Network Professional Handbook

Updated April 25, 2025

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Updates Summary

April 25, 2025

This summary represents updates and clarifications added since the previous handbook edition, which was dated July 24, 2025.

Page	Description
10	Updated Claritev's Additional Network Participation Requirements regarding Medicare Advantage

COVID-19 Provider Bulletins

We periodically issue bulletins to providers regarding topics related to COVID-19 and make them available on our **provider portal**. We also occasionally post bulletins and notices from our clients and state agencies. We encourage you to visit the **provider portal** periodically to see the latest.

If you do not have access to our provider portal and wish to receive copies of these bulletins, please contact our Service team at 800-950-7040.

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Introduction

This Network Professional Handbook is the “Administrative Handbook” that applies to Network Professionals, including Individual, Group, and IPA Professional Network Providers and is referenced in your Participating Professional Agreement. Please read it carefully and refer to it as questions arise.

Please note that this administrative handbook supplements the terms and obligations specified in your Participating Professional Agreement. If a provision in this administrative handbook directly conflicts with state or federal law or the terms of your Participating Professional Agreement, the state or federal law or your Participating Professional Agreement takes precedence. For example, if the handbook states a notice time frameof 60 days and your Participating Professional Agreement states a notice time frame of 90 days, the Participating Professional Agreement will control and take precedence over the provision in the administrative handbook. Please note that if your agreement is silent on a particular issue and the administrative handbook affirmatively addresses that issue, it does not constitute a conflict between your Participating Professional Agreement and the administrative handbook. Instead, the administrative handbook acts to supplement the terms of your Participating Professional Agreement.

The terms of this administrative handbook may be modified at the sole discretion of Claritev. In addition to the obligations specified in your Participating Professional Agreement, this administrative handbook provides information about contractual obligations for Network Professionals which includes any Network Professionals participating in the Network through a subsidiary of MultiPlan, Inc. d/b/a Claritev, Inc., including but not limited to, Private Healthcare Systems, Inc. (“PHCS”), HealthEOS (“HealthEOS”), Beech Street Corporation (“Beech Street”), Health Management Network, Inc. (“HMN”), Rural Arizona Network, Inc. (“RAN”), and Texas True Choice, Inc.

When the word “you” or “your” appears in this administrative handbook, it means the Network Professional that is party to a Participating Professional Agreement or is obligated directly or indirectly, to comply with the terms of a Participating Professional Agreement. When “Claritev” or “MultiPlan, Inc. d/b/a Claritev, Inc.” is referenced, it includes MultiPlan, Inc. d/b/a Claritev, Inc., and its subsidiaries.

We are committed to positive relationships with our Network Providers, Clients and Users. To strengthen these relationships, we have a variety of information, including the most current version of this Network Professional Handbook at www.claritev.com.

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Definitions

Depending upon the specific form of agreement you signed, the following terms may be utilized in your Participating Professional Agreement and are intended to be defined as provided for in your Participating Professional Agreement:

Ancillary Provider may be referred to as Vendor

Billed Charges may be referred to as Regular Billing Rates

Client may be referred to as Payor or Company

Contract Rates may be referred to as Preferred Payment Rates or Specified Rates

Covered Services may be referred to as Covered Care

Network Provider may be referred to as Preferred Provider

Participant may be referred to as Covered Individual or Policyholder

Program or Benefit Program may be referred to as Contract or Plan

Billed Charges – The fees for a specified health care service or treatment routinely charged by a Network Professional regardless of payment source.

Benefit Program Maximum – An instance in which the cumulative payment by a Client or User, as applicable, has met or exceeded the benefit maximum for a particular type of Covered Service rendered to a Participant in accordance with the terms of the Participant's Benefit Program.

Certification – The determination made by the Client's or User's Utilization Management program that the health care services rendered by a Network Professional meet the requirements of care, treatment and supplies for which payment is available by a Client or User pursuant to the Participant's Program. Certification may also be referred to as "Precertification."

Clean Claim – A completed HCFA 1500 (or successor form), as appropriate, or other standard billing format containing all information reasonably required by the Client or User for adjudication.

Client – An insurance company, employer health plan, Taft Hartley fund, or an organization that sponsors Program(s), administers Program(s) on behalf of a User, or otherwise provides services to a User regarding such Programs.

Concurrent Review – Utilization Review conducted during a patient's hospital stay or course of treatment.

Contract Rates – The rates and terms of reimbursement to Network Professional for Covered Services as set forth in the Participating Professional Agreement.

Covered Service – Health care treatment and supplies rendered by a Network Provider and provided to a Participant for which a Client or User, as applicable, is responsible for payment pursuant to the terms of a Program.

Network – An arrangement of Network Providers created or maintained by Claritev, or one of its subsidiaries, which may be customized by Clients/Users, under which such Network Providers have agreed to accept certain Contract Rates for Covered Services provided to Participants.

Network Provider(s) – A licensed facility or licensed, registered, or certified health care professional that agrees to provide health care services to Participants and that has been independently contracted for participation in the Network.

Participant – Any individual and/or dependent eligible under a Client's/User's Program that provides access to the Network.

Program – Any contract, insurance policy, workers' compensation plan, auto medical plan, government program, health benefit plan or other plan or program under which Participants are eligible for benefits. "Program" may also include the ValuePoint® by MultiPlan program, a non-insured business arrangement under which, in exchange for a fee or other consideration paid by Participant directly to Client or User, and upon presentation of an identification card bearing the *ValuePoint* logo or other Claritev authorized name and/or logo, a Participant has the right to reimburse Network Providers directly at the Contract Rate as payment in full for health care services rendered.

Protected Health Information (PHI) – Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium as defined by 45 C.F.R. 160.103.

Provider Data - Any information that may be used to identify, select, contact, or locate a provider, including: first name or initial and last name, employment information, education credentials, telephone number, business address, email address, NPI, network credentialing information, medical license number, Medicare and/or Medicaid number.

Quality Management Program – A program designed to promote quality assurance and improvement activities within an organization and assess the credentials of Network Providers and the quality of health care services rendered by each Network Provider. A Quality Management program may include a complaint investigation and resolution process.

Retrospective Review – Utilization Review conducted after services have been provided to a Participant.

User – Any corporation, partnership, labor union, association, program employer or other entity responsible for the payment of Covered Services, entitled to access to the Contract Rates under the Participating Professional Agreement. Client may also be a User. For purposes of the ValuePoint by MultiPlan program, User shall mean an individual.

Utilization Management Program (Sometimes referenced as "Utilization Review.") – A program established by or on behalf of a Client or User under which a request for care, treatment and/or supplies may be evaluated against established clinical criteria for medical necessity, appropriateness and efficiency.

Claritev's Clients

The list of Clients is subject to change and is updated monthly. Participating Network Providers may obtain an updated Client list at http://provider.multiplan.com.

Claritev's Network Products, Programs, and Participation Requirements

Your agreement with MultiPlan, Inc. d/b/a Claritev, Inc., on behalf of itself and its subsidiaries, (collectively "Claritev") is governed by each Client's or User's specific benefit plan. Claritev Clients (and their customers) are not required to access every Network offered by Claritev, or to access every Network Provider participating in the Network(s) they do access. Therefore, Claritev Clients and Users may elect to not access your Participating Professional Agreement, and in those situations, the terms of your agreement will not apply. This may happen under a number of circumstances including but not limited to: claim-specific conditions, exclusion of certain Network Providers, specialties or conditions (e.g. diagnostics, dialysis, hemophilia, etc.); and when Clients or Users have direct or indirect contracts with your organization which take precedence over the Claritev arrangement.

Claritev Clients may access our networks to support a variety of plan configurations. These may include, but are not limited to, limited benefit plans, hospital services only plans, etc. In these cases, a tagline may be included below the logo to describe how the network is used. Questions regarding the plans should be directed to the plan indicated on the ID card. Samples of the logos, provided for illustrative purposes only, can be found on our website at https://www.multiplan.com/provider

Under your Participating Professional Agreement and applicable to all of Claritev's Networks, you are obligated to bill in accordance with industry-accepted coding and bundling rules and are subject to claim edits which may be performed by Claritev and/or our Clients in accordance with these rules. In addition, Network Providers will not be reimbursed for procedures that Claritev and/or our clients determine, based onindustry standard coding rules, to be fraudulent, wasteful or abusive.

Descriptions of Claritev's network products follow. A complete list of the Claritev Network Brands and authorized logos can be found at https://www.claritev.com/healthcare-providers

Primary Network

The Primary Network may be offered on a national or regional basis. The primary network name or logo is typically displayed on the front of a Participant's identification card. The Network name and logo must be reflected on the EOB/EOP. Participants are directed to the primary network through online and downloadable directories and a telephonic locator service.

Clients that have contracted with Claritev to access Claritev's Value-Driven Health Plan ("VDHP") will have the right to access the Primary Network Contract Rates for claims submitted on a HCFA form.

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Complementary Network

The Complementary Network is typically used as an extended or secondary network to a Client's/User's primary network or service area or when the Benefit Program does not utilize another network as primary. Participants can be directed to Network Providers through online and downloadable directories and a telephonic locator service. A Claritev authorized name or logo may be placed on the front or back of the Participant's identification card. The Network name must be reflected on EOB/EOPs. Complementary Network Clients/Users may pay for Covered Services at an in or out-of-network benefit level.

Clients that have contracted with Claritev to utilize the Complementary Network are not required to access the terms of your Participating Professional Agreement, including the Complementary Network Contract Rates, for a specific claim for Covered Services rendered to a Participant in the event that the Contract Rates for such Covered Services exceed the maximum amount of reimbursement eligible under the terms of the Participant's Benefit Program or the Client's/User's and/or Claritev's reimbursement policies ("Maximum Reimbursement Policy"). The terms of your Participating Professional Agreement shall not apply to Client/User with respect to the specific claim that Client/User elects not to access under the Participating Professional Agreement, regardless of the identification requirements specified in your Participating Professional Agreement. Please note that the Maximum Reimbursement Policy is limited to a Client's/User's access to the Complementary Network only and is not applicable to the Primary Network.

ValuePoint® by MultiPlan

ValuePoint by MultiPlan is an access card Network used in place of, or as a complement to, a member's health insurance plan. Participants are directed to ValuePoint Network Providers by their Program operators through online directories and a telephonic locator service. The ValuePoint logo must be displayed on the Participant's identification card. The Participant's identification card must also clearly state the Program is not insurance.

Workers' Compensation Network

The Workers' Compensation Network is used by Clients that access the MultiPlan Network in conjunction with workers' compensation claims. The Network name must be reflected on EOB/EOPs.

Auto Medical Network

The Auto Medical Network is used by Clients that access the MultiPlan Network in conjunction with medical claims covered by auto insurance (e.g. personal injury protection, no fault, med pay, etc.). The Network name must be reflected on EOB/EOPs.

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Simplicity Complete Payment Network*

The Simplicity Complete Payment Network is a unique opportunity offered by Simplicity Interchange, LLC (“Simplicity”) through your Network Agreement with Claritev that lets you take finance out of the provider-patient relationship. Simplicity provides you with one complete payment for primary network Covered Services from the Participating Payer and the Covered Member with no action whatsoever on your part. You receive your full payment from the Participating Payer at the time of Adjudication for primary in-network Covered Services, less a Simplicity Adjustment. The Simplicity payment is made for any Covered Member enrolled with Simplicity and accessing your services through any participating primary PPO Network. This benefit is not limited to services you provide to members of Claritev clients.

As a provider participating in the Simplicity Complete Payment Network, you agree to abide by the Simplicity Terms and Conditions attached as Appendix A of this Administrative Handbook. Please note that while your participation in the Simplicity Complete Payment Network is separate from your participation with Claritev, it is through your Claritev contractual relationship that Healthcare Benefit Plans will be able to access the Simplicity Complete Payment Network. Your reimbursement for Covered Services provided to Covered Members of those Healthcare Benefit Plans will depend on the Network Contract Rate you have with the primary Network utilized by that Health Benefit Plan, and will only be based on the Contract Rates in your Claritev Network Agreement if that Health Benefit Plan is using it for its primary network services. Claritev assumes no liability or responsibility for the services provided by Simplicity.

For those Covered Members enrolled in Simplicity, your reimbursement for Covered Services will be determined by subtracting the Simplicity Adjustment at a line level from the Network Contracted Rate. As noted above, not all Healthcare Benefit Plans accessing the Simplicity Complete Payment Network will access the Claritev Network, therefore, the Network Contracted Rate used to calculate the Simplicity Net Reimbursement Amount will not always be the Claritev Network Contracted Rate.

*The capitalized terms used in this section with regard to the Simplicity Complete Payment Network shall have the meaning ascribed to them in the Simplicity Terms and Conditions, attached as Appendix A (as opposed to the defined terms under “Important Definitions”).

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Additional Network Participation Requirements

Proprietary Information

All information and materials provided to you by Claritev, Clients or Users remain proprietary to Claritev, Client or Users. This includes, but is not limited to, your Participating Professional Agreement and its terms, conditions, and negotiations, any Program, rate or fee information, Claritev Client or User lists, any administrative handbook(s), and/or other operations manuals. You may not disclose any of such information or materials or use them except as may be permitted or required by the terms of your Participating Professional Agreement.

Multiple Network Participation Agreements

In the event that you are participating in the Network through one or more participating provider agreements with Claritev (or its subsidiaries) using the same tax identification number, Claritev, in its sole discretion, will determine the agreement that will apply to your claims, including but not limited to the applicable Contract Rates. Once Claritev determines which agreement applies, Covered Services shall be deemed to have been rendered under the terms and conditions of that agreement.

Consent to Communications from Claritev

As part of your participation in the Claritev Network, you agree to receive communications from Claritev. Such communications include, but are not limited to: contact by manual calling methods, prerecorded or artificial voice messages, text messages, emails, faxes, and/or automatic telephone dialing systems.

Network Professional Responsibilities

As part of the Network, you are responsible for meeting certain requirements for Network participation. You have the responsibility for:

- the care and treatment of Participants under your care. You must ensure that all care is rendered in accordance with generally accepted medical practice and professionally recognized standards and within the scope of your applicable license, accreditation, registration, certification and privileges;
- providing health care services to Medicare Advantage beneficiaries in a culturally competent manner and promoting equitable access to all Medicare Advantage beneficiaries, pursuant to 42 C.F.R. 422.122(a)(8), if you participate in the MultiPlan Medicare Advantage Network;
- open communication with patients regarding the appropriate treatment alternatives available to the patient, regardless of benefit coverage limitations. Neither Client/User nor Claritev will penalize you if you in good faith, report to state or federal authorities any act or practice by the Client/User and/or Claritev that jeopardizes a patient's health or welfare.

- complying with any and all applicable state and/or federal laws related to the delivery of health care services and the confidentiality of Protected Health Information and taking all precautions to prevent the unauthorized disclosure of such Participant's medical and billing records;
- complying with Claritev and Client and/or User requests for copies of a Participant's medical and billing records for those purposes which Claritev and/or its Clients or Users deem reasonably necessary, including without limitation and subject to any applicable legal restrictions, quality assurance, medical audit, credentialing, recredentialing or payment adjudication and processing;
- cooperating with the Quality Management and Utilization Management programs of Client or Users;
- meeting the Claritev credentialing criteria, as referred to later in this section; and
- honesty in all dealings with Claritev, its Client and Users. As a Network Professional, you agree not to make any untrue statements of fact in any claim for payment, nor any untrue statements of material fact or any intentional misrepresentations of any fact in any statement made to Claritev or any Claritev Client or User.

In addition, you must meet the following requirements for Network participation:

- You may not engage in inappropriate billing practices, including but not limited to billing for undocumented services or services not rendered or inconsistent with generally accepted clinical practices including overutilization of services, unbundling, up-coding or balance billing.
- You may not change hospital affiliations, admitting privileges or specialty status in such a way as to substantially limit the range of services you offer and/or Participants' access to your services.
- You may not be the subject of publicity, as determined by Claritev, that adversely affects (i) your reputation, (ii) the reputation of Claritev, or (iii) patient trust and/or confidence in your abilities to provide services as a Participating Provider.
- You may not commit professional misconduct that violates the principles of professional ethics.
- You may not engage in illegal or illicit activities, regardless if such activities are related to the delivery of healthcare services, including but not limited to: violations under federal laws/regulations, violations under state laws/regulations, and/or fraudulent activities whether civil or criminal.
- You may not engage in any action or behavior that disrupts the business operations of Claritev or any Client or User.
- Your responses to inquiries by Claritev shall be timely, complete and delivered in a professional manner.

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Quality Monitoring Activities

The Quality Management Committee

The Claritev Quality Management Committee provides support and oversight of quality management and improvement activities at Claritev. This integrated support and promotion of quality initiatives is vital to Claritev and the Committee's objectives, listed below, reflect this:

- To strengthen the position of Claritev as an organization that continually strives to deliver services of optimal quality to its Clients, Users and their Participants;
- To promote companywide awareness of, and participation in, quality initiatives;
- To oversee activities throughout Claritev that contribute to quality and process improvement; and
- To assist Claritev with meeting national accreditation standards, state and federal mandates and Client and User expectations.

In addition to the Quality Management Committee, the Claritev commitment to quality includes maintaining provider credentialing, recredentialing and Quality Management programs. Specifics of these programs follow.

Credentialing

We apply rigorous criteria when we initially credential providers seeking participation in our Network(s) and upon recredentialing. Claritev has established and periodically updates credentialing criteria for all categories of providers it accepts into its Network(s). The credentialing criteria may include but are not limited to:

- Board certification or requisite training in stated specialty
- Acceptable licensure history as provided by the National Practitioner Data Bank (NPDB) and/or the state licensing board(s)
- Acceptable malpractice claims payment history
- Adequate liability insurance
- Admitting privileges at a Network Facility
- Current, valid, clinically unrestricted license

The Claritev Credentials Committee makes all decisions regarding provider participation in the Network(s) in accordance with Claritev credentialing criteria. Credentialing criteria vary by provider type and applicable law. To obtain a copy of the Claritev credentialing criteria, please contact Service Operations via the online Provider Portal at http://provider.multiplan.com or by phone at (800) 950-7040.

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Delegated Credentialing for Groups of Professionals

Claritev offers a delegated credentialing option for large groups of health care professionals. Claritev delegates the credentialing function to groups that meet Claritev standards, as well as National Committee for Quality Assurance (NCQA) standards. The decision by Claritev to delegate the credentialing function results from a review of the group's credentialing policies and procedures and an on-site audit of the group's credentialing files. The Claritev Credentials Committee reviews the resulting delegation report and makes a determination to approve, defer or grant provisional delegated status for the group. If provisional status is granted, this is followed by a reassessment within a specified period of time and a final decision to approve or defer. Groups granted delegated status are required to sign a delegated credentialing agreement with Claritev.

Recredentialing

Network Professionals - Claritev recredentials Network Professionals on a set schedule in accordance with state and federal law and national accreditation standards. Claritev compares Network Professionals' qualifications to credentialing criteria and considers any history of complaints against the Network Professional. Recredentialing activities may also be triggered as a result of quality management investigations or information received from state or federal agencies. Following the submission of a signed, complete recredentialing profile, Network Professionals are considered to be successfully recredentialed unless otherwise notified by Claritev.

Delegated Recredentialing for Groups of Professionals - On an annual basis, Claritev conducts group audits and may delegate the recredentialing function to delegated groups using the same process used to initially delegate the credentialing function.

Quality Management Program

Claritev maintains a Quality Management program that is responsible for the management of complaints originating from various sources, including Participants, Clients or Users.The Quality Management program acknowledges, tracks and investigates complaints about Network Professionals, and manages their resolution through a standard process. Complaints may include but are not limited to perceptions of:

- Unsatisfactory clinical outcome
- Inappropriate, inadequate, over-utilized or excessive treatment
- Unprofessional behavior by Network Professional or office staff
- Inappropriate billing practices

As part of your participation in the Network, you are responsible for participating in, and observing the protocols of the Claritev Quality Management program. The Claritev Quality Management Program consists of the following:

Investigation Process

Claritev facilitates the complaint investigation process by gathering information from various parties (including the Network Professional involved) to determine the circumstances surrounding the complaint. Requests for information from Network Professionals may include a patient's medical and/or billing records. Claritev recognizes that the Network Professional's participation in the investigation process is critical. When requesting information, Claritev reports the complainant's concerns and affords the Network Professional an opportunity to respond to the complaint.

While complaints are investigated in a timely fashion, it is important to note that timeframes are predicated upon the receipt of information necessary to complete the investigation. Depending upon the nature of the complaint, it may be thirty to sixty (30-
60) days before an initial determination is reached. Claritev conducts the investigation process with strict confidentiality. If the complaint is of a clinical nature, Claritev clinical staff (including a Claritev Medical Director) participates in the investigation process.

Outcome of Investigation

Investigation outcomes vary based on the type and severity of the complaint and the complaint record of the Network Professional. Based upon the outcome, complaints may be categorized as "No Incident," or in levels ranging from "Patient Dissatisfaction" to "Termination." If the investigation reveals the presence of imminent danger to Participants, termination may be immediate.

Claritev communicates investigation outcomes and resulting actions directly to the Network Professional involved. Network Professionals terminated from participation in the Network are notified in writing and informed of the right to appeal. All complaint records are maintained confidentially and reviewed during the recredentialing process. Data obtained from analysis of complaint records may also be used in aggregate form to support other initiatives, including provider education.

Hearing and Appeals Process for Professionals Terminated or Rejected from the Network

Claritev complies with all state and federal mandates with respect to hearings and appeals for providers terminated or rejected from the Network. Terminated and certain rejected providers may submit a request for an appeal as outlined in the letter of rejection/termination sent by Claritev. Otherwise, Providers that do not meet certain Network criteria during the application screening process for initial credentialing have the option to reapply to the Network. In addition, the request for appeal must be received by Claritev within thirty (30) days of the date of the rejection/termination letter.

The hearing or appeal is conducted on the basis of any written information submitted by the terminated or rejected provider, in conjunction with any information previously in possession of or gathered by Claritev. Unless required by state or federal law, Claritev

does not offer meetings in person or by telephone with the terminated or rejected provider, or any representative of the provider. In the event that Claritev upholds a decision to terminate a Network Provider upon appeal, the original effective date of the termination is upheld unless otherwise determined by Claritev.

If the termination decision is reversed, the Network Professional's participating status is reinstated as of the date of the initial adverse decision, unless otherwise determined by Claritev.

Claritev Agreement with the National Practitioner Data Bank (NPDB) for Professionals Terminated from the Network

As a requirement of the participation agreement between Claritev and the National Practitioner Data Bank (NPDB), Claritev is obligated to report the termination of a Network Professional if the termination resulted from a quality of care issue resulting in harm to a patient's health and/or welfare. Any provider subject to this reporting requirement is notified via a letter of termination from Claritev. The Network Professional may have additional appeal rights afforded by state or federal law. For Network Professionals participating in any of Claritev's Networks for government programs (e.g. Medicare Advantage or Medicaid), Claritev is obligated to report to the NPDB upon affording you a due process right concerning your termination.

Identifying Participants

Clients and Users furnish Participants with a means of identifying themselves as covered under a Program with access to the Network. Such methods of identification include, but are not limited to, affixing an authorized name or logo on an identification card; a Claritev phone number identifier, written notification by Client of an affiliation with Claritev at the time of benefits verification, a Claritev authorized name or logo on the explanation of benefits form, or other means acceptable to Claritev and the Network Provider. Clients and Users will also furnish a telephone number to call for verification of the Participant's eligibility. These forms of identification are evidence of the Client or User's right to access you as a Network Provider and to reimburse you at the Contract Rates for Covered Services rendered to Participants. Claritev may update the list of authorized logos by posting such modifications to the Claritev website.

Always contact the Client or User to obtain eligibility and benefit information before rendering services. Please note that confirmation of eligibility does not guarantee payment. Program restrictions and limitations may apply.

Claritev does not determine benefits eligibility or availability for Participants and does not exercise any discretion or control as to Program assets, with respect to policy, payment, interpretation, practices, or procedures. Be sure to notify Participants of restrictions and/or limitations identified after contacting the Client or User.

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Utilization Management

You are required to participate in and observe the protocols of Client or User's Utilization Management programs for health care services rendered to Participants, to the extent such Utilization Management program is consistent with industry standards. Utilization Management requirements may vary by Client or User, and by the Participant's Program and may include, but is not limited to, pre-certification, concurrent review, and retrospective review. Utilization Management programs may also include case management, disease management, maternity management, and mental health management services.

Certification

Most Utilization Management programs used by Clients or Users require Certification. Please verify any certification or other Utilization Management requirements at the time you verify benefits and eligibility. As part of the Certification process, please be prepared to provide the following information by telephone, facsimile, or through any other method of communication acceptable to the Client or User's Utilization Management program:

- Client or User name
- Group policy number or name
- Policyholder's name, social security number and employer (group name)
- Patient's name, sex, date of birth, address, telephone number and relationship to policyholder
- Network Professional's name and specialty, address and telephone number
- Facility name, address and telephone number
- Scheduled date of admission/treatment
- Diagnosis and treatment plan
- Significant clinical indications
- Length of stay requested

You may be required to obtain Certification from the Utilization Management or Utilization Review program for the following:

- **Inpatient admissions, outpatient surgery and other procedures identified by the Claritev Client or User's Utilization Management program** - To obtain Certification for these procedures, call the telephone number provided by the Participant or the Client or User prior to the date of service to the Participant. You may be required to obtain separate Certifications for multiple surgical procedures. To facilitate a review, be sure to initiate the Certification process a minimum of seven to ten (7-10) days before the date of service.
- **Emergency admissions** - Certification of all admissions following an emergency room visit is usually required within forty-eight (48) hours after the admission.
- **Length of stay extensions** - In the event a length of stay extension is required for those health care services initially requiring Certification, you may be required to obtain additional Certification from the Utilization Management program prior to noon of the last certified day.

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Concurrent Review

Network Professionals must participate in the Utilization Management program of Concurrent Review. A nurse reviewer performs Concurrent Review to document medical necessity and facilitate discharge planning.

Case Management

Case Management identifies those Participants whose diagnoses typically require post- acute care or high level and/or long-term treatment. The case manager works with providers and family members to formulate a plan that efficiently utilizes health care resources to achieve the optimum patient outcome. Case Management services are provided for Participants who may benefit from:

- Change in facility or location of care
- Change in intensity of care
- Arrangements for ancillary services
- Coordination of complex health care services

Before completing the Certification process, always contact the Client or User to obtain eligibility information.

In cases where multiple procedures are performed, be sure to confirm benefit eligibility from the Client or User for each procedure.

Appeals Process for Utilization Management Decisions

The appeals process may vary by the Client or User's Utilization Management program and/or as mandated by state or federal law. In the event you or a Participant do not agree with a non-certification determination made under the Utilization Management program, you or the Participant has the right to appeal the determination in accordance with the Claritev Client or User's Utilization Management program appeals process. To obtain details of the Client or User's Utilization Management program appeals process, please contact the appropriate Claritev Client or User.

Failure to observe the protocols of the Utilization Management program may also result in a reduction of benefits to the Participant. You are responsible for notifying theParticipant of any potential financial implications associated with failure to observe the Utilization Management Program protocols.

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Referrals to Other Network Providers

To help Participants avoid a reduction in benefits, you are required to use your best efforts to refer Participants to Network Providers within the same respective Network, when medically appropriate and to the extent these actions are consistent with good medical judgment. For assistance in finding other providers participating in the Network for referral purposes, contact Service Operations via the online Provider Portal at http://provider.multiplan.com or by phone at (800) 950-7040.

In the event a Participant requires hospitalization and you do not have hospital privileges with a facility within the same respective Network, you agree to exercise best efforts to refer the Participant to another Network Professional with hospital privileges at a facility within the same Network. Be sure to inform the Participant whenever a referral is made to an out-of-network provider.

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Waiting Times for Participants

As a Network Professional, you agree that the expected waiting time for Participants to schedule an appointment shall not exceed the following:

- Twenty four (24) to forty eight (48) hours for urgent appointments
- Four (4) weeks for specialty care appointments
- Six (6) weeks for routine appointments

For Network Professionals offering behavioral health services, you agree that the expected waiting time for Participants to schedule an appointment shall not exceed the following:

- Six (6) hours for non-life-threatening emergencies
- Forty eight (48) hours for urgent appointments
- Ten (10) business days for routine appointments

You should be aware that more stringent wait time requirements may apply as required by applicable state or federal laws.

As a Network Professional, you agree to inform Claritev by December 31st of each year of your average waiting time for routine and urgent care appointments. Updates are required annually and can be sent to Claritev via US mail, fax or e-mail as follows:

Mail: Claritev, 16 Crosby Drive, Bedford, MA 01730, Attn: Registrar

Fax: 781-487-8273

Email: registrar@multiplan.com

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Submission of Claims

Claims should be sent by following the instructions on the back of the member's ID card. As a Network Professional, you agree to submit claims for payment within ninety (90) days of furnishing healthcare services (or as otherwise required by state or federal law or your Participating Professional Agreement). Claims received after this time period may be denied for payment by Client or User, and Network Providers shall not bill Client, User, Claritev or Participant for such denied claims. All claims should be submitted using your Billed Charges and the appropriate procedure code per American Medical Association (AMA) and Center for Medicare and Medicaid Services (CMS) standards.

Submitting Claims by Mail

Claims must be submitted to the address found on the Participant's identification using a HCFA-1500 or CMS-1500 claim form. Clean Claim that are mailed shall be deemed to have been received by the Client or User five (5) calendar days following the deposit of such Clean Claim in the U.S. Mail, first class postage prepaid and addressed to the Client or User at such address set forth on the Participant's identification.

Submitting Claims Electronically

All claims may be submitted electronically through transaction networks and clearinghouses in a process known as Electronic Data Interchange (EDI). This method promotes faster, more accurate processing than paper claims submitted by mail, and is required by federal benefit plans. We encourage you to exercise your best efforts to implement electronic claims submission capability as soon as reasonably practicable. Clean Claims that are transmitted electronically shall be deemed to have been received by the Client or User on the date that such Clean Claim is transmitted to the Client or User.

The National Provider Identifier (NPI) is a required identifier on all electronic health care transactions. Claritev recommends that you submit your NPI information as part of your standard submission of practice information updates. Claritev supplies this information to Clients and Users for use in electronic transaction processing.

Disputing Claims

As a Network Professional, you and the Client/User have the right to dispute a claim. When a problem arises, contact Claritev Service Operations via the online Provider Portal at http://provider.multiplan.com or by phone at (800) 950-7040 as soon as possible, as required by your Participating Professional Agreement, and provide all information pertinent to the problem. If the issue can't be resolved on the call, it will be escalated to a provider service representative who will conduct an inquiry, contacting the Client/User and/or regional provider relations specialist as appropriate.

Erroneous Claim Submission

If you discover that a claim you sent to a Client was meant for another Client or the claim had incorrect information, please notify the Client.

Failure to Submit a Clean Claim

If a Client or User receives a claim that is not a Clean Claim containing all complete and accurate information required for adjudication or if the Client has some other stated dispute with the claim, they will provide you with written notification prior to payment of the claim. The Client will pay, or arrange for User to pay, you at the Contract Rate(s) for all portions of the claim not in dispute. Please provide complete and accurate information requested within thirty (30) business days of the Client or User's request.

Timeframe for Disputing a Claim

You may challenge whether payment was made to you in accordance with the terms of your Participating Professional Agreement by providing written notice to Claritev and Client within one hundred and eighty (180) days following your receipt of payment from Client or User (unless otherwise required by law). Otherwise, such payment shall be deemed final.

Reimbursement and Billing Requirements

Payment of Claims

Clients or Users typically reimburse Network Professionals on a fee-for-service basis. Clients understand the importance of timely payment of Clean Claims. Please refer to your Participating Professional Agreement for specific requirements regarding timely payment of Clean Claims.

Any payments due by Client/User shall be reduced by any applicable:

- Co-payments, deductibles, and/or co-insurance, if any, specified in the Participant's Program
- Any non-Covered Service
- Service or procedure which is deemed by Claritev and/or Client or User to be fraudulent, wasteful, abusive, or inconsistent with generally accepted clinical practices

Payment by Client or User, as applicable, shall be subject to the Participant's Program, as well as the application of industry standard coding and bundling rules, modifiers and/or edits.

Note: Claritev and its subsidiaries are not administrators, insurers, underwriters, guarantors, or payers of claims and are not liable for any payment of claims for services under Programs submitted by the Network Professional to Claritev or any Client or User.

Administrative Fees

When Contract Rates are negotiated by Claritev for Covered Services, it is recognized that such Covered Services may include an administrative and maintenance component. As a result, the fees paid for Covered Services pursuant to your Participating Professional Agreement include payment for administrative, oversight, overhead and/or similar charges related to the provision of any Covered Service rendered. You may not separately bill or collect from the Participant or the Client or User any additional amount for administrative, oversight, overhead and/or similar charges related to the provision of such Covered Services.

Professional Fees

As a Network Provider, you are obligated to bill in accordance with the nationally recognized coding standards set by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association for all services performed, and you will be subject to claim edits which may be performed by Claritev and/or our Clients in accordance with these rules. We refer to CMS reimbursement methodologies to help us develop our provider reimbursement structure for the services you render at approved clinical, institutional and non-institutional settings.

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You may bill a professional fee when you have specifically provided a professional service to a Participant. You may not bill a professional fee for a computer-generated report.

Since we apply the industry standard coding and bundling rules, modifiers and/or edits, we recommend you verify that all services performed have a signed physician order, are medically necessary and are coded correctly. Claritev ensures that all contracted providers maintain a current chargemaster or fee schedule and urge you to verify that the codes and descriptors used match the services performed. For further documentation, please refer to your Participating Professional Agreement with Claritev.

Fragmentation (Unbundled Billing)

Individual CPT codes may include more than one associated procedure. It is inappropriate to bill separately for any of the procedures included in the value of another procedure.

Place of Service

Place of Service (POS) codes are two-digit codes placed on healthcare professional claims to indicate the setting in which a service was provided. The Centers for Medicare & Medicaid Services (CMS) maintain POS codes used throughout the healthcare industry.

Reimbursement is based on the Place of Service as listed in box 24b of the CMS 1500 form.

Professional services are processed using the Facility Allowed Amount defined by CMS for claims submitted with the following Place of Service Codes:

Place of Service Code	Description
02	Telehealth Provided Other than in Patients Home
10	Telehealth Provided in Patient’s Home
19	Off Campus – Outpatient Hospital
21	Inpatient Hospital
22	On Campus - Outpatient Hospital
23	Emergency Room Hospital
24	Ambulatory Surgical Center
26	Military Treatment Facility
31	Skilled Nursing Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Center

All other Place of Service Codes submitted on a professional claim will be processed based on the Non-Facility Allowed Amount.

If the place of service is not indicated on a professional claim, reimbursement will be made based on the value assigned to services rendered in the provider's office.

Modifier Repricing Rules

Certain modifiers (TC, 26, P1-P6, 51, NU and RR, for example) are applied at the time claims are repriced by Claritev even if the modifier is not billed by the provider. All other modifiers are considered optional. Clients can elect to turn processing "off" for these optional modifiers. Clients may or may not apply those optional modifier rules upon receipt of repriced claims from Claritev. If Clients elect to turn processing "on," Claritev will apply the appropriate rule(s) before sending the repriced claim back to the Client.

The table below identifies the current list of modifiers supported by Claritev for purposes of repricing claims on behalf of Clients and Users that access the PHCS Network, the HealthEOS Network, the Beech Street Network, the HMN Network, the RAN Network, and the MultiPlan Network. The list of modifiers in the table below is not intended to be an exhaustive list. Claritev may update the list of modifiers that are applied at the time claims are repriced by Claritev on behalf of the Client, regardless of whether the modifier is listed in the table below. As noted above, the Client may also apply those optional modifier rules upon receipt of the repriced claim from Claritev.

Modifier	Description	Repricing Rate
22	Unusual procedural services	120%
23	Unusual anesthesia	120%
25	Separately identifiable evaluation and management service by the same physician/health care professional on the same day of the procedure	50%
50	Bilateral procedure	100%, then 50%
51	Multiple procedures	100%, then 50%
52	Reduced services	80%
53	Physician elects to terminate a surgical or diagnostic procedure due to extenuating circumstances	20%
54	Surgical care only	70%
55	Postoperative management only	15%
56	Preoperative management only	10%
62	Two surgeons	62.5%
73	Reduced or discontinued services	50%
80	Assistant surgeon	16%
81	Minimum assistant surgeon	10%
82	Assistant surgeon (when qualified resident surgeon not available)	16%
83	Physician Assistant or Nurse Practitioner as Assistant Surgeon	10.7%

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Modifier	Description	Repricing Rate
AA	Anesthesia	Accepted
AS	Services performed by an assistant to the MD, covering non-MD assistants	10%
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant	85%
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapy assistant	85%
FX	X rays taken using film	80%
FY	X rays taken using Computed Radiography	90%
GF	Services performed by non-physician	85%
P1	Anesthesia Modifier - A normal healthy patient	0 ASA Base Units
P2	Anesthesia Modifier - A patient with mild systemic disease	0 ASA Base Units
P3	Anesthesia Modifier - A patient with severe systemic disease	1 ASA Base Unit
P4	Anesthesia Modifier - A patient with severe systemic disease that is a constant threat to life	2 ASA Base Units
P5	Anesthesia Modifier - A moribund patient who is not expected to survive w/o the operation	3 ASA Base Units
P6	Anesthesia Modifier - A declared brain dead patient whose organs are being removed for donor purposes	0 ASA Base Units
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.	50%
QX	CRNA service: with medical direction by a physician	50%
QY	Medical direction of one CRNA by an anesthesiologist	50%
26	Professional component	Fee Schedule
NU	New equipment	Fee Schedule
RR	Rented equipment	Fee Schedule
TC	Technical component	Fee Schedule

Multiple Procedure Payment Reduction Rules

Unless otherwise required by law, in the event that multiple procedures are included on the claim, Client will pay or arrange for User to pay (i) one hundred (100%) percent of the applicable Contract Rate for the procedure with the highest Contract Rate, and (ii) a reduced percentage of the Contract Rate, as determined by Claritev, for any additional procedures thereafter. Claritev may, in its sole discretion and without notice, modify the codes subject to a multiple procedure payment reduction (e.g. surgical, diagnostic, therapy, etc.), as well as the percentage reduction applicable to such multiple procedures, which are based in part on CMS guidelines. Upon request from Network Provider, Claritev will provide to Network Provider the specific codes administered by Claritev that are subject to a multiple procedure payment reduction and/or the current percentage reduction applicable when multiple procedures are included on the claim.

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Billing of Participants

Please review the Explanation of Benefits (EOB) form sent to you by the Client or User to determine the amount billable to the Participant.

At the time of the visit, you may collect any co-payment or encounter fee specified inthe Participant's Program. Following the receipt of an EOB, you may also bill for deductibles and co-insurance, if any, as specified in the Participant's Program, and/or payment for non-Covered Services. As a Network Professional, you may not routinely waive any portion of the Participant's payment obligations.

As a Network Professional, you may not bill Participants for the difference between your Billed Charges and the Contract Rate, or any amounts not paid to you due to your failure to file a timely claim or appeal, or due to the application of industry standard coding and bundling rules, modifiers and/or edits. In the event that you collect fees from the Participant that exceeds the Participant's responsibility, you must refund those amounts to the Participant promptly upon notice of overpayment.

Benefit Maximums

As previously mentioned, Participants cannot be billed for the difference between Billed Charges and the Contract Rate for Covered Services, whether the Client or User is primary or secondary. In instances where the cumulative payment by a Client or User has met or exceeded the Benefit Program Maximum, Network Providers may not "balance bill" Participants for the difference in billed charges and the Contract Rates. However, you may bill the Participant for the Contracted Rate once the Participant has reached the Benefit Program Maximum.

A benefit maximum limits the Claritev Client or User's cumulative responsibility for payment of a select set of services to some annual or lifetime dollar amount or service count. This prohibition will remain in effect as long as the patient remains a Participant under a Program.

Coordination of Benefits

Participants are sometimes covered by more than one insurance policy, benefit plan or other health plan or program. In that instance, the Claritev Client or User uses the following rules for the Coordination of Benefits (COB) with regard to payment:

Claritev Client or User is Primary - When a Claritev Client or User is primaryunder the COB rules, the Client will pay, or arrange for User to pay, for Covered Services according to the Participant's Program (e.g., 90%, 80%, or any other percent based on the Participant's coinsurance amount) and pursuant to the Contract Rate.

Claritev Client or User is Secondary - Except as otherwise required by law or the Participant's Program, if a Client or User is other than primary under the COB rules, the Client will pay, or arrange for User to pay, a reduced amount only after the Network Professional has received payment from the primary plan. Please refer to your participating Professional Agreement for the specific terms related to payment when a Client or User is other than primary under the COB rules.

As a Network Professional, you are required to cooperate fully with Claritev and/or Clients or Users in supplying information about other entities providing primary medical coverage or otherwise having payment responsibility for services rendered to Participants, and in all other matters relating to proper coordination of benefits.

Note: Payment may vary based on state or federal law when Medicare is a primary or secondary payer.

Assignment of Benefits and Release of Medical Information

Clients can pay, or arrange for Users to pay, Network Professionals directly only when the Participant has approved the assignment of benefits. Participants should present a signed form for this purpose during the first visit to you. If the Participant does not have an appropriate form from the Client or User, you may obtain an assignment using your standard form. Signatures need only be provided once and can be filed with the Participant's record. All claims submitted should indicate that signatures for assignment of benefits are "on file."

For some types of treatment, Clients or Users may require the Participant's consent (and possibly the consent of family members) to release Protected Health Information. These signatures should be kept on file with the Participant's record.

Dispute Resolution

Claritev provides a comprehensive process for resolving disputes as stated in your Participating Professional Agreement. Unless your Participating Professional Agreement indicates otherwise or as otherwise prohibited under applicable state and/or federal law, the following dispute resolution process shall apply.

As a Network Provider, in the event you have question or grievance regarding your obligations, or cannot resolve a dispute with a Client/User, you may contact Claritev Service Operations via the online Provider Portal at http://provider.multiplan.com, call Claritev's Service Operations Department, or submit your dispute in writing, including all pertinent information, to Claritev at the following address;

MultiPlan, Inc. d/b/a Claritev, Inc.

Service Operations Department 16

Crosby Drive

Bedford, MA 01730.

If the parties are unable to reach a resolution, then subject to the time frames noted in your Participating Professional Agreement, Claritev, Client or User may pursue binding arbitration in accordance with JAMS.

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Maintaining Your Practice Information

Claritev requires that you provide all Tax Identification Numbers (TINs) currently in use, including the name of the owner of each TIN, for each of your practice locations. If a TIN is not recorded with Claritev, Participants' benefits may be reduced and your payment may be delayed. Please inform Claritev promptly of any change in TIN, practice location (including change of state), telephone number or billing address. Failure to provide updated information may result in a delay or error in payment of claims for Covered Services rendered to Participants.

All sites at which you practice shall be considered in-Network sites. If you also practice independently and have not contracted with Claritev directly with respect to that independent site, services rendered by you at that site will be considered out-of-Network. You must use different Tax Identification Numbers to distinguish between in-Network and out-of-Network sites.

Report all practice information updates to Claritev via US mail, fax or e-mail as follows:

Mail: MultiPlan, Inc. d/b/a Claritev Inc., 16 Crosby Drive, Bedford, MA 01730, Attn: Registrar

Fax: 781-487-8273

Email: registrar@multiplan.com

Email for HNM and RAN: hmanetwork.operation@multiplan.com

Online: Updates may also be submitted through our online Provider Portal at http://provider.multiplan.com.

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Confidentiality

All information and materials provided by Claritev, Client and/or User to you are proprietary to Claritev, Client and/or User respectively. As such, you are expected to keep all such information confidential and cannot disclose or use such information or materials except as may be required to carry out your obligations under the agreement with Claritev. Claritev may disclose certain terms of your Agreement in order to comply with applicable state or federal law or to assist our Clients and/or Users in their compliance with state or federal law. Confidential Information shall not include information in the public domain.

In accordance with applicable data privacy regulations, as a Network Provider, you understand - and consent - to the collection, storage, processing, transmission, and disclosure of your Provider Data, as necessary, by Claritev, its subsidiaries, and any authorized third-party, in connection with Claritev carrying out its service obligations, fulfilling applicable regulatory requirements, and publishing of your Provider Data in provider directories.

Claritev shall use, where applicable, appropriate security controls, as required by current (and applicable) Federal, State, and any other applicable data privacy laws or regulation requirements, to secure your Provider Data.

Claritev Statement of Member Rights

Claritev is committed to preserving and respecting member rights. Below is our statement recognizing member rights and protections. We expect our Network providers, including individual practitioners, to support and act in accordance with these rights.

Members have the right to receive accurate, easily understood information about Claritev, the services we provide, the providers in our networks, the rights of members and Network providers, and how to contact us regarding concerns about Claritev services or networks.

Members have the right to be treated with respect and recognition of their dignity and the right to privacy. This right includes protecting the confidentiality of medical and other personal information. It also includes members' rights to review their medical and personal information on file at Claritev, as required by applicable state and federal law.

Members have the right to communicate with providers in making decisions about their healthcare without interference from Claritev.

Members have the right to register complaints about Claritev, our services, determinations, or the care provided by a Network provider. This includes the right to have complaints addressed in a timely manner through formal procedures appropriate to the nature of the complaint.

Members have the right to a choice of healthcare providers from the Network, consistent with the terms of their health benefit plans and applicable state and federal law.

Members have the right to receive healthcare services without discrimination. Network providers are precluded by contract from differentiating or discriminating against members in the provision of healthcare services due to certain member characteristics, and are required to render such services to all members in the same manner, in accordance with the same standards, and with the same availability as offered to the Network provider's other patients.

Claritev uses its best efforts to assure that all members are afforded these rights. If you feel that your rights as a member have not been met, you may voice your concern through the Claritev complaint resolution process. The complaint resolution process is the formal mechanism by which Claritev addresses members' concerns about their health care from our Network providers. To begin the complaint resolution process, kindly document the complaint in writing and send it to:

MultiPlan, Inc. d/b/a Claritev, Inc.
16 Crosby Drive
Bedford, MA 01730
Attn: Corporate Quality Management

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Appendix A

Simplicity Complete Payment Network Terms and Conditions

I. Definitions

Whenever used in this Agreement with initial letters capitalized, the following terms will have the following specified meanings:

a. "Adjudication" or "Adjudicates" means a written decision by Participating Payer (or Claims Administrator on Participating Payer's behalf) to deny or pay a Claim, in whole or in part, including the decision as to the amount to be paid, based upon the terms of the Covered Member's Healthcare Benefit Plan.

b. "Balance Billing" means billing a Covered Member for any amount after a Complete Payment has been made, with the exception of the amounts specified in sub-section 2 of the Agreement.

c. "Billed Charges" means the fees for a specified health care service or treatment routinely charged by Provider regardless of payment source.

d. "Claim" means a request for payment made by or on behalf of Provider to a Participating Payer, or its intermediary, Claims Administrator or representative, for health care services under a Participating Plan.

e. "Claims Administrator" means any entity that Adjudicates claims on behalf of a Participating Payer for Covered Services rendered to Covered Members.

f. "Complete Payment" means a payment made to Provider by Participating Payer or its Claims Administrator through the Simplicity Complete Payment Network at the Simplicity Net Reimbursement Amount that compensates the Provider both for the Participating Payer's portion of the Network Contracted Rate and for the Covered Member's portion of the Network Contracted Rate. The Complete Payment fully discharges the obligations of both the Participating Payer and the Covered Member to the Provider.

g. "Covered Member" means an individual, including a n y dependent, covered under a Participating Plan and who has enrolled in Simplicity.

h. "Covered Services" means health care services that are eligible for payment pursuant to the terms of the Covered Member's Participating Plan. Examples of common services that potentially would not be Covered Services are cosmetic services and experimental services.

i. "Healthcare Benefit Plan" means any contract, insurance policy, health benefit plan or other plan or program under which individuals are eligible for certain health benefits.

j. "Network" means the set of health care providers who have a direct or indirect contractual relationship with the Participating Payer in which they agree to certain Network Contracted Rates for Covered Services.

k. "Network Agreement" means the direct or indirect contractual agreement between Provider and Participating Payer for participation in the Network.

l. "Network Contracted Rate" means the compensation levels set forth by a Network for Covered Services in which a provider participates.

m. "Participating Plan" means a Healthcare Benefit Plan that has agreed to participate in Simplicity.

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n. "Participating Payer" means a corporation, partnership, labor union, association, program, employer or any other entity responsible for the payment of Covered Services rendered to a Covered Member through a Participating Plan.

o. "Simplicity Adjustment" shall be equal to seven (7%) percent.

p. "Simplicity Explanation of Provider Payment" means the remittance document for the Simplicity Complete Payment.

q. "Simplicity Net Reimbursement Amount" means the compensation levels payable to Provider determined by subtracting the Simplicity Adjustment at a line level from the Network Contracted Rate.

II. Description of Simplicity Complete Payment Process

a. Following the submission of a Claim by Provider to Participating Payer or its Claims Administrator, Participating Payer or its Claims Administrator, based upon the existing Network Agreement (together with any other contractual conditions Provider may have agreed to with the Participating Payer or Network), shall Adjudicate the Claim, thereby determining the total amount due from the Participating Payer and the Covered Member for Covered Services rendered by Provider.

b. Simplicity shall then calculate the Simplicity Net Reimbursement Amount. Payment of this amount to Provider shall be made by Participating Payer or its Claims Administrator as a Complete Payment.

c. All Complete Payments made through Simplicity will be identified on the Participating Payer's or its Claims

Administrator's Explanation of Provider Payment.

III. Rights and Obligations of Provider

a. Provider agrees to submit proper Claims to Participating Payer and to accurately account for any and all Covered Services provided to any Covered Member.

b. Provider agrees to accept the Complete Payment from a Participating Payer or its Claims Administrator, as payment in full for the total amount of the Claim.

c. Provider agrees that once the Complete Payment is made by the Participating Payer or its Claims Administrator, Simplicity owns the obligation and shall have the sole right to collect same.

d. Provider agrees that the Complete Payment is without recourse to Provider even if the Covered Member fails to pay its obligations, subject to the charge-back provisions set forth in this notification or in any applicable Network Agreement.

e. Provider will not accept payments for Covered Services (subject to the provisions herein) from or through any source other than through the Simplicity Complete Payment Network, including, but not limited to, any HRA, HSA, healthcare FSA and/or secondary source of insurance.

f. Provider will not separately bill or take steps to collect funds from a Covered Member, Participating Payer (or Participating Payer's Claims Administrator), or Participating Plan for any Covered Services paid through the Simplicity Complete Payment Network (except that Provider may collect from the Covered Member the pre- Adjudicated co-payment and/or non-Covered Service amounts).

g. Provider agrees to credit Simplicity under the name of the Covered Member, any payment(s) from any source other than through the Simplicity Complete Payment Network (except that any amounts incorrectly collected from Covered Member for co-payments or non-Covered Services should be credited to the Covered Member).

h. Provider agrees that Balance Billing a Covered Member is not permitted and will be deemed a breach of this Agreement.

i. Provider acknowledges that a Covered Member's participation in Simplicity is a benefit offered through the Covered Member's Participating Plan and is not a reflection on a Covered Member's creditworthiness, ability to pay, or other financial factors, and Provider will not make any treatment or credit decisions based on a Covered Member's eligibility or ineligibility to participate in Simplicity.

IV. Disputed Claim Chargebacks

a. In the event that the validity or value of the Covered Service has been placed in dispute by the Covered Member, Participating Payer or Network in writing, and such dispute has been validated through the Participating Payer's or Network's appeals process, Simplicity may chargeback to the Provider the total amount of the applicable Complete Payment.

b. In the event that Simplicity determines that a chargeback is required, based upon Provider's breach of its Rights and Obligations set forth herein, Simplicity shall be entitled to make collections by direct demand to the Provider. Provider and Simplicity may, however, agree to handle the chargebacks through offsets against future payments.

V. Termination of Agreement

a. This Agreement will stay in full force unless terminated as follows: (i) by either Party upon ninety (90) days' prior written notice to the other Party, (ii) by either Party in the event the other Party materially breaches one or more of its respective obligations hereunder, and fails to substantially cure such default within thirty (30) days after receiving written notice of the default, (iii) within thirty (30) days by Provider if Simplicity makes changes in the Simplicity Complete Payment Network that Provider does not accept, or (iv) automatically if either party becomes insolvent or enters, voluntarily or involuntarily, into bankruptcy or other any other proceeding that relates to insolvency or protection of creditor's rights.

b. If Provider elects to terminate this Agreement and no longer participate in the Simplicity Complete Payment Network, or is otherwise removed from the Simplicity Complete Payment Network for any reason: (1) Provider will be identified to Covered Members as an out-of-Simplicity Complete Payment Network provider; and (2) in the interest of avoiding confusion among Covered Members, Provider shall be excluded from the Simplicity Complete Payment Network for a period of six (6) months, after which Provider may re-enroll in the Simplicity Complete Payment Network.

VI. Miscellaneous

a. Amendment. Unless otherwise required by law, upon at least thirty (30) days' prior written notice, Simplicity shall have the right, in its discretion, to amend this Agreement, including, but not limited to, changes to the amount of the Complete Payment, which changes shall be effective within the time periods specified in written notice thereof from Simplicity. This is subject to the ability of Provider to terminate this Agreement as provided in part V (a) (iii) above.

b. Governing Law/Jurisdiction/Venue. This Agreement shall be governed by and construed in accordance with the local laws of the State of Ohio. The federal and state courts located in Cuyahoga County, Ohio shall have exclusive jurisdiction and shall be the exclusive venue over disputes arising from this Agreement. Each Party consents to such jurisdiction and venue and to service of process from such courts.

c. Binding Effect. The covenants and conditions contained in this Agreement will apply to and bind the successors, representatives and permitted assigns of the Parties to this Agreement.

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d. Severability. All provisions of this Agreement are severable. If any provision or portion of this Agreement is determined to be unenforceable, the rest of the Agreement will remain in effect, provided that its general purposes are still reasonably capable of being effected.

e. Notices. All notices and other communications hereunder shall be in writing and shall be deemed to have been given: (a) when delivered by hand (with written confirmation of receipt); (b) when received by the addressee if sent by a nationally recognized overnight courier (receipt requested); (c) on the date sent by facsimile or e- mail of a PDF document (with confirmation of transmission) if sent during normal business hours of the recipient, and on the next business day if sent after normal business hours of the recipient; or (d) on the third day after the date mailed, by certified or registered mail, return receipt requested, postage prepaid. Such communications must be sent to the respective parties at the following addresses (or at such other addresses for a party as shall be specified in a notice given in accordance with this Section). If to Simplicity: 868 Corporate Way, Westlake, OH, 44145, Attention: CEO, with Copy to General Counsel at same address; and if to Provider, to Provider's mailing address set forth on the signature page hereto.

f. Headings and Captions. The headings and captions used in this Agreement may be considered in construing or interpreting this Agreement.

g. Counterparts. This Agreement may be executed in any number of counterparts and by different parties in separate counterparts, each of which when so executed shall be deemed to be an original and all of which when taken together shall constitute one and the same agreement. Delivery by facsimile or by electronic transmission in portable document format ("PDF") of an executed counterpart of this Agreement is as effective as a delivery of an originally executed counterpart of this Agreement.

h. Relationship of the Parties. The relationship of Simplicity and Provider is that of independent contractors. Neither Party's employees, consultants, contractors or agents: (i) are agents, employees or joint ventures of the other, or (ii) have any authority to bind the other by contract or otherwise to any obligation, and Provider will not represent to the contrary, expressly, implicitly, or otherwise.