpreted in accordance with the laws of the state of Colorado, excluding its conflicts of laws provisions. Jurisdiction and venue for any dispute relating to this Exhibit shall exclusively rest with the state courts of Denver County, Colorado and the federal courts of the state of Colorado.

g. **Nature of Agreement; Independent Contractor.** Nothing in this Exhibit shall be construed to create (i) a partnership, joint venture or other joint business relationship between the Parties or any of their affiliates, or (ii) a relationship of

employer and employee between the Parties. Business Associate is an independent contractor, and not an agent of Covered Entity. This Exhibit does not express or imply any commitment to purchase or sell goods or services.

EXHIBIT B

MEDICARE ADVANTAGE REGULATORY ADDENDUM

The provisions in this addendum supplement the Agreement between Physician and RMG.

Physician agrees to comply with all applicable Medicare laws, rules and regulations, including, but not limited to, instructions issued by the Centers for Medicare and Medicaid Services (CMS) as well as Medicare Advantage or Medical Cost Payor's applicable policies and procedures as they relate to the provision of services to its Medicare Advantage or Medicare Cost Covered Individuals including, but not limited to, eligibility verification, utilization management, claims submission, and quality assurance programs.

1. Payment. Payor agrees to make payment to Physician for Covered Services rendered to Covered Individuals under any Medicare Advantage Health Plan Agreement within thirty (30) calendar days of receipt by Payor of an electronically submitted Clean Claim or within forty-five (45) calendar days of receipt if submitted by any other means or within the time required by applicable state, federal law or regulation, whichever is sooner. Penalties for non-compliance shall be as per CRS 10-16-106.5. Member Held Harmless. Physician agrees that in no event, including, but not limited to, nonpayment by Payor, insolvency, or breach of this Agreement shall Physician bill, charge, collect a deposit from, seek compensation, remuneration or other reimbursement from, or have any recourse against Covered Individuals or persons other than Payor for Covered Services provided under a Medicare Advantage or Medicare Cost Health Plan Agreement. This provision shall not prohibit collection from Covered Individual of copayments, coinsurance, deductibles or services not covered under any Medicare Advantage or Medicare Cost Health Plan Agreement. Physician further agrees that (a) 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 Medicare Advantage or Medicare Cost Covered Individuals and (b) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Physician and Medicare Advantage or Medicare Cost Covered Individuals or persons acting on their behalf. Any modification, addition or deletion of or to the provisions of this clause shall be effective on a date no earlier than fifteen days after the applicable regulatory agency has received written notice of such proposed change and has approved such change.

2. Access to Records; Audits. Subject to applicable State and Federal confidentiality or privacy laws, Medicare Advantage or Medicare Cost Payors or their designated representatives and designated representatives of local, state and federal regulatory agencies having jurisdiction over Payor shall have access to Provider's records or the applicable records of any subcontractors with which Physician contracts at Physician's place of business on request during normal business hours to inspect, review and make copies of such records. Such governmental agencies shall include the State Department of Public Health and Environment, State Department of Health Care Policy & Financing, State Division of Insurance, United States Department of Health and Human

Services and the Controller General or their designees. When requested by Payor or representatives of local, state of federal regulatory agencies, Physician shall produce copies of any such records at the State prevailing rate. Physician agrees to permit Medicare Advantage or Medicare Cost Payor, its designated representatives and designated representatives of local, state and federal regulatory agencies having jurisdiction over Payor to conduct site evaluations and inspections of Physician's and/or subcontractor's offices and service locations. Physician shall keep all records for a period of ten (10) years from the last day of the CMS contract period with Payor, unless otherwise required by law.

3. Delegation. Upon the delegation by Medicare Advantage or Medicare Cost Payor to RMG of any activity or responsibility required under the contract between Medicare Advantage or Medicare Cost Payor and CMS, RMG agrees that such delegation will be in writing. Such written agreement must specify delegated activities and reporting responsibilities, must provide for revocation of the delegated activities, and must specify that the delegated function will be monitored by Medicare Advantage or Medicare Cost Payor on an ongoing basis. For delegation of credentialing, the written agreement must specify that the credentialing process will be reviewed and approved by Medicare Advantage or Medicare Cost Payor and that Payor shall audit the credentialing process on an ongoing basis.

Designation of Tax Identification Number

Owner Authorization

Use this form if you are applying for participation with MultiPlan and will be billing under a Tax Identification Number (TIN) that is owned by another entity. This designation will remain in effect at MultiPlan until it is revoked in writing by the TIN owner.

To confirm your authority to use a designated TIN for billing purposes, complete the fields below, have this form signed and dated by the TIN owner, and send the form to MultiPlan via mail, e-mail or fax.

Mail	**E-mail**	**Fax**
MultiPlan Registrar Department 1100 Winter Street Waltham, MA 02451	registrar@multiplan.com	781-487-8273

To be completed by TIN owner

As the owner of the TIN below, I designate the provider indicated here to utilize my TIN in conjunction with a MultiPlan Provider Agreement for billing purposes. I understand that as the owner of the TIN, it is my responsibility to satisfy all applicable IRS reporting requirements. I also understand that this designation will remain in effect at MultiPlan until I notify MultiPlan that it is revoked.

TIN: ☐☐ - ☐☐☐☐☐☐☐

Name of TIN Owner (please print): _____

Signature of TIN Owner: _____

Date: _____

To be completed by TIN designee

Name of Provider (please print): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Contract Selection Form

PracticeHealth
Independent Practice Resources

Practice:	
TIN Owner signature:	**I am the TIN Owner of the above named practice. The selections marked on this document indicate the Practice Health group agreements I choose to participate with.**
	(The Contract Selection Form requires the signature of the TIN Owner) (Date)
Completed by:	
	(If other than the TIN Owner, name of the practice member or representative completing this form)

			Mark all selections clearly in this column >	**X**
Aetna	I choose to remain on my existing Aetna practice-level agreement OR my practice does not accept this insurance			
	HMO, PPO, EPO, Medicare Advantage, Worker's Compensation	I would like to join the Practice Health Aetna contract		
		Please do not include Medicare Advantage on my Aetna contract		
		Please do not include Worker's Comp on my Aetna contract		
Anthem	I choose to remain on my existing Anthem practice-level agreement OR my practice does not accept this insurance			
	HMO, PPO, FEP, Managed Indemnity	I would like to join the Practice Health Anthem contract		
Beech Street	I choose to remain on my existing Beech Street practice-level agreement OR my practice does not accept this insurance			
	PPO	I would like to join the Practice Health Beech Street contract		
Cigna	I choose to remain on my existing Cigna practice-level agreement OR my practice does not accept this insurance			
	HMO, PPO	I would like to join the Practice Health Cigna contract		
Colorado Access	I choose to remain on my existing Colorado Access practice-level agreement OR my practice does not accept Medicaid			
	CHP+, CHP+ State Managed Care Network	I would like to join the Practice Health Colorado Access contract. I understand each provider in the practice must be validated with Medicaid and I will forward the **Medicaid Approval Letters** to Practice Health as soon as they are received.		

Contract Selection Form

Cofinity	I choose to remain on my existing Cofinity practice-level agreement OR my practice does not accept this insurance		
	PPO	I would like to join the Practice Health Cofinity contract	

Coventry First Health	I choose to remain on my existing Coventry First Health practice-level agreement OR my practice does not accept this insurance		
	PPO, Worker's Compensation	I would like to join the Practice Health Coventry First Health contract	
		Please do not include Worker's Comp on my Coventry First Health contract	

Humana	I choose to remain on my existing Humana practice-level agreement OR my practice does not accept this insurance		
	HMO, PPO, Medicare Advantage	I would like to join the Practice Health Humana contract	
		Please do not include Medicare Advantage on my Humana contract	

MultiPlan & PHCS	I choose to remain on my existing MP/PHCS practice-level agreement OR my practice does not accept this insurance		
	PPO, Veterans Administration	I would like to join the Practice Health MultiPlan/PHCS contract	
		Please do not include VA on my Humana contract	

Rocky Mountain Health Plans	I choose to remain on my existing RMHP practice-level agreement OR my practice does not accept this insurance		
	HMO, PPO	I would like to join the Practice Health RMHP contract	

United Healthcare	I already have a DIRECT UHC contract in place for this TIN		
	Direct Individual Contracts Practice Health does not have a group agreement with UHC	I would like Practice Health to **initiate** credentialing for a DIRECT CONTRACT with UHC. I understand that once credentialing has been initiated by Practice Health, all communication with UHC will be handled directly with the practice.	

If you are a PCP and would like to learn more about our Colorado Care Partners' ACO value-based contracts, please visit H1CCP.com or contact us to arrange a practice visit, (303) 320-2073.

If you are interested in integrating Behavioral Health services into your practice, please call us, (303) 320-2073; currently Practice Health holds BH contracts with Anthem, Colorado Access, & RMHP.

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MESSENGER MODEL CONTRACTING METHODOLOGY

Physicians, like any other business in the U.S., are subject to state and federal antitrust laws, which are intended to prohibit physician practice groups from working together to set reimbursement rates. Under the law, practice groups working together is considered to be collusion and anti-competitive. Accordingly, to meet the requirements of current antitrust laws, Independent Practice Associations (IPAs) that have not achieved full clinical integration routinely use a "Messenger Model" when working with a health plan/payor to determine a medical group's reimbursement rate. The definition of a clinically integrated network (CIN) is a network of interdependent healthcare facilities and providers that work collaboratively to develop and sustain clinical initiatives through evidence and data driven care. PH is not currently considered a CIN.

If you chose to designate PH as your agent for purposes of identifying and soliciting offers from payors, PH will act as the messenger between your group and the health plan. In this role, we may only deliver information from you to the payor regarding the reimbursement that you are willing to accept and the response from the payor to you. RMG does not "negotiate" the reimbursement in any way. Rather, it only acts as the go-between to deliver the messages between the payor and the group. The following information about the Messenger Model is important to remember:

- Each physician or physician group will be required to provide PH with a minimum fee that you or your group will accept for all managed care contracts. This rate should reflect your ideal minimum reimbursement and is the rate that will be initially communicated to the health plan during the negotiation process.

- In reaching your proposed fee, it is critical that you not discuss reimbursement levels with other physicians or practice groups. Doing so may be a violation of federal law.

- We are prohibited by law from disclosing to you any information about other individual physician's or practice group's minimum reimbursement rates or what a particular health plan has agreed to pay another physician or practice group.

- Similarly, your reimbursement request will not – and cannot – be shared with other physicians, including the PH Board of Directors.

- Once PH has your information, we will communicate to the health plan the number of physician participants that will be participating in the health plan's proposed fee schedule.

- If the health plan's proposed fee schedule meets your minimum reimbursement rate, then a contract will be formed with the health plan.

- Even if a health plan's proposed fee schedule falls below the acceptable range for reimbursement for your practice, the proposed fee schedule will be sent to you. If the health plan's proposed fee schedule does not meet your minimum requirements, you will still be given the opportunity to accept or reject any and all contract offers from the health plan.

If you have questions, please contact Practice Health at (303) 320-2073.

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INSTRUCTIONS:

Please indicate below, an acceptable minimum reimbursement rate for each health plan. PH requires either a Physician or Practice Administrator to sign this form for each minimum rate requested in order for PH to engage in the messenger model process with the identified health plan. This will be the rate that is initially communicated to the health plan below during the messenger model process. You will have the opportunity to accept or reject any contract offers from the health plan in the event that the health plan responds with a rate lower than the acceptable minimum reimbursement rate.

Minimum rate requirements may be submitted for each physician or for the practice as a whole. If the practice would like to request different rates from each health plan, please provide one (1) form per health plan.

Health Plan or Network:_____

I hereby agree to:

- ❑ **PERCENTAGE OF MEDICARE RBRVS (specify % below)**
- ❑ **OTHER**
  - ➢ CPT specific rates, case rates, global rates, etc.

	MINIMUM MEDICARE RBRVS PERCENTAGE
Example:	125% of 2014 RBRVS
HMO:	
PPO:	
	MINIMUM RATE
Global OB/Vaginal (59400)	
Global OB/C-Section (59510)	
CPT code(s):	
Other (please specify):	

PHYSICIAN/PRACTICE NAME: _____

SIGNATURE (Physician/Practice Administrator): _____