PROVIDER SERVICES AGREEMENT

THIS PROVIDER SERVICES AGREEMENT ("**Agreement**"), effective as of ***DATE*** (the "**Effective Date**"), is entered into by and between ***Employer*** ("**Plan**"), and Midwest Physician Administrative Services, LLC DBA Duly Health & Care ("**Providers" or "Provider"**). Provider, Providers and Plan may be referred to individually as a "Party" and collectively as the "Parties:

WHEREAS, each Party wishes to enter into this Agreement to facilitate the delivery of Covered Services (as defined below) by Providers to Participants.

NOW THEREFORE, in consideration of the terms and conditions set forth herein, the parties agree as follows:

SECTION 1. DEFINITIONS

1.1 Covered Services. Covered Services means the health services, drugs, and supplies covered under a contract, certificate, policy, or any other legally enforceable instrument issued and sponsored by Plan to a Participant which contains the terms and conditions of a Participant's coverage for health care services ("Plan Document"). Provider shall provide Covered Services to Participants in accordance with the applicable Plan and this Agreement. A "Participant" shall mean an individual who is enrolled and participating in the Plan and eligible for Covered Services through the Plan Document.

1.2 Non-Covered Services. Provider may bill Participant directly for services that are not Covered Services, so long as Provider, prior to providing such services: (a) informs Enrollee of the specific services that are not Covered Services: and (b) obtains Participant's written consent to assume financial responsibility for such services

SECTION 2. DUTIES OF PROVIDER

2.1 Health Care Services. Provider shall furnish Covered Services to Participants pursuant to the terms and conditions set forth in this Agreement. Provider shall verify the eligibility of Participant(s) prior to furnishing Covered Services, in accordance with Section 3.1. Each Provider shall ensure that its employees, health care Provider, directors, officers, representatives, contractors, and agents ("**Personnel**") comply with the applicable requirements of this Agreement. Provider retain full authority to control their business operations, locations, equipment, Personnel, and scope of services, provided that they also satisfy their respective obligations under this Agreement.

2.2 Standards. Provider shall furnish Covered Services in accordance with applicable law, ethical guidelines, and standards of care. Provider shall not differentiate or discriminate in the treatment of any Participant because of (i) the person's status as a Participant; or (ii) any protected classification, including but not limited to race, national origin, sex, gender, sexual orientation, and disability. Provider shall ensure that the services it generally offers to the public are readily available to Plan Participants.

2.3 Credentialing. Provider and their respective Personnel shall maintain all necessary licenses, accreditations, certifications and/or training required by law and the Plan in order to furnish Covered Services. Providers shall (i) provide Plan Sponsor or its designee with evidence of each Provider's qualifications prior to the Effective Date and upon request; and (ii) as soon as reasonably practical shall notify Plan of any change to such information or the occurrence of any event identified in Section 5.2(b).

2.4 Entities, Locations and Roster. The Provider entities listed on Attachment A may be modified upon written notice to Plan, without the necessity of amending this Agreement. Plan shall add each new entity within thirty (30) days of receipt of notice. Provider shall promptly notify Plan of any changes to the name, address or tax identification number of any Provider entities and Plan shall make such changes in its systems within ten (10) business days of receipt of Provider's notice. Upon request and no more frequently than monthly, Provider shall make a full roster of individual physicians, providers and locations available to Plan or Plan's Administrator.

2.5 Records. Provider shall maintain Participant medical records in compliance with section 6.1 and as required by applicable law. Provider shall provide Plan and government agencies with access to and/or copies of any records related to Participants or this Agreement as reasonably necessary or as required by law.

2.6 Data. Providers and Plan Sponsor shall exchange data necessary to fulfill the purposes of this Agreement, subject to Section 6.1.

SECTION 3. DUTIES OF PLAN

3.1 Participant Identification; Benefits. Plan or its designee shall provide a readily accessible means for verification of Participants' eligibility and benefits in compliance with Section 6.1. If Provider follows the procedure for verification of eligibility or pre-certification or authorization of coverage or benefits and provides Covered Services in reliance on such verification or authorization, Plan Sponsor shall not retroactively deny, withhold, reduce, or request a refund for, payment for any Covered Services if it is later determined that the determination of eligibility or authorization of coverage or benefits was in error.

3.2 Cost Share. For Covered Services rendered by Provider under this Agreement, Plan Sponsor shall either (i) ensure that the Plan does not require any cost share amounts from Participants; or (ii) collect any such cost share amounts directly from Participant.

3.3 Policies and Procedures. Plan reserves the right to adopt and amend policies and procedures for administration of the Plan and this Agreement. Plan shall make any such policies and procedures available to Provider, and, to the extent not in conflict with the terms of this Agreement, Provider agrees to comply with the same. Notwithstanding the foregoing, any policies or procedures which are reasonably likely to: (i) result in denials of claims for payment submitted by Provider; (ii) result in delays of payment for claims submitted by Provider; (iii) change the processes, protocols or procedures Provider must follow in order

for services to be covered or claims to be paid; (iv) require collection of payments from plan participants for covered services; or (v) increase the administrative procedures which Provider must follow or otherwise impose an additional administrative burden on Provider; shall require the prior written agreement of Provider. In the event of a conflict between this Agreement and the Plan's policies and procedures, this Agreement shall prevail.

3.4 Plan Document. Plan retains sole responsibility for ensuring that (i) its Plan(s) and its operations comply with ERISA and any other applicable law; and (ii) its Plan document(s) are consistent with the requirements of this Agreement, such that the terms and conditions of this Agreement may be given full force and effect without violating the Plan document(s). Plan is also solely responsible for ensuring that its designee(s), including but not limited to any third party administrator, comply with the terms of this Agreement.

SECTION 4. PAYMENTS

4.1 Payments. Plan agrees to reimburse Provider at the rates set forth in Attachment B and Provider agrees to accept the rates as payment in full for Covered Services furnished to Participants. Provider shall file any claims with all applicable supporting documentation to Plan/claims administrator no later than ninety (90) days from the last date of service rendered or in circumstances where Coordination of Benefits is applicable, ninety (90) days from the date of processing by the primary payor. Provider agrees to comply with industry standard coding logic, NCCI, and Centers for Medicare and Medicaid Services ("CMS") standards. Claims will be billed using Electronic Data Interface ("EDI") in compliance with section 6.1. A "Clean Claim" shall mean a post service claim for healthcare rendered by Provider during the term of this Agreement which contains all necessary information to determine whether the services rendered by Provider are Covered Services under the Plan. If Plan or Plan's third-party administrator determines that a bill is not a complete claim, it must notify Provider via EDI within fifteen (15) calendar days of receipt of the claim of the specific additional information needed to constitute a complete claim and pay the complete claim within thirty (30) calendar days of receipt of the resubmitted claim from Provider. If the Plan or Plan's third-party administrator fails to notify Provider of additional information needed to complete the claim within fifteen (15) calendar days of initial receipt of the claim, the claim shall be deemed to be complete and paid accordingly. If complete and accurate payment of a complete claim is not received by Provider within thirty (30) days of receipt of the complete claim, Plan shall no longer be eligible for the rates set forth on Attachment B and shall be obligated to pay the claim at Provider's normal billed charges and Provider may elect to terminate this Agreement.

4.2 Coordination of Benefits. Provider shall follow coordination of benefits rules as directed by the Plan. Where Plan is the secondary payor, Provider shall bill and collect from the primary payor before filing applicable claims using the process outlined in Section 4.1. Plan shall pay all the amount which, when added to the amounts paid by other payors, does not exceed the lesser of (i) 100% of Provider's billed charges or (ii) 100% of the reimbursement amount set forth in Exhibit B.

4.3 Overpayments. The parties acknowledge and agree that Plan will not conduct prepayment utilization management for Covered Services rendered by Provider under this Agreement. In the event the Plan determines that it has paid for item(s) and/or service(s) where a finding of fraud, waste or abuse by the Provider is identified, in Plan's sole discretion, Plan may request a refund of such payment upon written notice to the applicable Provider with documentation supporting the refund and Provider shall refund or appeal such overpayment

within thirty (30) days of demand from Plan. Disputes about such overpayments shall be subject to the dispute resolution procedures set forth in Section 6.5. Plan may not seek refund of an overpayment from Provider more than one hundred eighty (180) days after the payment date.

4.4 Survival. This Section shall survive the termination or expiration of the Agreement for any reason.

SECTION 5. TERM AND TERMINATION

5.1 Term. The term of this Agreement shall be for one year commencing on the Effective Date and shall continue from year to year thereafter unless terminated pursuant to the terms of this Agreement.

5.2 Termination.

a. Either party may terminate this this Agreement by giving at least one hundred and twenty (120) days' advance written notice of termination to the other party; provided, however, that no such termination shall be effective prior to the first anniversary of the Effective Date.

b. Notwithstanding anything to the contrary set forth herein, a party may terminate this Agreement for cause in the following circumstances: (i) upon written notice to the other party if either party becomes insolvent; or (ii) upon written notice in the event of a material breach of this Agreement by the other party not remedied within sixty (60) days after notice thereof from the terminating party.

c. Plan may terminate this Agreement or a Provider immediately by written notice in the event Provider: (i) fails to maintain licensure or accreditation; (ii) fails to maintain insurance as required by this Agreement; (iii) is convicted of a crime; (iv) is excluded from a federal health care program; (v) is insolvent; or (vi) engages in fraud, waste or abuse.

d. Any obligation arising prior to the date of termination, and any provision that by its nature is intended to survive, shall survive termination.

e. Upon termination of this Agreement, unless termination was due to quality of care issues or as otherwise directed by Plan or Payor, Provider shall continue to provide Covered Services pursuant to this Agreement to Participants who are patients for up to ninety (90) days following the termination to support continuity of care and/or to allow Participants to transition to other health care providers.

SECTION 6. GENERAL PROVISIONS

6.1 HIPAA, Confidentiality, Non-Disclosure.

a. The parties, Plan Sponsor and Providers shall comply with all applicable laws and regulations regarding maintenance and disclosure of Participants' medical records, secure exchange standards inclusive of HIPAA Administrative Simplification standards and other individually identifiable health information. In particular, the Parties, Plan Sponsor and Providers shall comply with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and the applicable rules and regulations promulgated thereunder, all as amended from time to time (collectively, "**HIPAA**").

b. The Parties, Plan Sponsor and Providers shall keep strictly confidential any and all proprietary information of any of the other entities that may be given or disclosed, or that may be learned directly or indirectly, pursuant to this Agreement. In addition, no Party, Plan Sponsor or Provider shall use such confidential information for its own benefit (other than to implement this Agreement) or disclose such confidential information to any other person or entity (except those professional advisors who are bound to confidentiality) without the express prior written consent of the entity that owns or controls the confidential information, or as required by law. Notwithstanding the foregoing, this Agreement and its attachments shall not be considered confidential information hereunder.

c. This Section 6.1 shall survive the termination of this Agreement.

6.2 Patient Choice/Discussion of Treatment Options. The parties acknowledge and agree that nothing in this Agreement shall be construed to (i) interfere with a Participant's freedom of choice to receive medical services from Providers or any other health care provider; or (ii) prohibit, impede, or interfere in discussions between Participants and health care providers regarding medical treatment options. A Provider shall be under no obligation to furnish a Covered Service to which the Provider has a moral or ethical objection.

6.3 Independent Contractors. None of the provisions of this Agreement are intended to create any relationship between Plan and Provider other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. None of the Parties hereto, nor any of their respective employees, shall be construed to be the agent, employer, or representative of the other.

6.4 Insurance. Provider shall maintain for itself and participating Providers professional and general liability insurance which covers their respective acts and omissions in providing and arranging for or denying health care services under this Agreement, in amounts reasonably consistent with the coverage amounts of other similarly situated Providers or networks in the community.

6.5 Dispute Resolution. The Parties hereto agree to adhere to the dispute resolution process outlined in Plan or Plan's Administrator provider policies and/or manual per section 3.3 to resolve all disputes including but not limited to claims payment, administration, or operational issues. If the dispute is not resolved through this process within ninety (90) days, the Parties agree their sole and exclusive remedy is through arbitration administered by the American Arbitration Association ("AAA"). In such arbitration, the arbitrator shall have authority to award only compensatory and not punitive damages. Further the prevailing party shall be entitled to an award of attorney fees and costs.

6.6 Modification for Change in Law. To the extent that any law, rule, regulation or standard of any authority having jurisdiction over a party to this Agreement or the subject matter of this Agreement (including an applicable accrediting agency) shall raise question as to the legality, enforceability, or appropriateness of this Agreement or any provision hereof, the Parties agree to negotiate promptly regarding any modification needed to bring this Agreement into compliance with such applicable law, rule, regulation or standard. Should the Parties be unable to agree upon such modification within a period of thirty (30) days from the date either Party gave notice of the issue to the other party, or within such shorter period of time necessary to avoid illegality, this Agreement may be terminated by either Party upon notice to the other party.

6.7 Entirety and Modification. This Agreement, together with the exhibits which are hereby incorporated by reference, constitutes the entire agreement between the Parties with respect to the subject matter hereof, and as of the Effective Date, shall supersede any previous agreements or understandings, written or oral, between the parties. Except as otherwise set forth herein, all modifications of the Agreement shall be in writing and signed by both Parties.

6.8 Governing Law. This Agreement shall be interpreted and governed by the laws of the State of Illinois, without regard to any conflicts of law principles, and without regard to any construction in favor of either party by reason of the drafting of this Agreement.

6.9 Assignment. Neither Party may, without the express written consent of the other Party, assign this Agreement. Any such transfer or assignment shall be void. Notwithstanding the above, either Party may assign, delegate, or transfer this Agreement following reasonable notice to any affiliate or any entity that controls, is controlled by, or that is under common control with that Party now or in the future, or which succeeds to its business through a sale, merger, or other corporate transaction. However, the assignee, transferee, or designee without modification shall assume all rights and obligations.

6.10 Compliance with Laws. Each Party, Plan Sponsor and Provider will conduct itself in full compliance with applicable federal, state and local law. This Agreement has been

negotiated in an arms-length transaction and (i) does not require or guarantee any minimum level of Covered Services to be provided here under; and (ii) does not take into account any referrals or other business that may exist between the parties.

6.11 Indemnification. Provider agrees to protect, indemnify and hold harmless Plan and claims administrator and its agents, employees, directors, officers and affiliates (collectively, the "Plan Affiliates") from and against any and all damages, injuries, claims, liabilities and costs (including reasonable attorneys' fees) which may be suffered or incurred under this Agreement, as a result of a breach of this Agreement by, or the negligent or intentional acts of, Provider, its officers, directors, employees (including participating Providers), agents, consultants, affiliates, or subcontractors. Said indemnity is in addition to any other rights that the Plan Affiliates may have against Provider and will survive the termination of this Agreement.

Plan agrees to protect, indemnify and hold harmless Provider and its agents, employees, directors and affiliates from and against all damages, injuries, claims, liabilities and costs (including reasonable attorneys' fees) which may be suffered or incurred under this Agreement, as a result of a breach of this Agreement by, or the negligent or intentional acts of, Plan.

6.12 Waiver of Breach. The waiver of any breach of this Agreement by either Party shall not constitute a permanent waiver or continuing waiver of any subsequent breach of either the same or any other provision of this Agreement.

6.13 Severability. If any provision of this Agreement is held to be illegal, invalid, or unenforceable for any reason, that provision shall be read out of the Agreement and shall not affect the remaining portions of this Agreement unless such illegality or unenforceability frustrates the objectives and purposes of this Agreement rendering performance impossible. In that event, the Parties will immediately commence negotiations to reform the contract and or remedy the offending provision(s).

6.14 Force Majeure**.** Neither Party shall be liable for any failure to timely perform its obligations under this Agreement if prevented from doing so by a cause or causes beyond its commercially reasonable control including, but not limited to, war, fire, explosion, insurrection, riots, government requirement, civil or military authority, flood, the elements, earthquakes, acts of God, act or omission of transportation, energy, utility or communication facilities, services or companies, or other similar causes beyond its reasonable control ("Force Majeure Events").

6.15 Use of Names**.** Either Party may use the other Party's name only for the purpose of advising Members of Provider's ability to provide Covered Services to Members. Such advisement may be in the form of a printed or electronic announcement.

6.16 Notice. Any notice required to be given pursuant to the terms and provisions of the

Agreement shall be in writing and shall be sent via certified mail or commercial overnight carriers, return receipt or signature required, or by successful transmission of electronic mail, to the addresses below or such other addresses as may be later designated by either Party hereto:

If to Plan:
Name: _____
Attn: _____
Address: _____
Email: _____

If to Provider:
Name: _____
Attn: _____
Address: _____
Email: _____

6.17 Waiver of Breach; Severability. If either party waives a breach of any provision of this Agreement, it shall not operate as a waiver of any subsequent breach. If any portion of this Agreement is deemed unenforceable for any reason, it shall not affect the enforceability of any remaining portions.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as set forth below.

Plan	**PROVIDER**
Signature:	Signature:
Name:_____	Name:
Title:	Title

ATTACHMENT A

List of Applicable Entities and TINs

ATTACHMENT B

Reimbursement Rates

Reimbursement to Provider shall be paid at the lesser of Provider's total billed charges or the applicable percentage of current Medicare allowable, listed below, based on Provider's locality and licensure.

All Covered Services billed with CPT/HCPC that do not have an assigned Medicare reimbursement, or other specified allowable below, will be reimbursed at the indicated percent of Provider's total billed charges.

Covered Services shall be reimbursed XXXXXX of the current year Medicare allowable. Ech year, the rates will increase by the lesser of 3% or Medical CPI.

All Covered Services billed with CPT/HCPC that do not have an assigned Medicare reimbursement shall be reimbursed at XXXXX of Provider's billed charges.