



Network Facility Handbook

MultiPlan, Inc.
115 Fifth Avenue
New York, NY 10003
www.multiplan.com

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Introduction

This Network Facility Handbook is the “Administrative Handbook” that applies to Network Facility/Health Systems and Ancillary Providers and is referenced in your Participating Facility or Ancillary Agreement, or may be applicable to the Participating Facilities covered under your Participating Health System 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 Facility/Health System or Ancillary Agreement. If a provision in this administrative handbook directly conflicts with state or federal law or the terms of your Participating Facility/Health System or Ancillary Agreement, the state or federal law or your Participating Facility/Health System or Ancillary Agreement takes precedence. For example, if the handbook states a notice time frame of 60 days and your Participating Facility/Health System or Ancillary Agreement states a notice time frame of 90 days, the Participating Facility/Health System or Ancillary 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 Facility/Health System or Ancillary Agreement and the administrative handbook. Instead, the administrative handbook acts to supplement the terms of your Participating Facility/Health Systems or Ancillary Agreement. The terms of this administrative handbook may be modified at the sole discretion of MultiPlan, Inc. In addition to the obligations specified in your Participating Facility/Health System or Ancillary Agreement, this administrative handbook provides information about contractual obligations for Network Facilities and Ancillaries, including any Network Facility/Health System or Ancillary participating in the Network through a subsidiary of MultiPlan including but not limited to, Private Healthcare Systems, Inc. (“PHCS”), HealthEOS by MultiPlan, Inc. (“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 Facility that is party to a Participating Facility/Health System or Ancillary Agreement with MultiPlan, Inc. or one of its subsidiaries, or is obligated directly or indirectly, to comply with the terms of a Participating Facility/Health System or Ancillary Agreement. When “MultiPlan” or “MultiPlan, Inc.” is referenced, it includes MultiPlan 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 Facility Handbook at www.multiplan.com .

Important Definitions

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

- (i) *Ancillary Provider* may be referred to as Vendor
- (ii) *Billed Charges* may be referred to as Regular Billing Rates;
- (iii) *Client* may be referred to as Payor or Company
- (iv) *Contract Rates* may be referred to as Preferred Payment Rates or Specified Rates;
- (v) *Covered Services* may be referred to as Covered Care;
- (vi) *Network Provider* may be referred to as Preferred Provider;
- (vii) *Participant* may be referred to as Covered Individual or Policyholder; and
- (viii) *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 Provider regardless of payment source.

Benefit Program Maximum - An instance in which the cumulative payment by a User has met or exceeded 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 Provider 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 UB04 or HCFA/CMS 1500 (or successor form), as appropriate, or other standard billing format containing all information reasonably required by the Client for adjudication.

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

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 Facility for Covered Services as set forth in the Participating Facility/Health System 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 MultiPlan 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 - 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. Network Providers may be referenced in this handbook individually as "Network Facility," "Network Ancillary Provider" or "Network Professional."

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 MPI 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 - 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.

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 and entitled to receive access to the Contract Rates under the Participating Facility/Health System 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.

MultiPlan'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>

MultiPlan's Participation Requirements and Network Products

Your agreement with MultiPlan is governed by each Client's specific benefit plan. MultiPlan Clients (and their customers) are not required to access every Network offered by MultiPlan, or to access every Network Provider participating in the Network(s) they do access. Therefore, MultiPlan Clients and Users may elect to not access your Participating Facility/Health System or Ancillary 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 have direct contracts with your organization which take precedence over the MultiPlan arrangement.

Under your Participating Facility/Health System or Ancillary Agreement and applicable to all of MultiPlan'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 MultiPlan and/or our Clients in accordance with these rules. In addition, Network Providers will not be reimbursed for procedures that MultiPlan and/or our Clients determine, based on industry standard coding rules, to be fraudulent, wasteful or abusive.

MultiPlan's network products are listed below. A complete list of MultiPlan network brands and authorized logos can be found at <http://www.multiplan.com/webcenter/portal/MultiPlan/ournetworks>.

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.

Complementary Network

The Complementary Network is typically used as a secondary network to a Client's primary PPO. Participants can be directed to Network Providers through online and downloadable directories and a telephonic locator service. A MultiPlan 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 access is

available only to Clients that have contracted with MultiPlan to utilize the Complementary Network in conjunction with Clients' programs either as an extended network or when the program does not utilize another network as primary. Complementary Network Clients may pay for covered services at an in- or out-of network level.

Clients that have contracted with MultiPlan to utilize the Complementary Network are not required to access the terms of your Participating Facility/Health System or Ancillary Agreement, including the Complementary Network Contract Rates, for a specific claim if the Contract Rate for that claim exceeds the maximum amount of reimbursement eligible under the terms of the Benefit Plan or the Client's or MultiPlan's reimbursement policies ("Maximum Reimbursement Policy"), regardless of the identification requirements specified in your Agreement. If the terms of your Participating Facility/Health System or Ancillary Agreement are not applied to the specific claim, you may bill the patient for the balance amount unless otherwise prohibited by state or federal law. Please note that the Maximum Reimbursement Policy is limited to a Client'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. For more information, visit www.multiplan.com/valuepoint.

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. The Network name must be reflected on EOB/EOPs.

Additional Network Participation Requirements

Proprietary Information

All information and materials provided to you by MultiPlan, Clients or Users remain proprietary to MultiPlan, Client or Users. This includes, but is not limited to, your Participating Facility/Health System or Ancillary Agreement and its terms, conditions, and negotiations, any Program, rate or fee information, MultiPlan 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 Facility/Health System or Ancillary Agreement.

Multiple Network Participation Agreements

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

Preferred Facility Responsibilities and Requirements

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;
- Open communication with patients regarding the appropriate treatment alternatives available to the patient, regardless of benefit coverage limitations. Neither Client/User nor Multiplan will penalize you if you in good faith, report to state or federal authorities any act or practice by the Client/User and/or MultiPlan 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 MultiPlan and Client and/or User requests for copies of a Participant's medical and billing records for those purposes which MultiPlan 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 MultiPlan credentialing criteria, as referred to later in this section; and
- Honesty in all dealings with MultiPlan, its Client and Users. As a Network Facility, 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 MultiPlan or any MultiPlan 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, unbundling, up-coding or balance billing.
- You may not be the subject of publicity that adversely affects the reputation of MultiPlan, as determined by MultiPlan. You may not commit professional misconduct that violates the principles of professional ethics.
- You may not engage in any action or behavior that disrupts the business operations of MultiPlan or any Client or User.
- Your responses to inquiries by MultiPlan shall be timely, complete and delivered in a professional manner.

Quality Monitoring Activities

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

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

In addition to the Quality Management Committee, the MultiPlan 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. MultiPlan has established and periodically updates credentialing criteria for all categories of providers it accepts into its Network(s). The credentialing criteria include but are not limited to:

- Accreditation and/or Certification by an approved accrediting/certifying body
- Satisfactory completion of the MultiPlan Request for Information (RFI) and
- Adequate Professional liability insurance; or
- Adequate General liability insurance; and
- State licensure, if required by the state.

The MultiPlan Credentials Committee makes all decisions regarding provider participation in the MultiPlan Network in accordance with MultiPlan credentialing criteria.

Credentialing criteria vary by provider type and applicable law. To obtain a copy of the MultiPlan credentialing criteria, please contact Service Operations via the online Provider Portal at <https://custservice.multipan.com/> or by phone at (800) 950-7040.

Recredentialing

MultiPlan recredentials Network Facilities on a set schedule in accordance with state and federal law and national accreditation standards. MultiPlan reviews accreditation/certification databases as appropriate to confirm that accredited or certified status is current. Recredentialing activities may also be triggered as a result of quality management investigations or information received from state or federal agencies.

Quality Management Program

MultiPlan 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 Providers, 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 Provider 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 MultiPlan Quality Management program. The MultiPlan Quality Management program consists of the following:

Investigation Process

MultiPlan facilitates the complaint investigation process by gathering information from various parties (including the Network Facility involved) to determine the circumstances surrounding the complaint. Requests for information from Network Facilities may include a patient's medical and/or billing records. MultiPlan recognizes that the Network Facility's participation in the investigation process is critical. When requesting information, MultiPlan reports the complainant's concerns and affords the Network Facility 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. MultiPlan conducts the investigation process with strict confidentiality. If the complaint is of a clinical nature, MultiPlan clinical staff (including a MultiPlan 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 Facility. 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.

MultiPlan communicates investigation outcomes and resulting actions directly to the Network Facility involved. If the quality of care rendered at the Network Facility is below acceptable standards, MultiPlan will work with the Network Facility to develop a corrective action plan. If the corrective action plan does not result in acceptable standards of care, MultiPlan may terminate the relationship with the Network Facility. If a Network Facility is terminated from participation in the MultiPlan Provider Network, the Network Facility will be 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.

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 MultiPlan phone number identifier, written notification by Client of an affiliation with MultiPlan at the time of benefits verification, a MultiPlan authorized name or logo on the explanation of benefits form, or other means acceptable to MultiPlan 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. MultiPlan may update the list of authorized logos by posting such Modifications to the MultiPlan 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.

MultiPlan 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.

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. 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 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.

Concurrent Review

Network Facilities 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 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 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 the Participant of any potential financial implications associated with failure to observe the Utilization Management Program protocols.

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 MultiPlan Network for referral purposes, contact Service Operations via the online Provider Portal at <https://custservice.multiplan.com/> or by phone at (800) 950-7040.

Submission of Claims

Claims should be sent as usual by following the instructions on the back of the member's ID card. As a Network Facility, you agree to submit claims for payment within at least ninety (90) days of furnishing healthcare services (or as otherwise required by state or federal law or your Participating Facility/Health System or Ancillary Agreement).. 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 ID card using a UB92 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. MultiPlan recommends that you submit your NPI information as part of your standard submission of practice information updates. MultiPlan supplies this information to MultiPlan Clients and Users for use in electronic transaction processing.

Disputing a Claim

As a Network Provider you and the Client have the right to dispute a claim. When a problem arises, contact MultiPlan Service Operations via the online Provider Portal at <https://custservice.multiplan.com/> or by phone at (800) 950-7040 as soon as possible, as required by your Participating Facility/Health System or Ancillary 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 (unless otherwise specified in your Participating Facility/Health System or Ancillary Agreement).

Timeframe for Disputing a Claim

Following your receipt of payment from the Client or User, you may challenge payments made to you in accordance with the terms of your Participating Facility/Health System or Ancillary Agreement by providing written notice to MultiPlan 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 Providers on a fee-for-service basis. Clients understand the importance of timely payment of Clean Claims. Please refer to your Participating Facility/Health System or Ancillary 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 MultiPlan 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: MultiPlan is not an administrator, insurer, underwriter, guarantor, or payer of claims and is not liable for any payment of claims for services under Programs submitted by the Network Facility to MultiPlan or any Client or User.

Administrative/Facility Fees

When fees are negotiated for care, treatment and supplies pursuant to the MultiPlan Participating Facility/Health System or Ancillary Agreement, it is recognized that such services may include an administrative and maintenance component. As a result, the fees paid for health care services pursuant to the MultiPlan Participating Facility/Health System or Ancillary Agreement include payment for administrative, oversight, overhead and/or similar charges related to the provision of any 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 services.

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 MultiPlan, for any additional procedures thereafter. MultiPlan 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, MultiPlan will provide to Network Provider the specific codes administered by Multiplan that are subject to a multiple procedure payment reduction and/or the current percentage reduction applicable when multiple procedures are included on the claim.

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 in the 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 Provider you may not routinely waive any portion of the Participant's payment obligations.
- As specified in the Participating Facility/Health System or Ancillary Agreement, Participants cannot be billed for the difference between your Billed Charges and the Contract Rate, including 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 MultiPlan 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.

Assignment of Benefits and Release of Medical Information

Clients can pay or arrange to pay Network Facilities 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.

MultiPlan Statement of Member Rights

MultiPlan 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 MultiPlan, the services we provide, the providers in our networks, the rights of members and MultiPlan and PHCS Network providers, and how to contact us regarding concerns about MultiPlan 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 MultiPlan, 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 MultiPlan.

Members have the right to register complaints about MultiPlan, our services, determinations, or the care provided by a MultiPlan or PHCS 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 MultiPlan and/or PHCS 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. MultiPlan and/or PHCS 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.

MultiPlan 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 MultiPlan complaint resolution process. The complaint resolution process is the formal mechanism by which MultiPlan 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

16 Crosby Drive
Bedford, MA 01730
Attn: Corporate Quality Management