

## AGREEMENT

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**THIS AGREEMENT is entered into between VANTAGE PPO (the “Plan”) and the Provider named on page 4 hereof (the “Provider”).**

### WITNESSETH

WHEREAS, the Plan is a Pennsylvania for-profit corporation organized for the purpose of arranging improved and more cost-efficient health care delivery and which, pursuant to contracts with employers, administers a panel of Providers, hospitals and ancillary services.

WHEREAS, the Provider is licensed to practice medicine in the Commonwealth of Pennsylvania, State of Ohio or State of New York, and represents that his qualifications are as set forth in Appendix A hereof.

WHEREAS, the Plan desires to include the Provider on the panel of Providers, hospitals and ancillary providers it administers and the Provider desires to be included on such panel.

NOW, THEREFORE, it is agreed by and between the Plan and the Provider as follows:

1. SERVICES.

The Provider agrees to perform all services required by members of the Plan, provided that such services are services he is qualified to perform and are covered by the contracts between the Plan and the employers. The quality of such services shall be at or above the standards of skill, care and diligence possessed by reasonable Providers with similar qualifications in the light of present day scientific knowledge and shall be performed in accordance with high standards of competence, care and concern for the welfare and needs of members of the Plan. The Provider shall provide members of the Plan with the same quality of services which the Provider provides patients who are non-members.

The Provider shall not discriminate against any member of the Plan on the basis of race, color, national origin, ancestry, religion, sex, marital status or age.

2. COMPENSATION.

The PROVIDER will be compensated for performance of services, covered by the contracts with the PAYERS as set forth below:

The PROVIDER agrees to accept the lesser of the Vantage Fee Schedule, or the PROVIDER'S usual billed charges, as payment for all such services rendered, less any co-payment, deductibles, or co-insurance amounts that are the responsibility of the covered individual.

3. RELATIONSHIP OF THE PARTIES.

A. The Provider shall be an independent contractor, and the Plan shall not exercise any control or direction in a particular case over the Provider's performance of professional duties or exercises of professional judgment.

B. The Provider acknowledges that in agreeing to participate in the Plan, the insurance companies or self-funded employer health plans have a statutory responsibility to ensure that

its subscribers, by virtue of their participation in health benefits programs, receive adequate professional health services in accordance with the best professional health service practice in the community.

C. Provider agrees that for the purposes of participation in the Plan programs, all rules and regulations governing his/her participation shall be those established by the Plan.

D. Provider acknowledges that any insurance company or employer self-funded plan have the statutory responsibility to ensure that its subscribers receive quality care and to monitor the effectiveness of quality assurance and utilization.

E. Provider agrees to cooperate with the Plan, and all appropriate regulatory agencies in the investigation of any consumer complaint relating to quality of care which may be brought to the attention of the Plan.

4. PROFESSIONAL LIABILITY INSURANCE.

As a minimum, the Provider shall carry at his expense professional liability insurance in the amounts of \$400,000 for each incident and \$1,200,000 in the annual aggregate, or such minimums as may be required by the Commonwealth of Pennsylvania.

5. UTILIZATION REVIEW.

A medical advisory board will be established by the Plan, and a Provider or Providers will be selected from the panel to participate and cooperate with such board. The board shall review medical services rendered by the Provider and make recommendations to the Provider and to the insurance company or the self-funded employer plan which are designed to implement cost-efficient medical care.

The Provider agrees to supply all records necessary for compilation of reports required for administration of the Plan. The Provider agrees to comply with the Utilization Review Procedures established by the Plan.

6. UTILIZATION OF PLAN FACILITIES ONLY.

When proper patient care requires hospital admission or referral to another Provider, such admission or referral shall be to a panel member, except where inappropriate due to emergency or the unavailability on the Provider panel of an appropriate specialist. The Provider, except in the case of an emergency, is expected to consult with the Plan's Medical Utilization Management Department (or such other party as the plan may subcontract or assign) before directing any admission or referral outside the Plan's provider panel. The Plan shall provide the Provider with a list of panel members from time to time.

7. RECIPROCAL PRIVILEGES.

Provided the Plan has entered into a reciprocal privileges agreement with another PPO, the Provider agrees to provide treatment to a person who is a member of such PPO on the same basis as if the person were a member of the Plan. It is also agreed the Provider shall honor payments made on behalf of the Plan by any and all administrators approved by the Plan.

8. DISPUTE RESOLUTION.

All matters, disputes or controversies relating to the services performed by the Provider, including any dispute relating to the reduction or elimination of any payment to the Provider arising out

of the utilization review or quality assurance activities of the Plan or of the underwriter/administrator, or any questions involving professional ethics, shall be considered, acted upon, disposed of and determined only by a medical review committee composed of three Providers selected by the underwriter/administrator from a list of at least ten Providers submitted by the Plan. The Providers shall be afforded an opportunity for a hearing before the medical review committee. At such hearing such witnesses may be heard and such evidence may be received as is deemed relevant and of reasonable probative value, provided, however, that formal rules of evidence need not be adhered to. All testimony shall be stenographically recorded and a complete record shall be kept of the hearing. After the hearing, the medical review committee shall take whatever action it deems appropriate, and issue a written decision. Any action involving suspension or termination of the Provider from participation in the Plan shall be submitted to the Secretary of Health of the Commonwealth of Pennsylvania for approval before it may become effective in accordance with the provisions of 40 Pa C.S.A. Section 6324(a). The Provider may seek judicial review of an unfavorable medical review committee decision to the extent permitted by Pennsylvania law.

9. TERM.

This Agreement shall become effective as of the date of signing, and shall continue for twelve (12) months. This Agreement shall be automatically renewed for successive twelve (12) month periods thereafter on the anniversary date, unless either party notifies the other at least ninety (90) days prior to the anniversary date that this Agreement shall not be renewed. Either party may terminate this Agreement without cause as of the last day of any month by giving written notice of such termination to the other party at least sixty (60) days prior to such termination day.

This Agreement constitutes the entire agreement between the parties and may not be altered, amended, modified or terminated except in writing signed by all parties hereto. This Agreement shall be governed by and construed and enforced in accordance with the laws of the Commonwealth of Pennsylvania.

10. BENEFITS OF PARTIES.

The rights and duties arising hereunder shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, personal representatives, successors and assigns. No rights under this Agreement may be assigned by the Provider without the express prior written consent of the Plan.

11. NOTICE.

Any notice which may be required hereunder shall be deemed to have been sufficiently given to the addressees thereof at the time when sent by certified or registered mail, postage prepaid, providing that notice shall be addressed as follows:

To the PLAN: VANTAGE PPO  
11031 Perry Highway  
Meadville, PA 16335

To the PROVIDER at the address stated below:

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\_\_\_\_\_  
\_\_\_\_\_

12. REPRESENTATIONS.

The Provider represents that the requested information contained in **Appendix A** is true. In the event any representation becomes false in any respect during the term of this Agreement, the Provider shall immediately furnish the Plan in writing with the information necessary to correct representation.

IN WITNESS WHEREOF, the parties have executed this contract at \_\_\_\_\_ (location), on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_(Year).

By signing this document, the Provider attests to the fact that the information provided within this Agreement and **Appendix A** is accurate and thus, releasing the Plan to verify its legitimacy.

PROVIDER

BY \_\_\_\_\_  
Signature

VANTAGE PPO

BY \_\_\_\_\_  
Chief Executive Officer